

**A case study of Public Private
Partnerships in the Health Sector
in Malawi**

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Table of Contents

Executive Summary	2
1. Introduction	4
2. Background.....	5
2.1 An overview of public private partnerships in the health sector	5
2.2 The context for PPPs in the Malawi economy	6
2.3 Health sector organisation and financing	7
2.4 Population health profile	8
3. Policy and legal context for PPPs in the health sector in Malawi	9
3.1 Public-Private Partnerships in the Health Sector in Malawi	10
3.2 Service Level Agreements in health sector in Malawi	11
4. Health equity implications of PPPs in health sector in Malawi	12
5. Conclusions	13
6. References	15

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Executive Summary

Healthcare delivery in Malawi is provided by both the public and private sectors, by government, private-for-profit services, the faith based private-not-for-profit Christian Health Association of Malawi (CHAM), non-governmental organisations and faith based organisations other than CHAM. While there are various forms of Public Private Engagement (PPE) in Malawi, including social marketing, contracting out, public-private mix in health related sectors, integration of private sector in Sector Wide Approaches (SWAp), financial support and voucher programmes, and regulation of dual practice, and while some PPPs are under consideration, the government partnership with CHAM is the only PPP where government and private sector co-operate in health service delivery.

A Public-Private Partnership (PPP) is a legally enforceable contract in which a contracting authority partners with a private sector partner to build, expand, improve, or develop infrastructure or service. In a PPP the contracting authority and private sector partner contribute one or more of the know-how, financial support, facilities, logistical support, operational management, investment or other input required for the successful deployment of a product or service, for which the private sector partner is compensated in accordance with a pre-agreed plan. The payment typically takes note of the risk assumed and the value of the result to be achieved. Payment to the private partner can be through service user fees, budget allocation or a combination of the two (Malawi Govt., 2011).

This desk review was commissioned by the Regional network for Equity in Health in southern Africa (EQUINET) as a case study within wider regional work on PPPs in the east and southern Africa region. It explores PPPs in health sector in Malawi. It investigates the areas which government has used PPPs in the health sector, and their implications for equity in financing and access to services.

Specifically, the case study aimed to:

- a. Identify the different types of PPPs being explored, advocated and implemented in Malawi in the health sector, their activity and key features, and relevant contextual features such as in the fiscal, regulatory and contracting arrangements.
- b. Present the health sector and health equity implications for the particular PPPs found, particularly in terms of equity in financing; coverage, their social, labour and environmental consequences and their governance and management.
- c. Draw summary conclusions on the health sector and health equity risks and benefits in PPPs in the health sector in Malawi and make related recommendations.

The desk review identified from the available literature that:

- a. Malawi's policy framework is supportive of PPPs. The Health Sector Strategic Plan recognises the need for PPP to improve health infrastructure and equipment. The Public Private Partnership Commission has health sector as one of the areas eligible for PPPs. One of the five reforms in health sector is a PPP.
- b. The PPP between government and CHAM is on service provision and is implemented through Service Level Agreement (SLA) between local councils through District Health Office (DHO) and CHAM health facilities in the respective district. The SLAs have evolved over the years. Their scope of coverage has expanded from maternal and child health, to now cover all the essential health package interventions and additional services such as for injury from road traffic accidents. They have also expanded in number to a current figure of 146 facilities. The management of the framework has improved with establishment of SLA Management Unit.

- c. SLAs have been effective in improving service utilisation and in cost effectiveness supporting progress towards universal healthcare coverage, with some evidence of value for money.
- d. The equity gain in this PPP arises in CHAMs status as a not-for-profit provider that services mostly rural areas where the majority of the population lives and where poverty is high. SLAs help to enhance this by ensuring that services are free at point of care to support access, and by ensuring that the services are those at in Malawi's EHP and provided to an agreed standard, through both a central and local level contracts.
- e. However the SLAs also face challenges such as delayed payment by government to CHAM, cost escalation, and insecure government funding that undermine their performance and these potential gains. Cost escalation has arisen due to CHAM purchasing medicines from private suppliers when the Central Medical Stores Trust runs out of stock. Other challenges found included lack of transparency, poor communication, inadequate human and material resources and lack of systems to monitor performance of the SLAs.

The findings suggest that the equity impacts could be enhanced by addressing some of the current challenges, including:

- i. Ensuring and reporting on the effectiveness of the designated SLA Management Unit in improvement the management and oversight of SLAs.
- ii. Ministry of Finance, Economic Planning and Development and Ministry of Health and Population identifying earmarked revenue sources and other forms of mandatory prepayment to support health care financing and improve funding predictability to address challenges of delayed payments to CHAM and expand service delivery.
- iii. Ministry of Health and Population and PPPC exploring the PPP framework for health infrastructure and equipment development and skills transfer for improving services for non-communicable diseases to offer these in Malawi and avoid referral of cases to India and South Africa for treatment. This may save foreign exchange and enhance capacities for and access to these services. The current plan for this in relation to the National Cancer Treatment Center could this be extended to other non-communicable diseases.

