Extending health services to the poor through the private sector

Jane Thomason (Abt JTA), Susan Mitchell (Abt Associates), Daniel Brown (Abt JTA)

1. Introduction

Development agencies are increasingly looking to business as a partner in achieving development outcomes. AusAID’s business engagement agenda “seeks to achieve greater effectiveness in the aid program by cooperating with the business community to jointly deliver creative solutions that help people overcome poverty” (AusAID, 2012a). This is also recognised in the recent release of AusAID’s Private Sector Development Strategy that, broadly, commits AusAID to engaging more fully with the private sector both in Australia and in developing countries (AusAID, 2012b). This paper illustrates innovative private sector engagement strategies to support improved health outcomes, and is supported with case studies. Specifically, this paper offers evidence-based possibilities for AusAID to pursue its interest in partnerships for service delivery with the extractive industry in Papua New Guinea (PNG). In addition, it considers three opportunities for donor support for specific, poverty-reducing business ventures through risk-sharing with private sector project proponents: (i) partnering with private health providers; (ii) social franchising, and; (iii) private public investment partnerships.

This paper was originally presented at the “Engaging business in development” forum on 17 October 2012 at the Australian National University and is intended to be a constructive contribution to emerging AusAID thinking on the execution of its engagement with the private sector.

---

1. An earlier version of paper was originally presented at the “Engaging Business in Development Forum” at the Crawford School, Australian National University, October 17, 2012.
2. Abt JTA is the technical implementing service provider for the North Fly Health Program and the Lihir Islands Community Health Plan, discussed in this paper
3. Abt Associates is the managing contractor for the USAID SHOPS program discussed in this paper.
2. Extractive Industries Partnerships for Service Delivery

This section briefly summarises what is known of extractive industry partnerships and provides some additional thoughts on how the aid program could contribute to improved social outcomes from extractive industry developments in PNG.

The Global Health Initiative documented case studies of private sector participation in the management of HIV/AIDS, malaria and tuberculosis (World Economic Forum, 2007) including mining related case studies from South Africa, Tanzania and Zambia, (Anglo Gold, 2003, Anglovaal Mining, 2002, Barrick Gold, 2002, De Beers, 2002, Geita Gold Mine, 2002, Gold Fields, 2002, Gold Fields, 2003, Konkola Copper Mines, 2002, South Deep Mine, 2002) and oil and gas related case studies from Angola, Nigeria and Cameroon (Chevron Texaco, 2002, Chevron Texaco, 2003b, Chevron Texaco, 2003a, Exxon Mobil, 2002). More recent work by the donor group Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) analysing resource sector health Public Private Partnerships (PPPs) (Mining Health Initiative, 2012) found a positive benefit for health including a slowing of infection rates, increased community knowledge and generation of positive behavioral change with respect to infectious diseases. The study also found that extractive industry PPPs have lower cost per case cured than purely public models. This is due to lower recruitment costs for new employees, higher productivity, lower absenteeism and fewer deaths of skilled workers. The study also suggests because of a lower cost of providing services and lower need for government financing, that extractive industry PPPs are cost-effective ways of scaling access to health services.

2.1. PNG Case Studies on Extractive Industry Service Delivery Partnerships

PNG is a resource rich country and there are several documented examples of resource sector partnerships in PNG previously described by Thomason and Hancock (2011) including:

The ADB HIV in Enclaves Project: ($25 million) for HIV/AIDS Prevention and Control in Rural Development Enclaves. This focused on private sector operations in rural areas and aimed to help the Government initiate partnerships with the private sector
operators to set up or improve primary health care and HIV/AIDS treatment and prevention facilities. It received financing of $25 million of which Australia and New Zealand provided $3.5 million each and Government of PNG provided $3 million.

**Oil Search – Malaria:** Oil Search in Southern Highlands has achieved impressive results in malaria control, providing support and supervision for surrounding church, government and NGO health providers, making standard treatment courses and malaria diagnostics available through local community workers and storekeepers. Oil Search has also supported an HIV/AIDs control program for the area and the strengthening of local health physical infrastructure, both in collaboration with the ADB HIV in Enclaves Program and funding from the tax credit scheme. More recently Oil Search has established a foundation to extend its health contribution to PNG, which is partnering with AusAID and the Global Fund to extend health programs in PNG.

