

Organizing the Private Sector to Support Universal Health Coverage Goals





Introduction

Globally, the private health sector is an important source of family planning products and services, especially for clients seeking short-acting methods (Ugaz et al. 2016). Beyond family planning, private providers offer priority health services to many segments of the population, including youth, the poor, and other underserved communities (Ugaz et al. 2016). The human and technical resources available in the private health sector are therefore important assets as countries look to achieve global health goals such as universal health coverage (UHC). In family planning, donors have begun efforts to expand the availability and delivery of injectable contraceptives at pharmacies and drug shops, and long-acting reversible contraceptive methods at private health facilities. To be successful, these initiatives will need to reach

large numbers of private providers with training, supervision, and financing. The success of these efforts at the country level will depend on the ability of donors and governments to integrate the full range of private providers into these reforms.

Many low- and middle-income countries like India, Kenya, Nigeria, and Tanzania have large and growing numbers of for-profit and nonprofit providers. These providers generally operate on an independent basis and are not fully integrated into the health system. This lack of organization has constrained donor and government efforts to engage large numbers of private providers. Bringing together and coordinating large numbers of private providers into organized groups is therefore an essential step in taking donor investments to scale.

Forms of organization of private providers

When private providers are fragmented and operate independently, it is difficult to:

- Solicit private sector inputs into policy and regulatory processes
- Promote quality improvement or train providers on new best practices
- Contract or empanel private providers in new public health insurance programs
- Operate a comprehensive, up-to-date health management information system
- Implement supportive supervision programs to oversee private health facilities

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Private providers in many countries have managed to organize both across and within certain cadres or sectors. Led by grassroots mobilizers or external actors, these efforts have brought together a significant number of providers, successfully overcome barriers to achieve their goals, and continued attracting new members over time. Furthermore, these initiatives have successfully integrated private providers into the larger health system and facilitated interaction between private providers, public health officials, and donors. Although each case is different, common forms of organizing are:

- **Professional associations** that bring together a group of people with similar qualifications to pursue a common purpose, usually advocacy and information sharing. Associations tend to be nonprofits and place less demanding obligations on their members than do more formal networks. The American Medical Association, a professional advocacy body for medical doctors in the United States, is a prime example.
- **Cooperative businesses** that are jointly owned and operated by members who are responsible for operations and share the profits and losses. Cooperatives tend to be more popular outside of the health sector, especially in agriculture and the financial industry (credit unions).
- **Federations** that bring together smaller groups under the leadership of a central body. Each member retains significant autonomy to pursue its own aims. An example is the regional East Africa Healthcare Federation, which brings together national organizations from its member countries.
- **Provider networks**, a general term for a group of private providers who affiliate with each other under a larger umbrella structure. There is great variety in the way networks are structured, but they often include monitoring by an umbrella body and members' commitment to standards, quality, a given service offering, and prices. Provider networks can include associations and social franchises like those managed by Population Services International, Marie Stopes International, and the International Planned Parenthood Federation.

Past experiences offer lessons that can guide stakeholders in future efforts. The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project examined successful efforts to organize private providers in six countries to identify lessons and generate principles for organizing. The authors took into consideration the stakeholders involved, the general strategies employed, and the outcomes achieved. To show the diversity of contexts and situations in which private providers can successfully organize, they selected these countries: Japan, Philippines, Indonesia, Brazil, Germany, and South Africa. The country snapshots presented in this primer are grouped by the objective that motivated each effort:

- Strengthened private sector voice in the policy arena
- Improved quality of care at private health facilities
- Increased private sector access to new financing and revenue opportunities

The lessons learned from these accounts can serve as principles to guide future organizing efforts:

1. Identify and leverage the right motivations and incentives.
2. Have strong, local leadership, which is a key to continued success.
3. Target the membership base appropriately.
4. Determine organizing strategies based on goals.
5. Monitor, learn, and adapt.

While the selected examples were not led by family planning champions or focused on family planning results, they do offer lessons for family planning advocates looking to capitalize on UHC opportunities.



an Informasi
Kontrasepsi Swasta
n dan Apotek Terdekat

Pill
Suntik KB
MOW / Tubektomi
MOP / Vasektomi
AYO KOT KB
2 Anak Cukup
Kependudukan dan Keluarga Berencana Nasional
Pusat Bina Kesertaan KB Jalur Swasta



Pendidikan
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Organizing Private Providers: Global Success Stories

This section presents six examples of private providers successfully organizing to pursue a common end: strengthening their voice, improving quality of care, or improving access to new revenue opportunities.

Strengthening the voice of private providers

Private providers must have a strong voice to promote their professional goals, advocate for relevant legislation and policies, and provide input that reflects their concerns and views. Increasing private sector involvement in the development of policies, strategic plans, and programs increases the chance that these vehicles leverage the full range of human, technical, and financial resources available to support their implementation. Private sector involvement also promotes a truly integrated public-private health system, aligns all providers with national health policies and plans, and supports effective government stewardship.

Voice of the provider

Private providers often are left out of the policy-making process. There is no systematic way for them to make their viewpoints known or channel them to policy makers—essentially, they are voiceless. Strengthening the voice of private providers means giving them an avenue to make their thoughts known and facilitate communication.

