WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD **EB107/7**
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Partnerships with nongovernmental organizations

Report by the Secretariat

1. It is increasingly acknowledged that lack of service delivery capacity, especially of human resources, is responsible for the limited coverage of health services in many countries.

2. The reasons behind this are many and complex. One is certainly the poor collaboration of health actors. Many countries have concentrated exclusively on public-sector provision of health services, with provisional acceptance of the service delivery capacity of the private sector. Health organization and services have been highly compartmentalized. Health interventions were developed independently by the public and private sectors.[1] There was often rivalry and confrontation, which have had detrimental effects on the population's access to health services of high quality.

3. With the political and economic changes that began in the early 1980s – transition from planned to market economies, reduction of State intervention in national economies – development of the private sector was encouraged.

4. The organization of health systems has been changing considerably. Mitigation of the ideological confrontation between public and private sectors in all areas of economic, social and political life is undoubtedly a contributing factor to these changes. At the same time, more actors are involved in health and their contribution is more specialized (provision of services, management of health facilities, purchase of services, financing, distribution of risks, regulation of systems, etc.). This, with the development of the private sector, democratization and decentralization, has given rise to different levels of accountability and greater involvement of civil society, particularly of nongovernmental organizations.

5. Ministries of health in developing countries are increasingly working with the private sector, especially the private not-for-profit sector, in order to build up capacity for service provision and to improve access to care. Examples include, use of private providers of preventive services to combat malnutrition in Madagascar and Senegal; use of private practitioners and franchisees in Bangladesh, China and India to follow up tuberculosis cases; and agreements in Burundi between the Ministry of Health and the church organizations to manage and deliver health services. There are similar examples in a number of other developing countries.

[1] The private sector includes both not-for-profit and for-profit entities.

6. The private sector has also become more involved in the planning process. The "sector-wide approach" used in the United Republic of Tanzania, for example, included private sector and not-for-profit health organizations in one of its key management reform committees.

7. Increasingly, health programmes are looking to partnerships in order to deal with specific health issues. For example, Member States are encouraged to establish new partnerships with the private sector, in order to step up control of tuberculosis; an interagency working group on implementation of the integrated management of childhood illness is examining ways to work with the private sector, in order to make the best use of resources; Roll Back Malaria similarly advocates the development of public-private partnerships at all levels.

8. The gradual transformation of the roles and status of traditional agencies and institutions, and the emergence of new ones – some from outside the sphere of health – calls for a different kind of interaction between levels of government and private health care providers.

9. Actors in the health field are increasingly aware of the need to build partnerships, even between parties that have traditionally not worked together, but may not know how to set about it. Relationships have often remained at the level of consultation, though during the past decade new mechanisms for effective partnerships have been put into practice through formalized arrangements.

10. Contracting as a method of resource allocation, or management and delivery of services may improve health service performance if it is part of a coherent policy framed by the State, especially the ministry of health. Effective policies require the involvement of the relevant stakeholders.

11. Contractual relations characterized by legally guaranteed reciprocal commitments are becoming more common. Often a matter in the past of simple service contracts for nonmedical activities – building maintenance, hospital meals, hospital laundry – they increasingly, aim at improving the services provided, including management of health facilities, delivery of health care, and execution of health programmes such as leprosy or tuberculosis control, integrated management of childhood illness, and control of malnutrition.

12. The results of many experiments with contracting are promising, but their approach is often piecemeal, without regard to sustainability or impact on the health of the population. In some cases, contractual arrangements do not reinforce the health system because they are focused on narrow outputs that are not consistent with overall system objectives. More complex arrangements would include agreements between the public and private sectors, including nongovernmental organizations, to manage and provide services at national, subsystem or programme levels.

13. To maximize the contribution of private health care providers, including nongovernmental organizations, key capacities need to be developed or strengthened. Governments should have the capacity to articulate a clear policy for working with the non-public sector in order to undertake stewardship of the health sector, including negotiation and agreement on roles and responsibilities, monitoring on the basis of agreed performance criteria, enforcement of agreed terms, and evaluation of effectiveness.

14. Private health care providers, including nongovernmental organizations, need the capacity to engage in a policy and strategy dialogue with the health authority, to manage resources (including financial and human), to ensure quality of provision, and to fulfil the terms and conditions of the contract.

15. Development of policies to guide the use of contracts and their implementation will require the capacity to design and manage them, in both ministries of health and potential partners, including private health care providers.

16. By pooling experience, forming knowledge bases and developing frameworks for critical assessment, countries will obtain a better view of the potential, and the limitations, of partnerships.

ACTION BY THE EXECUTIVE BOARD

17. The Executive Board is invited to note the report.

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