**Ok Tedi - North Fly Health Services Development Program (K20 Million):** supports the local health system to deliver effective health interventions, essential infrastructure and logistics, human worker capacity, community participation and, population coverage. Key achievements have included: collaboration between partners for planning and coordination of health service delivery, particularly outreach patrols; a major bed net distribution project across the North Fly District; significant progress toward increasing the number of accredited voluntary counseling and testing (VCT) clinics in the district; establishment of regular delivery of essential medical supplies to remote areas that were previously under-supported; and increased immunization coverage.

**Lihir Islands Community Health Plan ($7 million):** is a five year plan that forms the framework for a comprehensive community health response for Lihir communities. This is funded through the community compensation package agreed between Lihir Gold Limited and the local community. The plan incorporates curative and preventative health services and programs, promotes community responsibility for health and targets existing and potential disease burdens.

Of these examples, only the ADB HIV in Enclaves Project was donor funded. The other three examples were funded from private resources (although the Oil Search Foundation is now receiving funding through donor channels). Resource companies
don’t necessarily need donor money to improve their community health. The usual donor approach, which involves allocation of aid resources to programs, would not be the first step in a private sector partnership with the resources sector. It is important to first focus on leveraging resource sector contributions to get better outcomes or increased coverage for poor people.

### 2.2. Potential AusAID Partnership Opportunities

AusAID is already connecting with existing private sector service delivery initiatives such as the Oil Search Foundation and the Ok Tedi Development Foundation in the Middle and South Fly Districts of Western Province. These collaborations enable the extension of existing private sector service delivery programs to achieve greater reach and impact. As well as providing support for existing private sector service delivery initiatives within the extractive industries, AusAID could also provide technical assistance necessary to support the government to enter into effective partnerships with the extractive industry. This could include technical assistance for coordinated planning, establishment of memorandum of understanding (MOUs), governance structures and application of national standards.

Furthermore, there is also a significant opportunity for AusAID to contribute to policy change to minimize the health risks associated with the extractive industries and to maximise social outcomes. For example, it is well known that there are health implications from resource sector development. Currently, PNG does not require a health impact assessment (HIA) as part of its compliance requirements for a new resource development. As a result, they are rarely done, nor is comprehensive long term health planning undertaken during project development. The operator’s generally only undertake their compliance requirements. They would see the health planning as the responsibility of government, although the government lacks the resources and capacity to undertake the needed health planning and risk identification and mitigation for health impacts. Inevitably, problems start to emerge during the project life, and only then are they addressed. This could be simply remedied with some initial planning support.

A valuable engagement for AusAID would be to provide technical expertise and
facilitation to government to ensure that resource projects have:

1) An HIA completed to international standards.
2) A multi stakeholder long term health development plan, based on the HIA and building the existing health care delivery system, with clear roles and responsibilities, and measurable indicators.
3) A mechanism for regular reporting review and monitoring of performance.
4) Innovative funding mechanisms to provide for the implementation of the plan

3. Partnering With Private Health Providers

In many low income countries, 50% or more of the resources spent on health are private resources (International Finance Corporation, 2007). The OECD found that private expenditure on health and public expenditure on health produce similar outcomes (van der Gaag and Stimac, 2008). There is growing evidence that private health providers are a critical channel for extending health services to the poor, particularly in Asia, and can play a vital role in achieving the MDGs. For example, in sub-Saharan Africa and South Asia, 51 and 79 percent of mothers who sought treatment for children under five with diarrhea, cough or fever respectively accessed care from the private sector (Private Healthcare in Developing Countries, 2008a). In relation to the unmet need for family planning, in approximately half of the 21 sub-Saharan countries with recent Demographic and Health Surveys (DHS) data (2006 or later), a third or more of modern family planning users obtained their methods from the private sector, and amongst the lowest three quintiles of women this increased to 50 percent (International Finance Corporation, 2007, Private Healthcare in Developing Countries, 2008a). Globally, approximately 40 percent of malaria patients seek treatment in the private sector (World Health Organisation, 2011).