1. Introduction

Healthcare delivery in Malawi is provided by both the public and private sectors. Recent count indicates that there are 1,545 health facilities owned by government (696;45%), private-for-profit (495; 32%), the faith based private-not-for-profit Christian Health Association of Malawi (CHAM) (192;12%), non-governmental organisations (65;4.2%). The rest (6.8%) are owned by faith based organisations other than CHAM (MoHP, 2020). There are also a few established companies that run medical insurance. These include Medical Aid Society of Malawi (MASM), Horizon and Med-health. The financial sector especially banks and non-health insurance companies have also designed health-related products such as funeral plans.

Although the facility count cited above places private-for-profit second after government, in terms of service provision, CHAM facilities play a major role after those provided by government, as the majority of CHAM facilities are in rural areas where 80% of Malawi population lives (NSO, 2018). Further, the fee charged for CHAM facilities is affordable and for the essential healthcare package (EHP), CHAM facilities provide services free of charge at point of access as part of a Service Level Agreement (SLA) which government and CHAM have implemented since 2006 (Zeng et al., 2017).

A Public-Private Partnership (PPP) is a legally enforceable contract in which a contracting authority partners with a private sector partner to build, expand, improve, or develop infrastructure or service. In a PPP the contracting authority and private sector partner contribute one or more of the know-how, financial support, facilities, logistical support, operational management, investment or other input required for the successful deployment of a product or service, for which the private sector partner is compensated in accordance with a pre-agreed plan. The payment typically takes note of the risk assumed and the value of the result to be achieved. Payment to the private partner can be through service user fees, budget allocation or a combination of the two (Malawi Government, 2011).

This paper was commissioned by the Regional network for Equity in Health in southern Africa (EQUINET) as a case study within wider regional work on PPPs in the east and southern Africa region. It explores PPPs in health sector in Malawi. It investigates the areas which government has used PPPs in the health sector, and their implications for equity in financing and access to services. Specifically, the case study aimed to:

- d. Identify the different types of PPPs being explored, advocated and implemented in Malawi in the health sector, their activity and key features, and relevant contextual features such as in the fiscal, regulatory and contracting arrangements.
- e. Present the health sector and health equity implications for the particular PPPs found, particularly in terms of equity in financing; coverage, their social, labour and environmental consequences and their governance and management.
- f. Draw summary conclusions on the health sector and health equity risks and benefits in PPPs in the health sector in Malawi and make related recommendations.

The study used a desk review of relevant documents from internet searches using search terms reflecting the areas identified in the objectives above. The online sources included the Malawi Ministry of Health website, Google and EQUINET. Some documents were sought from officials in the Ministry of Health and Population. While some of the available information was not up-to-date, to the extent practically possible use was made of the most recent available information.

2. Background

2.1 An overview of public private partnerships in the health sector

PPPs as defined earlier are a form of partnership within the more comprehensive concept of Public Private Engagement (PPE). Other forms of PPE include social marketing, contracting out, various forms of public-private mix in health related sectors, integration of private sector in Sector Wide Approaches (SWAp), financial support and voucher programmes and regulation of dual practice. PPEs are deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programmes (Whyte and Olivier, 2016). According to this description, Malawi has implemented a number of PPEs including social marketing, contracting out, public private mix, SWAp, PPPs and a voucher programme (Whyte and Olivier, 2016). While these PPEs are pertinent to the public-private mix in health in Malawi, this case study only examines the specific form of PPP where government and private sector co-operate in health service delivery.

PPPs are recognized globally as a way of resourcing for delivering services including healthcare (Hellowell, 2019). Sustainable Development Goal (SDG 17) advocates for countries to encourage and promote effective public, public-private and civil society partnerships in all areas including health, building on the experience and resourcing strategies of partnerships (UN, nd). Generally, the drive for partnerships in the health sector is said to have been fueled by three triggers: a shift in philosophy about the roles of the private and public sectors; a recognition by both public and private sectors of their interdependence and a better understanding of how each party can gain from the partnership (Mitchell, nd).

A partnership is defined as a relationship based upon agreements, reflecting mutual responsibilities in furtherance of shared interests (OECD, 1996). Raman (2009) argues that not all interactions qualify as a PPP, describing a PPP as having clear terms and conditions; clear partner obligations; clear performance indicators; a stipulated time period and clear overall health objectives.