Creating large groups of private providers is an effective way to amplify their voices and increase their credibility. Large membership bases can reassure policy makers that a group's inputs to the policy-making process broadly reflect and are supported by its members. Creating cadre-specific professional associations is a common strategy for engaging large numbers of providers in policy dialogue. Two examples presented here—the Japan Medical Association (JMA) and the Integrated Midwives Association of the Philippines (IMAP)—show how private providers can effectively use this organizing strategy in different contexts. JMA is an example of a private provider-only group focused exclusively on its own concerns. IMAP shows how private providers can effectively operate within groups that have a mixed public-private membership yet still address private sector concerns.

Midwives who are part of the Bidan Delima social franchise in Indonesia.

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The Japan Medical Association

Changing policies in a changing health system

In the late 1800s, the government of Japan instituted reforms to modernize the country. In the health system, the country shifted away from traditional Chinese practices toward Western forms of medicine. During this transition, the government created a new cadre of medical doctors educated and licensed under a new Western-based examination system. With little public infrastructure other than large hospitals, the majority of these newly trained providers went into the private health sector—either as independent general practitioners or staff at small nonprofit hospitals that currently make up more than 70 percent of hospitals in Japan. Most private providers operated independently at small-scale facilities.

These reforms also addressed health financing. Inspired by efforts taking place in Germany, the Japanese government began developing its first health insurance programs. In 1922, the government passed the Health Insurance Act, which created health insurance programs for blue-collar workers. The Health Insurance Act covered small firms and large industries. In 1938, the government expanded coverage to include self-employed workers. To be successful and ensure that members could access health services, these insurance programs had to engage independent general practitioners and small nonprofit hospitals on a large scale.

Turning effective leadership into quick wins for members

The JMA evolved out of an organization originally formed in 1875 to bring together the new cadre of medical doctors working in the public and private sectors. With the growth of the private sector—and more importantly, the new health insurance programs—JMA became a powerful

voice representing the private general practitioners in the Japanese health system. In 1923, Kitasato Shibasaburo, a well-respected physician and former head of Japan's National Institute of Infectious Diseases, formally relaunched a strengthened and reorganized JMA as a national group advocating on behalf of licensed private physicians. As the first president of the new JMA, Dr. Shibasaburo focused on representing his constituents in the design and implementation of the new insurance schemes. Under his leadership, JMA led the drafting of the first fee schedule to pay providers, thereby immediately proving its ability to influence government policy. In addition, JMA positioned itself as the conduit through which private providers would be paid by government-managed health insurance programs. This role would last through 1943, when payments switched from capitation to fee-for-service-based payments.

Adapting to changing times through strong leadership

At the end of the World War II, the Japanese health system experienced a dramatic transformation. With its role as a payment channel ending, JMA began focusing on its advocacy role to augment the voice of independent private general practitioners in policy dialogue. Under the presidency of Dr. Taro Takemi (1957–1982), JMA used Takemi's political connections to closely link itself with elected officials and policy makers in the Ministry of Health, Labor, and Welfare and cement its continued influence. Reforms the JMA advocated for expanded the scope and scale of Japan's insurance programs until the country achieved UHC in 1961. JMA now sits on the Central Social Insurance Medical Care Committee, which reviews and approves the fee schedule for Japan's health insurance system. JMA is the largest provider voice in this negotiation process; other cadres' (e.g., nurses, dentists) professional associations

channel their inputs through JMA. Since the fee schedule is used by policy makers as a tool to incentivize provider behavior, JMA's role in developing it is especially important for private providers. In addition, JMA is an active voice in policy formulation, helping to defeat and reshape regulations that it views as potentially damaging

to its members—including negotiations in 2004 to reform the country's insurance program. In addition, JMA operates one of the largest pension programs in the country to benefit its members. By 2008, JMA had grown to more than 165,000 members, or approximately 60 percent of private general practitioners in the country.

Key points: Japan Medical Association

- New social health insurance (SHI) programs created a need for the Japanese government to engage private providers on a large scale and motivated the providers to organize.
- Effective leaders were able to position JMA as a champion for private providers at key points throughout its history, giving members a reason to join and lending immediate credibility to the association.

Integrated Midwives Association of the Philippines

Formalizing an informal cadre

The practice of midwifery began informally in the Philippines. By 1901, the practice had grown to such an extent that the Medical Board of Examiners formally recognized the cadre and became the regulatory board for both the medical and midwifery professions. Dr. Jose Fabella, the former executive officer of the Public Welfare Board and a leading expert on maternal and child health in the Philippines, saw the need for improvements in health—especially in the country's high infant mortality rate. In 1922, he founded the first formal school of midwifery in Manila. The school sought to increase the number of women trained in midwifery to eventually replace unqualified midwives with qualified ones.

Dr. Fabella's efforts helped legitimize the nascent cadre of trained midwives and gave them increased stature in the health system. Following the creation

of the first school, many other midwifery schools and hospitals opened throughout the country. As the number of licensed midwives grew, the use of their services also increased. Viewing this cadre as essential to reducing high infant and maternal mortality rates, the Filipino government formally defined an expanded midwifery scope of practice as part of the 1960 Philippines Midwifery Law. This and subsequent laws have codified a strong position for midwives vis-à-vis other cadres, such as nurses, in the Philippines health system.