In order to reduce the impact of infectious diseases such as TB and HIV and reach MDG 6, it will be critical to align the treatment practices of the private sector with international standards and ensure effective coordination of private sector TB services with national TB control programs. In Asia 55 percent of TB cases in 2007 occurred where a large percentage of clients utilize the private sector for care (Hazarka, 2011). A lack of coordination will lead to non-standardized TB diagnosis and treatment quality,
as well as a lack of alignment with national TB program notification and control efforts. This in turn leads to increased air-borne transmission of TB, including drug-resistant strains, among the most vulnerable segments of the population such as children, pregnant women, the elderly and the HIV-infected.

These examples illustrate the importance of private sector health providers and how they can be a complementary partner in extending health outcomes to the poor. In the following section, we summarise a case study of donor engagement with the private health sector to deliver outcomes for the poor, pioneered by USAID which has been investing in strengthening the private health sector for two decades.

3.1. Case Study on Strengthening Health Outcomes through the Private Sector

Currently, USAID’s flagship project in this area is the Strengthening Health Outcomes through the Private Sector (SHOPS) (SHOPS Project, 2012). This is a five year project working in Asia, Africa and Latin America to increase the role of the private sector and, in particular, private health care providers in the sustainable provision of quality family planning, reproductive health, HIV, maternal and child health as well as other health products and services.

SHOPS often begins by conducting private sector assessments that map the landscape of private providers and then works closely with local stakeholders to prioritize areas for intervention. These range from strengthening private health provider business and technical skills, linking private providers with health financing options including insurance and contracting arrangements, and ensuring that private providers have access to quality products and information to support client needs.

The progress of the SHOPS Project provides useful lessons for the Australian aid program. Some examples of its achievements are summarised below:

- In Jordan, SHOPS reached 60,581 women with family planning and reproductive health counseling through community outreach activities. These activities are being

4 More information on the SHOPS Project is available at www.shopsproject.org.
scaled up and will be evaluated through a random control trial, which is set to commence in the coming months.

- Through the SHOPS pharmaceutical partnership program for zinc in Ghana, monthly sales of ZinTab have risen dramatically—from 86,000 tablets sold in January 2012 to 678,000 in April 2012 (when the training program began), to more than 2.2 million tablets in July 2012, following the launch of the mass media campaign. As of August 1, 2012, 536,000 zinc treatments have been sold to retailers, representing 51 percent of seasonal demand.

- In Paraguay in collaboration with the USAID | DELIVER project, SHOPS/Paraguay led the development and finalization of the operating guidelines for Paraguay’s Contraceptive Security Committee or DAIA (Disponibilidad Asegurada de Insumos Anticonceptivos), laying the foundation for decision-making and activity planning for contraceptive security and efficient market segmentation across the commercial, NGO, and public sectors.

- In Uganda, SHOPS produced a replicable text message platform to improve provider performance and quality of care through text messages. Daily text messages were sent to 34 family planning providers at Marie Stopes Uganda, providing training reinforcement tips, reminders, and assessment questions. In a qualitative process evaluation, providers reported changes in their knowledge, practice, and motivation related to the four behaviors targeted in the messages, and positive increases in information-sharing on service standards and increased use of training reference manuals and clinical guidelines (SHOPS Project, 2012).