Mitchell (n.d) stresses that two elements are critical for a partnership; the specification of shared interests or objectives of the partnership; and mutual responsibilities. For the former, partnerships work when both parties benefit from the relationship and the benefits are made in advance. For the latter, partners must understand that they will share both risks and benefits and the sharing model should be specified in advance (Mitchell, nd). Buse and Walt (2000) observe that a successful partnership has the following characteristics;

- a. clearly specified, realistic and shared goals;
- b. clearly delineated and agreed roles and responsibilities;
- c. distinct benefits for all parties;
- d. the perception of transparency;
- e. active maintenance of the partnership;
- f. equality of participation; and
- g. meeting agreed obligations.

Buse and Walt (2000) identify shared policy goals, and Raman (2009) identifies that a PPP implies that policy (including governance) and operational (including performance) rules of the agreement must be shared and known in advance. Thomas and Curtis (2003) contend the distinguishing feature of PPPs to be that parties develop a shared governance structure and decision-making process.

There are arguments for and against PPPs. PPPs are identified as having benefits in that the immense threats to health cannot be tackled by governments alone; that PPPs enrich the capacity, quality, and reach of public health services; that partnerships help to put health in all policies; that they improve self-regulation and that PPPs promote sustainable business models that allow innovation in more healthful design and content of products (Parker et al., 2019). Hellowell (2019) argues that governments often favour PPPs over public procurement because they provide access to private capital. This is seen to impact on public budgets enabling up-front expenditures to be deferred. PPPs are also seen to transfer risk in relation to infrastructure and service delivery to the private sector resulting in the state realizing better value for money.

Arguments against PPPs include that alliances between public and private sectors have inherent conflicts of interests that cannot be reconciled when the products or services provided by the private partner are harmful to health. Collaboration in health promotion is argued to confer legitimacy and credibility on industries that may lead to harms to health, damaging the credibility of public health institutions. Public-private interactions are seen to potentially lead to institutional capture, such as when companies influence governments to undermine regulatory measures to protect population health, including by regulations relating to tax (Parker et al., 2019). There is caution that weaknesses in the State's capacity to run competitive procurements, write complete contracts and budget for them may generate risks for public budgets and providers (Hellowell, 2019). An evaluation of 36 PPPs in different high and low income countries concluded that some PPPs were costly and difficult to manage by the public sector (Parker et al', 2019).

These potential positive and negative impacts make it important to have background information to define and demonstrate the characteristics, features of any PPP, to understand their strengths and weaknesses as well as what government needs to put in place to control risks and ensure benefit in PPPs.

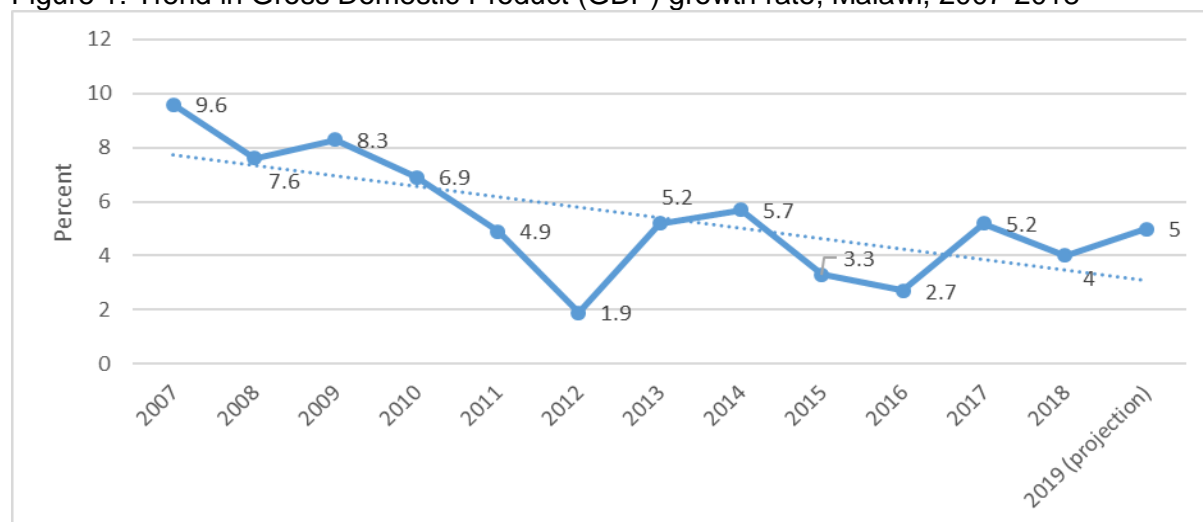
2.2 The context for PPPs in the Malawi economy

The state of economy has influence on health status of the population and on the resources for and nature of health services. The economy signals what form of PPP can work and what financing modalities are feasible.