Founding an alumni association to strengthen post-training coordination and communication

The Medical Board of Examiners remained the regulatory body for both doctors and midwives. As the number of midwives rose and their scope of practice broadened, the board was unable to adequately regulate and provide supportive supervision. Responding to this gap, a group of licensed midwives from across the country organized an alumni association of midwifery graduates. In 1947, these individuals, led by

Angelina C. Ponce, created the Philippine Midwifery Association, later reincorporated as the Integrated Midwives Association of the Philippines in 1976, to serve, train, and provide health services and continuing education among midwives and the wider community. Capitalizing on the association's success attracting new members, the government began to engage it in policy development. In 1959,

this engagement resulted in an important success for midwives: the creation of a board of examiners for midwives that would split the regulation of midwifery practice from medical practice. This new regulatory body, coupled with IMAP's provision of continuing midwifery education, helped facilitate improved service delivery.

Achieving quick wins

In order to quickly establish its bona fides with members, the Philippine Midwifery Association first focused on disseminating policy and clinical updates to midwives. This line of communication provided a quick win for the association by showing potential members that it could effectively channel information between regulators and providers.

Leveraging its voice to benefit private and public midwives

IMAP now represents almost 131,000 public and private sector members in 134 local chapters nationwide. IMAP's work has benefitted midwives broadly through its seat on government committees and technical working groups that conduct research and develop and review policies related to the midwives' scope of practice. The partnership the association has with the government allows its members' voices to be heard by policy makers, enabling it to provide policy updates and other information to its members. An important outcome of this collaboration was the Philippine Midwifery Act of 1992, which further expanded the midwifery scope of practice to ensure the delivery of basic health services. The act allows certified midwives to administer life-saving drugs such as magnesium sulphate, oxytocin, steroids, and oral antibiotics when no physician is available. It also empowers midwives to administer essential newborn care, including immunization and Vitamin K injections.

Although IMAP has a mixed membership of both public and private midwives, it has established

an affiliate, the Private Practicing Midwives Association, to address concerns of private sector members. They have successfully used the association to support activities that are specific to their needs. For example, IMAP members currently own and operate several private clinics, most of which are accredited by PhilHealth, the Philippines national health insurance program. In order to achieve PhilHealth accreditation, providers must undergo several clinical trainings, including family planning counseling and most nonsurgical methods. By ensuring that members can be paid by PhilHealth, IMAP helps to increase the number of private providers that are able to deliver a wider range of family planning methods, increase access to significant new revenues for its members, and improve the sustainability of its members and the association. In addition, IMAP operates its own private midwifery schools and offers distance-learning courses to increase the number of midwives working in rural areas. The courses offered by IMAP schools are designed to provide midwives with the skills necessary to gain PhilHealth accreditation upon graduation.

Key points: Integrated Midwives Association of the Philippines

- Midwives in the Philippines were motivated to organize after recognizing that they needed to do more to ensure effective regulation and supervision, especially as their scope of practice expanded.
- A key factor that facilitated IMAP's success was its ability to produce a mix of both quick wins and long-term benefits to members.
- IMAP demonstrates that even when associations have mixed public-private membership, private providers can use them to effectively address their specific concerns.

Discussion

As the IMAP and JMA examples show, providers will recognize and respond to policy-related opportunities to organize. In Japan, this opportunity came from the new social health insurance legislation; in the Philippines, it was an opportunity to shape and expand how the providers would be regulated and supervised. In both cases, two factors greatly influenced the success of their efforts. First, effective leadership was essential. The rapid growth in the number of Filipino midwives, which precipitated the founding of IMAP, resulted partially from Dr. Fabella's professional reputation and support. JMA benefitted from the leadership of two influential presidents at critical points in its history. Dr. Shibasaburo's support at the outset lent legitimacy to the fledgling association and opened doors to participate in policy formulation at the highest levels of government. Later, Dr. Takemi's political connections helped ensure that JMA retained its seat at the policy-making table during the final drive to achieve UHC.

The second important factor was the ability to immediately demonstrate the value of the group to potential members while remaining flexible enough to adapt to changing circumstances. IMAP delivered a mix of training and supportive services to attract members and grow quickly. It leveraged

its large membership base to engage in dialogue and partnerships with the government and produced policy wins, including shaping the new regulatory regime, advocating for private midwives' concerns with regard to PhilHealth, and further expanding the midwifery scope of practice. By serving as a channel for both influencing the design of reimbursement rates and for receiving some of those payments, JMA translated its powerful voice into financial rewards for its members, giving tangible benefits to joining an organization more strictly focused on advocacy and voice. JMA's current role on the Central Social Insurance Medical Care Committee and its demonstrated ability to reshape or defeat policies that could harm its members continue to be a powerful tool for recruiting and retaining members.

A focus on only one cadre of providers was a central feature of both organizations. It is common for countries to have multiple professional associations—one for doctors, one for nurses, and so forth. These groups generally operate independently and do not tackle issues that span cadres. As presented in the text box, the Kenya Healthcare Federation demonstrates how stakeholders addressed this challenge in Kenya: by creating a federation of associations to serve as a strong and vocal presence in the country's policy-making process.