3.2. Potential AusAID Partnership Opportunities

This style of program would be applicable in Asia where there is already a large private sector servicing the poor. The forthcoming Indonesia Maternal Neonatal and Child Health Program, includes a private sector partnership component, which could be informed by the SHOPS experience. In PNG and the Pacific, where the private sector is growing, there is also an opportunity for AusAID to work with governments to develop mechanisms for creating and enforcing quality standards; enact regulations that are more encouraging of the private sector, and; improve access to capital to support private health care enterprises (International Finance Corporation, 2007).
4. Social Franchising

Social franchising is an approach to extending services to the poor using commercial franchising methods to achieve social goals. A social franchise is defined as a network of private health providers with the following characteristics: (i) outlets are operator-owned; (ii) payments to outlets are based on services provided, although the mechanism of payment may vary and may include client out-of-pocket payments, vouchers, third party insurance or other systems; (iii) franchised services are standardized, although additional, non-franchised products and services may also be offered; and (iv) clinical services are offered, with or without franchise-branded commodities (The Global Health Group, 2010b).

Within the health sector there are over 50 recognised social franchises that provide health services in developing countries. These include both for-profit and non-profit initiatives and the focuses range from family planning and HIV/AIDS testing, to tuberculosis treatment and the provision of safe deliveries (The Global Health Group, 2010b).

Social franchises offer individuals or small businesses an opportunity to join into a franchise network and benefit from a set of incentives offered only to franchise members. These benefits can include: training; branding and brand advertising; subsidized or proprietary supplies and equipment; ongoing support services; and access to other professionals in the same field. In exchange, the franchisee must comply with a range of requirements, often including the provision of certain socially beneficial services, meeting quality and pricing standards, and a fixed payment or a profit-share franchisee fee (Private Healthcare in Developing Countries, 2008b).

This model is able to leverage off the large number of pre-existing private healthcare providers that are often already present in many developing countries. Social franchises have the potential to add value to the healthcare operation by improving quality of primary healthcare provision through training; maintaining quality through monitoring; and enable greater awareness and better use of the existing private health providers. It can also signal to patients the presence of high quality providers through the use of trademarks and brand names.
4.1. Social Franchising Case Studies

(i) BlueStar Healthcare Network

Marie Stopes International (MSI) is a UK based NGO that uses franchising as a means of improving women’s access to quality reproductive health services. MSI have 1,500 providers (doctors, nurses, midwives, clinical officers or pharmacists) in developing countries across the world, delivering high quality voluntary family planning services to clients. MSI has a ‘partial franchising’ model, meaning only some of the franchisees’ services and commodities are regulated by MSI and that the franchisee may offer additional health services that are not regulated by MSI. The services are then tailored for each social franchise network to best meet local needs. In return for a small annual fee, franchisees receive high quality but reduced-price commodities from MSI which they sell to clients according to an agreed pricing structure. They also receive extensive and ongoing training on client care, the provision of relevant services and stock control for instance, thus improving the range and quality of services (Marie Stopes International, 2011).

MSI social franchise in the Philippines, BlueStar Pilipinas, was launched in 2008 to increase the accessibility of high quality family planning services. Run by licensed midwives, BlueStar Pilipinas had 266 outlets serving over 150,000 clients by 2011. The services provided by the clinics include: oral contraceptives; condoms; injectables; Copper T; STI testing and treatment; cervical cancer screening; labour and delivery. Prices are affordable and clinics have an informal sliding scale of costs to ensure no one is turned away. BlueStar Pilipinas has also succeeded in integrating the network into the Philippines’ National Health Insurance Program, enabling clients to obtain a Maternity Care Package. A study was conducted on the network and it found that BlueStar Pilipinas i) increased equitable access to high quality modern family planning methods especially among poor women; ii) successfully promoted IUDs; and iii) customers were highly satisfied with services as they perceived them to be of a high quality and midwives as competent and customer focused (Schlein et al., 2011).
An example, which would suit the social and cultural context in PNG, is Living Goods, operating in Uganda. Living Goods is a social franchise that harnesses micro-entrepreneurs to use traditional trade and scale access to a wide range of essential health products at affordable prices. Living Goods operates an Avon-like network of independent health promoters who make a modest income selling affordable solutions to improve the health of the poor. Through these methodically screened and trained health promoters, Living Goods delivers uniform branded products such as anti-malaria treatments, clean-burning cook stoves, fortified foods, and solar lamps. Living Goods can sell goods at 10-40% below prevailing retail prices. Living Goods provides additional economic benefits for clients by saving transport costs, preventing lost income and reducing health spending through prevention (Speicher, 2011). By combining micro-finance and public health, Living Goods improves livelihoods by providing rural women with a reliable source of income as health promoters, and creates a sustainable system for improving access to basic health products (Living Goods, 2011). Recently the USAID SHOPS Project has developed a brief on agent distributor models like Living Goods, highlighting how these models can succeed in getting socially beneficial products to the poor (Kubzansky and Cooper, 2012).