Malawi is a landlocked country located in Southern Africa. With a per capita income of US\$389 and a human development index of 0.485 (UNDP, 2019), Malawi is a low income country according to the World Bank classification, a least developed country by Organization of Economic Cooperation and Development (OECD) classification and a low human development country according to the United Nations. Poverty is pervasive with 51.5% of the population living below a US\$1 poverty line. Inequality is high with a gini coefficient of 0.45 (UNDP, 2019). Economic growth has been low in recent years and has taken a downward trend, as shown in *Figure 1* overleaf. This has affected the capacity to finance healthcare services.

High poverty and wide income inequality underlie high levels of poverty related diseases and a large proportion of population depending on public healthcare services, unable to afford private health services, or covered by employer supported medical aid schemes. A weak economy and financing capacity can also limit the scope and scale of PPP frameworks that government can negotiate with private sector.

Figure 1: Trend in Gross Domestic Product (GDP) growth rate, Malawi, 2007-2018

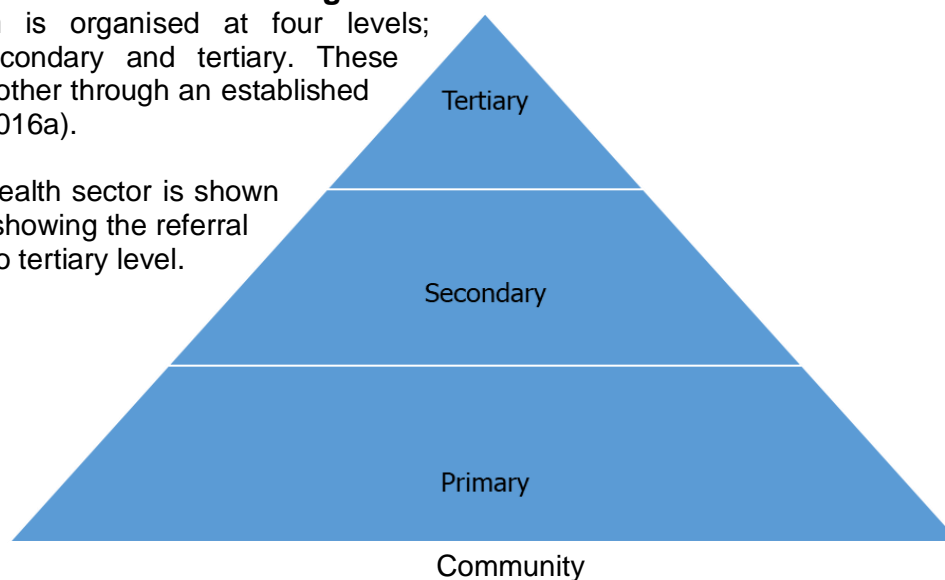


Source: Ministry of Finance, Economic Planning and Development, 2018; 2019

2.3 Health sector organisation and financing

Malawi's health system is organised at four levels; community, primary, secondary and tertiary. These levels are linked to each other through an established referral system (MoHP, 2016a).

The organogram in the health sector is shown in the pyramid adjacent, showing the referral system from community to tertiary level.



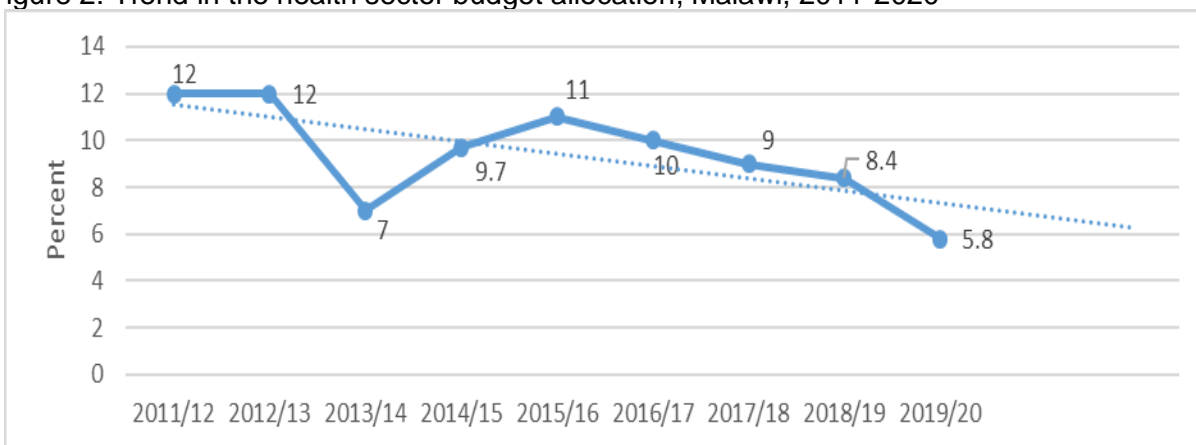
The private health sector comprises both private-for-profit and private-not-for profit (Kachala, 2011). The private-for-profit sector includes private practitioners' associations, private practitioners and private facilities. The private practitioners include dentists, doctors, nurses, clinical officers, traditional healers and informal shops. The private facilities include hospitals, chemists/pharmacies, health centers and others. The private-not-for profit sector includes faith based facilities such as CHAM, Partners in Hope, and Muslim supported health services. Non-governmental organisations and civil society organisations' facilities include Banja La Mtsogolo (SHOPS Project, 2012). According to aggregated data from the 2004 MDHS, 58.7% of caregivers sought treatment for illnesses in a child under five from the private sector, compared to 41.3% from the public sector. The majority 82% of these private sector services for child