Emerging practice: Multi-stakeholder advocacy groups

The Kenya Healthcare Federation is emerging as a strong and vocal actor in the country's policymaking process. It formed in 2004 when seven corporate health organizations came together in response to a proposed SHI program and value-added tax that would drive up health care costs. Both proposals would have negatively affected the private health sector. In response to this threat, the federation served as an umbrella organization to unite and advocate for the entire spectrum of private health sector stakeholders (providers, insurance programs, and the pharmaceutical industry). This strategy differed from traditional professional associations that focus on a single cadre of health worker or single type of health system stakeholder (for example insurance companies or providers). The group's advocacy helped halt passage of the proposed insurance act and provided alternatives for a new SHI bill. Its actions led to the exemption of imported pharmaceutical raw materials from the value-added tax. Since then, the federation has continued to participate in policy making by providing key inputs to subsequent health bills and policies and public-private fora at the national and county levels. It also supported the development of the East Africa and West Africa Healthcare Federations. The 81 members of the Kenya Healthcare Federation include institutional associations, professional medical associations, and corporations. This broad membership base has helped the organization respond to issues that affect multiple types of stakeholders, although it has also made achieving consensus among diverse members challenging.

Implications for family planning advocates

In the country examples from Japan and the Philippines, providers organized to influence the policy-making process. Globally, family planning stakeholders are debating whether to task share the delivery of a wider range of family planning methods to lower level cadres of health workers, including pharmacists and drug shops. As this debate shifts down to the country level, it will present a significant opportunity to motivate providers to strengthen their voice by organizing. Donors and family planning champions at the country level can leverage momentum generated by policy discussions to spur affected cadres to join an organizing effort to advocate for the adoption of task-sharing protocols.

Improving quality of care

Ensuring quality of care is necessary as donors seek to expand family planning product and service offerings through the private sector or to expand the delivery of certain methods (such as injectables) to new cadres. Organizing private providers can support this goal in several ways. Private provider networks and associations present a streamlined entry point for donors and governments to reach a large number of providers at once with new trainings, quality standards, and supportive supervision. The networks and associations themselves can develop and implement accreditation systems to ensure the quality of care at their members' facilities. They can also build connections and linkages between providers to strengthen referrals or allow providers to pool their procurement of family planning and other commodities, thereby strengthening the supply chain and reducing costs and stockouts.

The organizing strategies used to pursue this goal can vary greatly. The following examples from Indonesia and Brazil demonstrate how country contexts and specific quality concerns shape the strategy that providers take to organize themselves to achieve their goals. In Indonesia, the need for greater support and quality improvement led to the development of a social franchise that could promote adherence to quality standards. In Brazil, physicians chose a more flexible approach that would allow them to retain greater control over patient care and pursue innovative strategies to ensure quality as the private health sector expanded.

Bidan Delima Social Franchise in Indonesia

Recognizing a need for quality improvement

The Indonesian Midwives Association (IBI) is a professional association with approximately

130,000 members—more than 80 percent of all midwives in the country. Its membership includes 40,000 midwives who operate and staff private health facilities. Although the number of private midwives in Indonesia has been increasing for many years, the Indonesian public health sector does not have the resources to monitor and improve their clinical skills. In the early 2000s, this gap was a major concern for both the government and its development partners. Indonesia has one of the highest maternal mortality rates in the world, partly due to a significant percentage of births unattended by trained providers and a lack of access to emergency obstetric care. Donors and the Indonesian government looked for opportunities to leverage the large numbers of private midwives as part of a solution to filling this gap.

Partnering with donors to create a new social franchise

To improve maternal mortality rates and address the quality assurance issue of private midwives, the USAID-funded Sustaining Technical Achievements in Reproductive Health program worked with IBI to create a social franchise specifically for private midwives in 2003. The franchise, Bidan Delima, was designed to standardize, improve, and regulate the quality of services provided by its members. As with most social franchises, the franchisor offered quality oversight, clinical trainings, and assistance with marketing and branding to support its members and attract customers. One of the core clinical trainings included family planning counseling and services, an important step in increasing access to postpartum family planning services. To support increased use of antenatal care generally—and at Bidan Delima facilities specifically—USAID and other donors also implemented multiple voucher programs designed to decrease costs, and thereby increase demand, for these services.

Benefits of a social franchise

Social franchises provide benefits to both providers and clients. Providers get access to business and clinical skills trainings, marketing and branding support to advertise their facility, and often access to reduced-price or free commodities. Clients get access to higher quality services and products, usually at a subsidized price.

Since its founding, Bidan Delima has changed and expanded with donor support. Under USAID's Sustaining Technical Achievements in Reproductive Health, the franchise adopted the minimum requirement of the midwifery practices from the Ministry of Health into its standard of care. In 2005, program management shifted to USAID's Health Services Program and the original Bidan Delima qualifications expanded to a broader set of technical qualifications, including newborn care, early initiation of breastfeeding, active management of the third stage of labor, and manual removal of the placenta. In 2010, with the support of Johnson & Johnson, Bidan Delima began to separate from IBI and began independently overseeing its own administration, finances, and qualification assessments. The franchise has grown to include more than 14,000 members in 196 districts in 15 out of 34 provinces. A 2010 evaluation by USAID and Bidan Delima management found that the franchise's quality assurance processes improved the quality of care (as measured by provider-client interaction, compliance with standards of care, and management practices) in 75 percent of participating providers.