### 4.2. Potential AusAID Partnership Opportunities

As part of a country portfolio of programs in countries like Indonesia and PNG, where AusAID has a significant and continuing interest in the health sector, a social franchising element could be built into a country strategy. Considerations to be built into any program based on MSI lessons learned (Marie Stopes (2011) include:

1. **Extensive training** is required to ensure appropriate clinical or technical expertise as well as good customer service.

2. **Branding, social marketing and communication** activities should respond to barriers to the uptake of services and be pre-tested with the target audience to ensure they are culturally and contextually relevant.
(iii) Quality of care must be ensured at all times through ongoing monitoring and evaluation as well as refresher training courses for all franchisees.

(iv) Any pricing structure should reflect local circumstances; encouraging clients to seek certain services whilst increasing franchisees’ income.

(v) Social franchise networks can increase their effectiveness and client-base by delivering government–contracted services and being accredited by a national social health insurance scheme if one exists or establishing a voucher scheme that offers clients subsidised services.

Managing a distributed clinical care network is a complex management task. Franchising is complex and for this reason requires highly skilled management. To justify this fixed cost in a subsidized program, the management, must be allocated across many franchisee outlets - the management cost to set up and oversee 60 clinics or pharmacy outlets is almost the same as for 2,000. “Franchising makes sense at large scale, and makes little or no sense at a small scale. Many of the programs in the developing world now were not designed, nor pushed by donors, to go to scale. This remains a significant failure of implementation and understanding” (Private Healthcare in Developing Countries, 2008b). Social franchising has potential to expand services to the poor, but would only be an effective strategy for the aid program, if AusAID were prepared to invest to take it to scale in a country.

5. Public-Private Investment Partnerships

Public-private investment partnerships (PPIPs) harness private financing and expertise in order to achieve public policy goals. PPIPs are an innovative way for resource-constrained governments in developing countries to improve health infrastructure and simultaneously improve healthcare service provision, while also addressing other system-wide inefficiencies. While many PPPs are concerned with the building and maintenance of infrastructure such as hospitals, PPIPs are also concerned with the delivery of clinical services.

PPIPs comprise long-term, highly structured relationships between the public and private sectors. They position a private entity, or consortium of private partners in a
long-term relationship with a government to co-finance, design, build, and operate healthcare facilities, and deliver both clinical and non-clinical services at the facility. The structured relationship harnesses the respective strengths commonly associated with both the public and private sectors while still accounting for the profit motive of the private sector partners. The private sector is responsible for (and carries the risk of) construction delays, cost overruns, inadequate or poorly trained staff, and, inefficient care that fails to meet agreed-upon benchmarks. The government still retains responsibility for general oversight of quality and performance standards to ensure public health goals are achieved. The government remains the ultimate payer for the public health care at the facility. The private partner is paid based on service outputs at specified performance levels by the government and common methods for payment include capitation or global budgets (Sekhri et al., 2011).

The benefits of this approach include:

(i) The long term, shared investment results in mutual dedication and common interest in successful outcomes.

(ii) As return on the investment comes over time and is based on performance, it is difficult for either party to walk away from the partnership, strengthening its stability.

(iii) Utilising private capital spreads the government payment for the infrastructure over the useful life of the facility rather than requiring a large up-front payment. In some instances the government makes no payments to the private partners until facilities are completed and delivery of care begins, improving the feasibility of building the facility.

(iv) Unlike privatization, the government still retains ownership of the asset throughout.

(v) Through PPIPs the government’s repayment includes maintenance over the life cycle of the asset, estimated at 30-35 percent of costs.