health were delivered by non-formal providers, primarily “stores”. As of 2010, 3.9% of people on antiretroviral therapy obtained this treatment from the private sector (SHOPS Project, 2012).

Malawi’s Health Sector Strategic Plan (HSSP II) for 2017-2022 estimates a total cost of US\$3.2 billion to deliver the plan over the 5 years of its implementation. It estimates that costs would increase from US\$629 million in 2017/18 to US\$646 million in 2021/2022 with total cost per capita ranging from US\$35 to US\$37, lower than the 2011 figure of US\$44 (MoHP, 2017; MoHP, 2016b). (See *Figure 2*).

The World Health Organization (WHO) recommends a minimum per capita expenditure on health of US\$86 for the essential health services and health system strengthening. Health sector allocation has been lower than the recommended 15% of national budget as per the Abuja Declaration commitment. This has led to domestic financing being overshadowed by external, foreign funding. Between 2012/13 and 2014/15, the financial contribution to total health expenditure (THE) of external funders accounted for 61.6%, followed by public financing at 25.5% and private financing at 12.9%. During the same period, out of pocket payment (OOP) averaged 8.5% of THE (Ministry of Health and Population, 2016b).

Figure 2: Trend in the health sector budget allocation, Malawi, 2011-2020



Sources: Ministry of Health and Population, 2019; UNICEF, 2019; Oxfam, 2016

2.4 Population health profile

Health outcomes in Malawi have improved over the years, thanks to efforts of government, development partners, non-governmental organisations and civil society organisations. Life expectancy has improved from 39 years in 1960 to 55 years by 2015, while some estimates set it at 63 years (World Bank, nd). HIV prevalence among people 15-49 years old is currently at 8.8%, a decline from 11.8% in 2004. Between 1992 and 2016, the under five year old mortality rate decreased from 234 to 63 deaths per 1,000 live births. Over the same period, infant mortality declined from 135 to 42 deaths per 1,000 live births. Maternal mortality decreased from 1,020 to 439 deaths per 100,000 live births over the same period. Neonatal mortality per 1,000 live births declined from 41 in 1992 to 27 in 2016 (NSO and ICF Macro, 2017).

There are new challenges. The 2016 National Health Accounts report acknowledges that non-communicable diseases are increasing, threatening a double burden of disease. Collectively, non-communicable diseases are THE second leading cause of death in adults after AIDS, accounting for 16% of all deaths, with 17% in males and 14% in females (MoHP, 2018). The report further showed that 61% of health spending was allocated to combat three disease

conditions, namely HIV/AIDS, malaria and reproductive health which collectively account for 58% of the burden of disease (MoHP, 2016b, See *Table 1*).

Table 1: Leading causes of Disability Adjusted Life Years in Malawi in 2016

	Conditions	% total DALYs
1	HIV/AIDS	18.33
2	Malaria	7.96
3	Lower respiratory track infections	7.93
4	Diarrhoeal diseases	6.00
5	Neonatal encephalopathy	5.12
6	Neonatal preterm birth	3.83
7	Protein-energy malnutrition	3.09
8	Meningitis	2.71
9	Tuberculosis	2.62
10	Neonatal sepsis	2.44

Source: Ministry of Health and Population, 2018

Inequalities in health outcomes are characterized by location (rural versus urban), wealth quintile and education level. The lowest wealth quintile households tend to have more children, with 5.7 children per woman, than highest wealth quintile, with 2.9 children per woman. The teenage pregnancy rate is 29% and unmet need for family planning for age group 15-19 years is 22.2%, the highest for all age groups and higher than the average 19% (NSO and ICF Macro, 2017). The fertility rate is higher among households with no education, at an average of 5.5 children, than in households with more than secondary education, where the average is 2.3 children. The under five year mortality rate per 1,000 live births is 77 in rural areas compared to 61 in urban areas. By wealth quintile, the under five year mortality rate per 1,000 live births is 83 for lowest quintile and 60 / 1 000 for highest quintile (NSO and ICF Macro, 2017). These wide variations call for some form of financial protection to enable poor households to access health services, especially where government facilities are far apart.