Addressing challenges to sustainability

Although Bidan Delima has grown quickly and studies show that the franchise does improve quality, decreased donor support, fee reimbursement problems, and a weak marketing

position have had an impact on its sustainability. The franchise has always relied heavily on donor support: USAID provided the initial funding, and it continues to receive financial support from Johnson & Johnson. In addition, Bidan Delima continues to benefit from other donors' voucher schemes. When the franchise took its first step toward becoming independent by breaking off from IBI in 2010, the process was much more difficult than expected because the franchise was not yet independently viable. Bidan Delima still relies on donor funding for operations management at the central level, while the district and province levels of the franchise are sustained only because work is done on a voluntary basis. Additionally, if donors stop supporting voucher programs, Bidan Delima midwives may have trouble with their facilities' sustainability due to reduced client flow. While the Bidan Delima model provides marketing support, there is low brand recognition throughout the country (1 out of 3 surveyed by Johnson & Johnson were unaware of the franchise) and brand names do not always affect clients' preferences in choosing midwifery services.

To transition off of donor funds, the franchise has sought to increase the use of domestic financing sources. In 2011, the Indonesian government introduced Jampersal, a reimbursement-based scheme to cover maternal and antenatal care, delivery assistance, and postnatal care. Jampersal requires participating health care providers

to register at their local health office in order to receive reimbursement. To help providers fulfill this requirement, Bidan Delima has made local registration a step in its qualification and certification process, so all franchise members will automatically qualify to participate in Jampersal. This relationship provides private midwives not

currently registered under Bidan Delima with a financial incentive to join the franchise since they will access new revenue streams. However, Jampersal presents a sustainability challenge as well, as reimbursement payments are not always reliably made on time.

Key points: Bidan Delima Social Franchise

- Viewing the growing number of private professional midwives as a possible solution to persistently high maternal mortality rates, USAID invested in the development of a new social franchise, Bidan Delima, to standardize, improve, and regulate the quality of services delivered by private midwives.
- Bidan Delima was able to leverage donor support to offer a comprehensive package of benefits that helped it grow quickly and improve quality of care among its members. However, overreliance on donor funding led to continued sustainability challenges.

UNIMED Cooperative in Brazil

A growing private health sector leads to competing interests

Beginning in the 1960s, the Brazilian government began supporting privatization across many sectors. This led to the rapid growth of the private health sector, especially in urban areas. As the private health market grew, corporate actors—including insurance companies and other non-health professionals—sought to profit from the increased revenue flows by creating their own medical groups. Private physicians recognized the value of organizing but were wary of incentives that would lead to suboptimal patient care. They therefore sought alternative approaches that would allow them to retain greater control over patient care to promote quality health services.

What UNIMED covers

UNIMED offers its clients multiple health financing plans that range in service benefits and premium payments. The costs of the plans are set by each cooperative and vary across the entire UNIMED network. In general, UNIMED plans cost less than commercial health insurance products and reimburse clients for services received at any UNIMED facility. Although plan details vary from cooperative to cooperative, they generally cover a comprehensive set of services, including family planning. For example, UNIMED Rio covers IUD insertion and permanent methods (in certain cases) under its hospital assistance plans.

Adopting the cooperative model in the health sector

In the late 1960s, a group of private physicians in the city of Santos came together to form the first UNIMED cooperative based on a model that was widely used in the agricultural and financial services industries. Physicians purchased ownership shares of the cooperative, which had begun operating clinics, hospitals, and other facilities in Santos. All of the facilities' revenue and investments would be jointly owned by the physicians. UNIMED facilities also employed non-shareholder physicians, nurses, and other personnel on a salaried basis.

This first UNIMED cooperative originated as an initiative of the local medical association of Santos until it grew too big and became an independent entity. Soon, physicians in cities throughout the country opened separate UNIMED cooperatives in their cities and towns. Currently, UNIMED is a network of 348 doctor-owned, doctor-managed cooperatives in Brazil that operate in 84 percent of Brazil's counties. One of the largest cooperative networks in the world, UNIMED covers 18 million patients and includes 113 cooperative-owned hospitals, 2,700 accredited hospitals, and more than 114,000 affiliated physicians as members. To coordinate across the individual cooperatives, members elect representatives to regional and national federations.

Innovating to improve quality of care

UNIMED cooperatives have experimented with several initiatives to improve the quality and efficiency of service provision. In Belo Horizonte, the cooperative implemented two pay-for-performance initiatives. One provides higher rates

to hospitals that meet targets in the accreditation process and the second rewards doctors for adherence to clinical guidelines for chronic disease management, an effort intended to reduce inpatient admissions rates. A 2011 case study revealed that the latter improved three indicators of chronic care management and decreased rates of hospital admissions for some classes of care for patients with chronic disease. This model also successfully increased the percentage of hospital admissions through UNIMED-Belo Horizonte at accredited hospitals (compared with unaccredited facilities). UNIMED cooperatives in other cities also participate in accreditation programs run by ANS, the Brazilian agency that regulates health plans and health insurance products. While there is no systematic process for quality assurance and improvement across all branches, UNIMED cooperatives in other cities have created quality protocols and guidelines for its members.