(vi) PPIP’s enable stability in operational budgets though payment methods that put the private provider at risk for budget overruns and make payment contingent on outputs meeting defined performance standards.
Systemic quality improvements can also result as the integrated partnerships include explicit agreements on performance monitoring that specify measurable, internationally recognized standards. (Sekhri et al., 2011, The Global Health Group, 2009, The Global Health Group, 2010a).

5.1. PPIP Case Study - Lesotho

Lesotho has a population of approximately 2 million and aging health system infrastructure. In 2007 as part of a national healthcare strategy, the Lesotho Ministry of Finance and Development Planning spearheaded a PPIP, and awarded a contract to Tsepong Ltd. to replace the tertiary hospital, which was in bad repair and consuming increasing amounts of government funds while delivering deteriorating services. Analysis of current facilities showed that by making an incremental increase in the resources devoted to these facilities, several thousand more patients could be seen through a PPIP. The PPIP also incorporated a clear plan for improvements in access and quality (i.e. clear value for money) which reduced opposition to the model by physicians, staff and others. The contract is an 18-year partnership between the private partner consortium and the government of Lesotho to replace the existing hospital and operate two feeder clinics, thus providing the full range of primary, secondary, and tertiary care (Sekhri et al., 2011).

The private consortium involved has been designed to ensure buy-in from the community. Tsepong is comprised of Netcare (40%), Africa’s largest private hospital and healthcare group; Excel Health (20%), an investment company for Lesotho-based specialists and general practitioners; Afri’nnai (20%), an investment arm of the Lesotho Chamber of Commerce; and the Women’s Investment Company (WIC) (10%), an investment company comprised entirely of Basotho women (The Global Health Group, 2010a).

The financial structure of Lesotho’s PPIP provides stability and assurance for the key stakeholders. The cost of the project is estimated at USD$120 million and is being funded by the Lesotho Government, Tsepong, the Development Bank of Southern Africa and, the Global Partnership for Output-Based Aid (an arm of the World Bank). The
government also has a Partial Risk Guarantee from the World Bank so that Tsepong can continue to operate with partial coverage at its own expense should the government fail to make their payment. These added measures minimize the risk and provide additional assurance for the consortium of private partners (The Global Health Group, 2010a). Local equity of 40% (growing to 60%) ensures a vested interest by the local community. The facilities will help retain current staff and provide opportunities and attract Basotho doctors and nurses who have left the country to return and practice in Lesotho, reflected with locals making up 80% of all staff employed and 1% of payroll being spent annually on staff training.

Tsepong is responsible for the designing, building, and operation of the hospital and associated clinics. They are responsible for employing staff, the general management of the hospital, and also for providing clinical and non-clinical services. The specific terms of the contract commit the partnership to accommodate a 24 percent increase in outpatient visits and a 21 percent increase in inpatient visits. The cost to patients will not increase from levels prior to the PPIP, and the quality of care at the new, well-equipped facility will improve. As a result of the improved care, as well as better referral protocols it is estimated that the average length of stay will be reduced by five to ten days (The Global Health Group, 2010a).

5.2. Potential AusAID involvement

The PPIP model may provide a means for the Australian aid program to provide support for major hospitals in PNG in a manner that ensures provision of quality services over time. AusAID could take a lead role as partnership broker or lead role in the negotiating process; fund technical assistance for financial advice for the Ministry and other areas required to finalise the highly structured contract agreement. Further, AusAID could help augment the Ministry's payments to private contractors to provide added assurance and incentive for potential private partners to participate. As demonstrated by the Lesotho case study, PPIPs may also be supported by IFC or World Bank as well as government and private financiers.

There are a number of factors that need careful consideration in order for a PPIP to succeed. These are discussed below.
**Political will:** PPIPs need strong, sustained political leadership. Given the length of such arrangement, this high-level commitment needs to be sustained and not change with the political changes of power.

**Commitment from the private sector:** Private sector partners chosen need to have a demonstrated commitment to serving patients and the government. PPIPs contracts need clear performance requirements to help ensure this remains the case.