3. Policy and legal context for PPPs in the health sector in Malawi

PPPs in Malawi are implemented through the Public Private Partnership Commission (PPPC). The PPPC evolved from a Privatisation Commission established in 1996 to implement divestiture of direct or indirect State Owned Enterprises within the Structural Adjustment Programme (PPPC, nd). The country embraced PPPs in 2005 to obtain anticipated benefits, including: acceleration of infrastructure provision through mobilisation of private sector capital; reduced overall costs due to private sector efficiencies; incentives to perform due to the private sector link between payment and performance; as well as generation of additional revenue as a result of the technical expertise in the private sector and efficiencies produced. In 2011, a PPP Policy was passed and later in the same year a PPP Act enacted, with the law becoming effective in July 2012. The Privatisation Commission was renamed Public Private Partnership Commission in 2013 (PPPC, nd).

Malawi's HSSP II aims to achieve universal health coverage of quality, equitable and affordable health care to improve health status, financial risk protection and client satisfaction (MoHP, 2017). It aims to increase equitable access to and quality of health care services delivery through providing the basic health package free at the point of access to all who need it, while ensuring that defined quality standards are adhered to. Regulatory bodies such as Medical

Council of Malawi, Nurses and Midwives Council of Malawi and Pharmacies and Poisons Board monitor operations of both public and private providers. The HSSP II addresses the need to improve availability and quality of the health infrastructure and medical equipment. One strategy identified for this is to explore PPP options for medical equipment acquisition and management. The HSSP II states a need to enhance opportunities for, and strengthen efficiency and effectiveness of PPPs (MoHP, 2017). This however is yet to be implemented. Government is constructing a National Cancer Treatment Center (NCTC) that will provide paying and non-paying chemotherapy and radiotherapy services. It is reported that government will seek a PPP for the private partner to recruit staff, mobilise equipment and offer services for this service, while government will regulate services and negotiate prices (AfDB, 2017). Since construction of the NCTC is underway and the PPP is yet to be negotiated, it is not covered in this case study.

3.1 Public-Private Partnerships in the Health Sector in Malawi

The health sector is among the priority areas which the PPC has earmarked for PPPs. The Ministry of Health and Population (MoHP) proposed five reform areas in the recent public service reform program which started in June 2014. In totality, the health sector reforms aim at improving equity in access to services and financing of services, increased efficiency, resourcing and management. The reforms include revision of the PPP with CHAM as pertinent to this case study; as well as other areas including central hospital reforms; decentralization of the district health system; establishment of a Health Fund and establishment of a national healthcare insurance scheme (MoHP, 2017). The decentralization of district health systems includes outsourcing of non-core functions as a form of PPE. The reforms thus include two PPEs, one of which is a PPP. Implementation of the outsourcing is yet to start. Thus the only PPP currently in force in the health sector is that between government and CHAM.

There are other forms of PPE underway. For example, government is implementing an Immunisation and Health System Strengthening Project with funding support from Gavi in collaboration with civil society organisations led by Malawi Health Equity Network (MHEN). In this project, government receives funds from the external funder and transfers part of the funds to civil society organisations to fulfill tasks in which MHEN and partners have comparative advantage. The parties have different roles which complement each other. They have joint meetings to share information. In another project called 'N'zatonse' (it is for us all), the German government through KfW gave support to government and Population Services International to promote sexual and reproductive health. The Global Fund program is another with PPE features. In Malawi, Global Fund resources are managed by ActionAid, World Vision and the National AIDS Commission (NAC) as principal recipients. NAC is a government entity while ActionAid and World Vision are international non-governmental organisations. The three sub grants to implementers thus include non-government entities. Malawi is one of the four countries implementing a Regional Tuberculosis (TB) in Mining Project financed by the World Bank. Through this project, as a form of private-public mix, government has partnered with private sector, including pharmaceutical companies, to increase uptake of services for TB control and management of occupational lung diseases (MoHP, nd).

Applying the descriptions of Whyte and Olivier (2016), the GAVI, N'zatonse and Global Fund programs appear to be global PPPs as a form of PPE. By definition, these are a collaborative three-way partnership, including international funders and recipient governments, usually funded by multinational health initiatives through a substantial disbursement of funds in which both government and non-government entities participate in decision-making through a mutually agreed upon and well defined division of labour (Buse and Walt, 2000; Whyte and Olivier,

2016). The next section focuses on the more conventional PPP in Malawi, the partnership between government and CHAM.

3.2 Service Level Agreements in health sector in Malawi

Collaboration between Christian health institutions and government existed in pre-independent Malawi, but were not formalised. In 1965, stakeholders of Christian owned health facilities recommended the establishment of an association called Private Hospital Association of Malawi (PHAM) which was registered with the Registrar General on 1 December, 1966 under the Trustees Incorporation Act. In 1992 the name was changed to CHAM (Kachala, 2011).