Many UNIMED cooperatives in Brazil are also engaged in efforts to increase access to and use of preventive services. Starting in the 2000s, some cooperatives established health promotion centers separate from their UNIMED facilities. Because these centers were outside the existing UNIMED structures, they were not well integrated into the cooperatives' existing continuum of care, and the effort was expensive. In an attempt to achieve better health outcomes, better patient experience, and lower costs, in 2011 UNIMED Guarulhos in Sao Paulo created the first primary care center within a UNIMED facility. This effort has been supported in part through collaboration with institutions such as the Cambridge Health Alliance and the Institute for Healthcare Improvement.

Key points: UNIMED Cooperative

- The private health sector should look outside the health system for proven organizing strategies that have worked in other sectors and adopt them as the models suit providers' needs.
- Agricultural cooperatives have helped organize farmers, increase the scale of their operations, and improve their outputs; UNIMED is one of the most successful examples of how this model can produce similar improvements in the health system.

Discussion

The examples from Indonesia and Brazil show that there are some organizing models that originated from a desire to improve quality of care for clients. Social franchises use benefits and resources provided by the franchisor to help increase provider skills as well as to monitor and ensure quality. Cooperatives allow providers to have an ownership stake in both delivering quality care and providing financial protection benefits to their clients.

Not every strategy is universally appropriate. For example, the UNIMED cooperative model succeeded because the doctors who founded the cooperatives operated exclusively in urban settings where there was a market large enough to support the cooperatives without external subsidies. Additionally, the Brazilian physicians were responding more to concerns about a potential reduction of quality that could result if doctors lost direct control over treatment procedures, rather than a need to improve quality overall. In Indonesia, stakeholders were primarily concerned about existing low quality of care; therefore, they required an organizing mechanism with strong quality oversight mechanisms to be built in.

Donor-led efforts to organize private providers, like Bidan Delima, benefit from a large and dedicated source of external financial, human,

and technical resources to support a rapid start-up. In Bidan Delima's case, this pool of resources quickly attracted a large membership base by significantly increasing benefits (access to trainings and marketing support) and decreasing costs of joining. However, such efforts can face significant sustainability challenges once donor resources are withdrawn or reduced. In these cases, stakeholders need to plan transition strategies to account for decreases in funding. In comparison, UNIMED, a market-based business that was led by private sector actors from the beginning, has had fewer challenges related to sustainability. UNIMED's success likely stems in part from the successful adaptation of the cooperative approach to the health care market. The doctors' independence from private health insurers and the density of the market may also have allowed them to provide financial coverage options at relatively low costs and experiment with programs to efficiently offer low cost, quality products.

Professional associations, though not discussed here, can be an effective mechanism to organize members from the private sector. As the following box shows, some are pursuing comprehensive strategies to increase their value to members by offering a wider range of benefits that would allow associations to grow their membership while improving the clinical service offerings provided by members.

Emerging practice: Expanding from advocacy to service delivery in Tanzania

Since the lifting of the 1977 ban on private for-profit medical practice in 1991, Tanzania's private health sector has grown significantly. A group of 30 practitioners in Dar es Salaam came together in 1994 to form the Association of Private Hospitals in Tanzania (APHTA). Although initially slow to grow, new leadership in 2002 began to pursue a more aggressive strategy and created a more inclusive association that would have increased negotiating power with government and donors. APHTA was rebranded as the Association of Private Health Facilities in Tanzania (APHFTA). With more than 500 members in four regional zones, it is now the largest group coordinating private commercial health facilities in Tanzania. In addition to its traditional policy and advocacy role, APHFTA is in the early stages of several initiatives that will further improve quality and increase the delivery of private health services, including:

- Building networking and referral systems within the private health sector
- Providing start-up financing to new providers
- Delivering guidance on management and working capital
- Pooling procurement of new medical equipment

Implications for family planning advocates

In the family planning space, donors have supported social franchises to improve quality among private providers for many years. As Bidan Delima shows, franchises can achieve rapid improvements in the quality of care. However, they require a number of inputs, which means they often rely significantly on donor support. Family planning stakeholders can—and should—continue to invest in expanding social franchises to improve family planning quality. However, donors and other family planning stakeholders may also consider testing other organizing strategies showcased in this primer. For example, UNIMED and APHFTA demonstrate that cooperatives and associations can also effectively organize private providers for quality improvement interventions. Experiences with these models should be evaluated to generate evidence about their ability to effectively address family planning quality concerns.

Improving access to new revenue opportunities

With the global drive to achieve UHC, many countries are contracting with private providers through SHIs, service level agreements, or other mechanisms. The success of these programs depends on the payer's ability to attract and retain a large number of participating private providers. In addition, as these reforms take place and health technology evolves, health markets in many countries will create new financial opportunities for the private health sector. As the following examples from Germany and South Africa illustrate, organizing can help private providers capitalize on these opportunities. Provider groups have greater leverage to negotiate contracts and payment terms than individuals, can achieve efficiencies in their operations, and facilitate public-private partnerships and collaboration.

Provider associations in Germany

The emergence of a new health financing system

Under Chancellor Otto von Bismarck, Germany developed one of the world's first SHI programs in the 1880s. Initial reforms required guilds and other labor groups to pool funds and purchase health care on their members' behalf from individually contracted hospitals and private physicians. These financing schemes—funded by a combination of employer and employee contributions—were set up to operate and be regulated at the state level. Reforms over the next several decades expanded the categories of workers that were required to purchase coverage, and so membership in the schemes quickly grew, reaching just over half the population by 1925.