**A partnership that can adapt:** The success of a PPIP depends on the ability of both the public and private sector partners to forge a relationship that can adapt to inevitable changes. This requires comprehensive planning and agreement as to the risk allocation and rewards, and methods for changes in prices, services and volume of services provided, moving forward. (Sekhri et al., 2011).

**Independent M&E:** An independent private or public agency should be engaged to collect and validate performance data, ensure all contractual obligations are met and administer or arbitrate financial rewards and penalties. The agency would be responsible to the government but needs to command the respect and trust of both public and private sector partners. The agency can also play an important role in maintaining public confidence in the PPIP arrangement (The Global Health Group, 2010a).

An additional risk to be managed is that within an overall country portfolio, PPIPs could steer disproportionate amounts of limited public resources to tertiary care for the urban population increasing inequity in access to care. This risk would need to be managed within the overall country portfolio and in the structure of the financing arrangements (Barnes, 2011).

**6. Considerations in the Implementation of Private Sector Partnerships**

The case studies discussed outline potential areas for AusAID to explore in its private sector engagement in the health sector. In presenting these case studies, we see it is essential that their pursuit be framed within the objectives of the Australian aid
program, its broader policies, the context for poverty elimination and ultimately lead to benefits for poor people.

Private sector partnerships should be chosen on the basis of due diligence and the establishment of a case showing a clear benefit in utilising a private sector partner for reasons such as physical presence in an isolated area, unique delivery capacity and opportunity to reduce cost of delivery through leveraging private funds.

As highlighted in the PPIP case study, the selection of the right private sector partners is an important issue. AusAID would be wise to undertake ‘due diligence’ to identify ethical partners who already conduct ethical business practices when operating in developing countries (Thomason, 2011). This might include complying with the UN Global Compact, which has 10 principles that all businesses should follow with respect to human rights, labour standards, the environment and anti-corruption. In practical terms, these say: uphold human rights and do not take part in human rights abuses; avoid forced labour and child labour; take environmental responsibility, and; avoid corruption. Judgment of ethical practices could also include complying with the Global Reporting Initiative; one of the worlds’ most widely used standards for sustainability reporting, through which organisations publicly report their economic, environmental and social performance.

Noting that the evidence base is still relatively light, it will be important to make concerted efforts to monitor progress and add to this evidence base to ensure that the private sector engagement is founded (and judged) on evidence.

There will inevitably be critics of engagement with the private sector and, in particular, the channelling of aid program funds to private sector partners. For this reason it would be prudent to adopt clear guidelines for use of public subsidy. We propose that public subsidy to the private sector should only be used in circumstances including: when it can add considerable value to achieving the objectives of the aid program; when markets, enterprises or institutions are significantly failing poor people and that public subsidy could potentially offer additional benefits, or; to enhance the facilitating environment for private sector participation to deliver outcomes for the poor. Public
subsidy should not be given to support work that the private sector is already willing or can be persuaded to undertake without subsidy.

While engaging with the private sector offers substantial potential, there is not a natural fit between the motivations, expectations, ways of doing business, and people issues of the public and private sectors. The business engagement agenda brings together two constituencies, with different objectives, which don’t usually talk to each other and, arguably, don’t even speak the same language. The management of these differences is crucial to its success. Private sector engagement needs to be ‘judgment free’, accepting that private sector motivations are different from those of the public sector. The whole basis, content and forum for engaging with the private sector need careful consideration. The way of transacting business in the private and public sectors are fundamentally different and thus successful engagement will depend on finding ways to communicate and work with the private sector to achieve social benefits for disadvantaged populations.

Development agencies, including AusAID, have signalled their intentions to engage more extensively with the private sector to achieve development outcomes. Intended as a constructive contribution to emerging AusAID thinking on the execution of its engagement with the private sector, this paper has discussed four innovative private sector engagement strategies to support improved health outcomes. An acceptance of the fundamental differences between the public and private sectors will be pivotal to the success of the outlined opportunities, and private sector engagement more broadly.
Bibliography