Despite having fewer facilities in number than the private-for-profit health facilities, as shown earlier, CHAM facilities service more people, especially in rural areas where there are a higher share of poor people working in informal sector farming without any form of employer-supported medical aid scheme. The first Memorandum of Understanding (MOU) between MoHP and CHAM was signed in 2002 (Beyeler et al, 2018). Since 2006, MoHP and CHAM have signed Service Level Agreements (SLAs) which are reviewed and renewed annually (Zeng et al., 2017). There are eligibility criteria for a CHAM facility to enter into SLA with government. They include: that the facility is registered with Medical Council of Malawi; that the facility provides primary healthcare services outside 8km radius of a non-paying facility; and that subject to the preceding criterion, the catchment population is higher than 7,000 persons (Zeng et al., 2017).

Over time, there has been an evolution in the scope of services provided under SLA, the number of CHAM facilities entering into SLA and the management of SLA. At the start, SLAs covered maternal and child health. Over time, the services have included all services in Malawi's Essential Health Package (EHP) and those covering injury from road accidents and outpatient services (MoHP, 2019). An EHP is a package of services that the government is providing or is aspiring to provide to its citizens in an equitable manner (Wright, 2015). EHP interventions currently cover reproductive, maternal, neonatal and child health; malaria; immunisable diseases; community health; HIV/AIDS; neglected tropical and non-communicable diseases; oral health and integrated management of childhood illness (MoHP, nda).

Two contracts are signed. One is between MoHP and CHAM secretariat which is an MoU specifying the terms of the agreement. Another is between District Health Office (DHO) and CHAM facilities in the respective district. This specifies the services to be provided and the prices to be charged for each service (Ministry of Health and Population, 2019). Government reimburses 70% of cost at actual market value for services provided. The remaining 30% is absorbed by CHAM in a spirit of cost-sharing (Zeng et al., 2017). (See *Box 1*).

Box 1: Contractual terms of the SLA

- a) Maximum reimbursement amounts are set in advance based on the population in the facility's catchment area. Reimbursement rates for each type of service are standardized at the national level by an SLA task force, but the maximum reimbursable rate is set annually for each facility based on assessment by the District Health Office (DHO).
- b) The type of services eligible for inclusion in the SLA are determined by the DHO based on an assessment of facility capacity, the health needs of the catchment area, and the availability of financial resources at the district level.
- c) Services covered by the SLA must be provided to patients free of charge.
- d) Only services provided to patients living within a facility's catchment area are eligible for reimbursement. (Beyeler et al., 2018)

In the MoU, government pays salaries for healthcare workers in CHAM facilities and also provides free or subsidized essential medicines for programs such as TB, HIV/AIDS, immunization, maternal and child health conditions (Beyeler et al., 2018). Resources for reimbursement are drawn from a pool in a Health Services Joint Fund, funded by external funders, including Germany, United Kingdom, Flanders and Norway. Germany through KfW Development Bank supported a project on strengthening Public Private Partnership within the health sector which targeted SLAs to the tune of Euro 6.8 million (EPOS Health Management, 2013).

As of the 2018/19 fiscal year, 146 SLAs were in force, an increase from 131 SLAs in the preceding fiscal year (MoHP, 2019). SLAs are paid on the basis of payment for results model. In 2018/19, US\$3 758 163 was paid to CHAM facilities. In the same year, 3 164 103 people are reported to have accessed free healthcare services at the point of care through SLAs (MoHP, 2019).

4. Health equity implications of PPPs in health sector in Malawi

SLAs are potentially effective for both service utilisation and cost-savings in Malawi. A study on cost-effectiveness of Malawi's SLA with CHAM found that cost per Quality Adjusted Life Years gained attributed to the SLA was US\$134.7. Using the GDP per capita for Malawi for 2015 at US\$381, the cost-effectiveness ratio - computed as the QALY gained divided by the GDP per capita - was found to be 0.35 per capita GDP. This was judged to make Malawi's SLA highly cost-effective (Zeng et al., 2017).

Manthalu et al., (2016) found that SLAs increased utilisation of maternal and child health services. Other studies found that SLAs were associated with 13.8%, 13.1%, 19.2% and 9.6% increase in coverage of antenatal care visits, postnatal care visits, delivery by a skilled birth attendant and BCG vaccination respectively (Zeng et al., 2017). Chirwa et al., (2013) found that SLAs had the potential to improve health and universal healthcare coverage particularly for the vulnerable and underserved population. SLAs facilitated achievement of Universal Health Coverage taking into consideration that CHAM provides 30% of health services nationally and 50% of health services in rural areas (Beyeler et al., 2018). The latter study quoted a National CHAM staff as saying:

"If we charge exorbitant prices to the poor masses then nobody will come to access our facilities and the poor will not get medical services. Then how fair are we as a nation? Because of that, the building principle of the MoU is universal health coverage. Make sure everybody has access to health at a reasonable price. We know that if the facilities have to find their own money to pay salaries, they will have to charge commercial rates. That is why we said we need to partner with the government to ensure that the unreached people are reached." (National CHAM staff quoted in Beyeler et al., 2018)

The authors concluded that the partnership between CHAM and government supported health goals of both parties as it enabled government to expand services to the rural areas while facilitating sustainability and affordability of services at CHAM facilities. The SLAs in Malawi have thus been found to be effective in terms both of cost-saving and service utilisation. While there is no specific evidence on who has benefited from these gains within the rural area services included, overall in extending key services to this population, improved access from the SLAs can be said to have improved equity.