Organizing private physicians to improve payment terms

As the amount of financing flowing through the SHI funds increased, so did the need for greater organization of participating providers in order to increase efficiency and decrease transactional costs. At first, regulations did not address the relationship between funds and providers. As the funds contracted physicians on an individual basis, this gap meant that the funds could impose a number of restrictions on both their members and contracted providers. As funds grew in size—and thus became an increasingly important source of revenue for physicians—this power differential led doctors to undertake a series of strikes and protests.

During a period of economic crisis in the late 1920s and early 1930s under the Weimar Republic, as unemployment rose and SHI contributions decreased, funds and providers engaged in a series of negotiations that strengthened the role of private physicians. The negotiations resulted in an emergency decree from the German chancellor in 1931 that led to the end of individual contracts

between SHI funds and providers. Physicians formed regional associations to negotiate reimbursement levels with regional associations of SHI funds on their members' behalf and to facilitate reimbursement payments, thereby strengthening the hand of contracted providers in the negotiations. Unlike most professional associations that promote broad professional goals and are often involved in quality oversight, these groups emerged primarily to facilitate negotiation and interactions with the SHI funds. Individual and small groups of physicians also gained a monopoly on SHI-funded outpatient services to the exclusion of hospital-based doctors and other cadres of health workers. In return, these providers guaranteed that SHI clients would be able to access care at any participating facility, thereby increasing access. In 1955, the state-level associations joined forces to create the National Association of Statutory Health Insurance Physicians to lobby and advocate on their behalf in national policy discussions and to work with the SHI funds to develop and finalize both the list of services covered under the SHI scheme and the associated fee schedule.

Securing payments and controlling costs

Since the SHI funds started, their number and scope has expanded to cover most outpatient services for 85 percent of Germany's population. Currently, the majority of independent private physicians delivering outpatient services—more than 165,000—are organized into 17 state-level associations. At the state level, SHI funds engage and contract with the 17 provider associations directly to finance the delivery of outpatient care. This arrangement benefits physicians and the health system in multiple ways. By coming together, physicians have a stronger voice to negotiate reimbursement rates with SHI funds. Additionally, by channeling payments through the associations, the funds give

these bodies the ability to control costs in a fee-for-service scheme, since the associations will want to keep the overall amount billed by providers in line with the budget envelope provided by the SHI funds. Finally, as the source of financing for providers, associations also have leverage to promote quality and support adherence to treatment guidelines.



Provider associations in Germany show that organizing can be an effective way to increase revenue flows.

How insurance payments flow in the German system

Payments flow from the SHI funds to providers in two steps. First, provider associations receive an overall funding amount based on the number of SHI beneficiaries in their state. Physicians then bill the associations for reimbursement on a fee-for-service basis.

This example demonstrates the important opportunity that the global drive to achieve UHC presents. As governments seek to engage private health care providers on a larger scale—and with larger budgets—it is in the providers' interests to ensure that they have the ability to shape the terms of this engagement. As the example from Germany shows, organizing is an effective way to improve payment terms and increase revenue flows.

Key points: Provider associations in Germany

- Associations can have a focus other than clinical concerns.
- For the first 50 years, the insurance funds contracted providers individually, which gave the funds greater negotiating power; inadequate payment terms led providers to organize and push for more favorable fee schedules from the SHI funds.
- This example demonstrates the important opportunity presented by the global drive to achieve UHC.

Hospital consolidation in South Africa

Realignment of the South African health system

Beginning in the 1980s, the government of South Africa began a series of reforms that focused its resources on fighting infectious diseases and serving the poor. This shift led to a decrease in public hospital beds, and many private medical aid schemes—a significant source of funding in South Africa—began shifting their focus from public to private hospitals. In response to this new market opportunity, the number of private hospitals rapidly expanded throughout the 1980s and 1990s.

Consolidating under corporate groups to grow market share

In the beginning, the private hospital sector grew in a fragmented fashion. However, in the late 1990s and early 2000s, the industry became more concentrated as three corporate groups purchased many independent hospitals. This consolidation occurred largely due to market forces. As the hospital groups grew in size, they were able to purchase newer equipment and offer more specialized medical care, which attracted an increasing number of medical specialists away from independent facilities. This led to an increase in clientele at the corporate groups' facilities. By 2013, more than 70 percent of the 35,000-plus private hospital beds in South Africa were owned by the three largest hospital groups: Life, Medi-Clinic, and Netcare.

This consolidation of private hospitals has had both positive and negative results. On the positive side, it has promoted effective public-private partnerships between the hospital groups and the government. For example, Netcare has had at least 14 partnerships with central and provincial government entities, including operating five hospitals in partnership with provincial departments of health. The partnerships have taken multiple forms, from co-locating public and private sector wings in the same hospital building to refurbishing and operating public hospitals. They have provided an additional source of revenue for the private hospitals. Corporate hospital groups have also helped promote quality in the private sector, as many of the larger ones have received accreditation from external groups such as the International Organization for Standardization.