This is facilitated by the fact that public healthcare services are provided free at a point of care, and that half of the healthcare services in rural areas are provided by CHAM facilities. With no national health insurance scheme in Malawi, the CHAM, as a not-for-profit provider has facilitated critical service coverage in rural areas, especially as government health facilities in rural areas are often under staffed both in number and in skill. SLAs thus do not only address financial barriers by enabling CHAM services to be free at point of care, but also address geographical barriers to care. In these respects, the SLAs with CHAM as a not-for-profit provider in Malawi have helped to foster equity in access to healthcare services.

The SLAs are, however, not short of challenges that may affect equity. These point to the importance of effective monitoring and oversight as well as service factors. A study by Beyeler et al., (2018) found that while government partnership with CHAM facilitates achievement of universal health coverage goals and streamlines private sector engagement, a number of challenges affect execution. These include: insufficient and delayed payment from government to CHAM; insufficient management and oversight mechanisms; and insecure funding, given the Ministry of Health and Population's dependence on external funders, with their own interests (Beyeler et al., 2018).

The performance of SLAs has been found to be affected by lack of clear guidelines and by cost-escalation, due to CHAM's purchase of medicines from expensive private suppliers when these were not available at the Central Medical Stores. Challenges were also faced in late payment of bills, lack of transparency, poor communication, inadequate human and material resources and lack of systems to monitor performance of the SLAs (Chirwa et al., (2013). These findings resonated with those in a study by Kachala (2011) which found that there were ghost workers on the claimed salaries in CHAM facilities participating in SLAs. In apparent move to address the management and oversight inadequacy, MoHP and CHAM established a designated SLA Management Unit (MoHP, 2017). At the time of writing this paper, no study had been conducted to assess the extent to which the SLA Management Unit has helped to address the management challenges.

5. Conclusions

This desk review found that Malawi, having included the health sector as an area eligible for PPP, still only has a single functional PPP with CHAM as a not-for-profit provider, even while others are planned. This PPP framework has evolved over the years between government and the faith-based health facilities under the umbrella of CHAM. The PPP is on service provision and covers essential health package interventions, with its recently added services.

The equity gain in this PPP arises in CHAMs status as a not-for-profit provider that services mostly rural areas where the majority of the population lives and where poverty is high. SLAs help to enhance this by ensuring that services are free at point of care to support access, and by ensuring that the services are those at in Malawi's EHP and provided to an agreed standard, through both a central and local level contracts. The findings suggest that in this context, SLAs can be cost-effective and increase service utilisation. However they also face challenges such as delayed payment by government to CHAM, cost escalation, and insecure government funding that undermine their performance and these potential gains.

There is a policy discussion in Malawi on the introduction of a national health insurance scheme that would see to improve health financing with cross subsidies between high and low risk

groups, productive and non-productive age groups and those with high and low income. While this could enhance domestic financing and enable more effective public leverage in PPPs, the reform is far from an implementation stage and is still being assessed for its feasibility.

The findings suggest that the equity impacts could be enhanced by addressing some of the current challenges, including:

- iv. Ensuring and reporting on the effectiveness of the designated SLA Management Unit in improvement the management and oversight of SLAs.
- v. Ministry of Finance, Economic Planning and Development and Ministry of Health and Population identifying earmarked revenue sources and other forms of mandatory prepayment to support health care financing and improve funding predictability to address challenges of delayed payments to CHAM and expand service delivery.
- vi. Ministry of Health and Population and PPPC exploring the PPP framework for health infrastructure and equipment development and skills transfer for improving services for non-communicable diseases to offer these in Malawi and avoid referral of cases to India and South Africa for treatment. This may save foreign exchange and enhance capacities for and access to these services. The current plan for this in relation to the National Cancer Treatment Center could this be extended to other non-communicable diseases.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHAM	Christian Health Association of Malawi
EHP	Essential Health Package
HIV	Human Immuno-deficiency Virus
HSSP	Health Sector Strategic Plan
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
OECD	Organization of Economic Cooperation for Development
PPP	Public Private Partnership
PPPC	Public Private Partnership Commission
SLA	Service Level Agreement