However, the consolidation has raised some concerns. The relatively lax regulatory environment in which this change occurred allowed a handful of corporate entities to dominate the private health sector. With their large market share, the three major groups have gained greater negotiating power vis-à-vis the medical aid industry. This shift in power dynamics has raised concerns that decreased competition has fueled increased costs in the private health sector, thereby limiting access.

Key points: Hospital consolidation in South Africa

- Changes in government public health strategies led to new market opportunities for the private health sector to grow. Without a strong regulatory environment, the private hospital industry soon consolidated into a limited number of large groups seeking to increase their market share.
- While this consolidation facilitated improved quality and the development of public–private partnerships, it also contributed to rising costs driven by a lack of competition in the system.
- This example underlines the benefits of organizing private providers to take advantage of new market opportunities. It also demonstrates the negative repercussions of organizing without effective government oversight or regulation.

Discussion

The examples from South Africa and Germany highlight the importance of revenue opportunities as a motivating factor to encourage greater organization. In South Africa, competition to take advantage of a new market opportunity led to consolidation of the hospital sector. A similar event is occurring in India’s pharmacy sector (see following textbox). Access to insurance reimbursements and links to payment schemes can also serve as an impetus for organizing private providers. As the German experience shows, private providers are willing to organize if it allows them greater ability to negotiate more advantageous terms to participate in financing and insurance programs. As countries implement reforms to achieve UHC—including new national health insurance programs—providers themselves, with support from donors and governments, should recognize and take advantage of these opportunities. Another advantage for governments and donors is that providers organized under the umbrella of a health financing scheme are more easily reached for other interventions and are an effective platform for reaching private health providers at scale.

The contrast between the South African and German examples is instructive for another reason. In Germany, the government has long taken an active role in creating and enforcing a clear policy and regulatory framework that attempts to achieve balance between providers and payers. This robust framework created a process for working together to contain costs and negotiate effectively. South Africa has largely lacked such a framework, allowing the market to consolidate around a smaller number of corporate interests and providing these organizations greater market power to determine prices. As the country has experienced rapidly rising health care costs, this power has led to a political backlash that the government is trying to address through proposed national health insurance reforms. These reforms would dramatically restructure the health system, engendering significant resistance from the private sector. Together, these country experiences highlight the need for effective government stewardship and regulation as soon as private providers begin to organize.

Emerging practice: Pooling commodity procurement in India

In India, the vast majority of pharmacies operate on an independent, small-scale basis. As the market for pharmaceuticals has grown, corporate chains (Apollo, MedPlus, Guardian Pharmacy, etc.) have begun to emerge. With greater scale and technological resources, these chains offer reduced costs to consumers. In response, some of the more traditional “mom and pop” pharmacies have started to join forces. The All India Organization of Chemists and Druggists has formed a corporate body of drug retailers. This body, when fully functioning, is intended to pool procurement of pharmaceutical commodities in order to bring costs down and help the independent stores compete with the larger chains.

Implications for family planning advocates

As discussed, opportunities to access financial revenue streams can serve as an incentive for greater organization of private health providers. As a preventive benefit, family planning is often left out of health insurance schemes and other financing mechanisms, and on its own is not likely to be a driver for organization. However, there are few opportunities more lucrative—or more likely to address financial barriers for women who have an unmet need for family planning—than health financing reforms intended to achieve

UHC. Globally, there are a number of efforts to accredit private health providers to be reimbursed by national health financing schemes. While those efforts continue, family planning stakeholders should target UHC advocacy efforts for the inclusion of a comprehensive range of family planning services. In doing so, family planning stakeholders will benefit. For example, they can use UHC-related accreditation requirements to get more providers trained on the full range of family planning methods, thereby increasing access, as IMAP has done in the Philippines.



Midwives who are part of the Bidan Delima social franchise in Indonesia.

Photo: © 2016 Radha Rajan, Courtesy of Photoshare.



Principles for Organizing

Organizing private providers can be a challenge. As the country examples demonstrate, there is no standard sequential process that will uniformly apply to every situation. The impetus and strategies for organizing vary greatly depending on the context. There are, however, several key features across these experiences that have helped providers respond to challenges and have facilitated their overall success. These features yield five key principles that providers, governments, and donors should keep in mind when they seek to promote greater organization in the private sector.

Principle 1: Identify and leverage the right motivations and incentives

Efforts to organize private providers need to convince potential members that participating will be of value to them and their health practices. If promised benefits are too vague, irrelevant, or unrealistic, organizing efforts will not succeed. Therefore, a key challenge for providers attempting to organize is identifying motivations that are both of significant relevance to their potential members' interests and within their ability to address.

Two themes relevant to this principle emerge from the country examples. First, financial incentives are incredibly important. Japan first saw the emergence of an effective private sector association in response to growth in SHI programs. South Africa's private health sector achieved greater organization as a result of market forces driving market consolidation. Second, organizers need to consider more than just financial opportunities related to increased income, access to equipment and commodities, and so on; they also need to highlight the threats to private providers' practices if they continue to operate on an independent, standalone basis. In Germany, private general practitioners organized because the payment terms under the existing contracting arrangements were insufficient to support their operations. In the Philippines, private midwives organized because they were concerned about the declining or poor quality of care provided by their cohort.

Clearly understanding and articulating the reasons that a more organized private health sector is needed are essential first steps to successfully organizing. Private providers, governments, and donors can identify key motivations and incentives for organizing by considering:

1. **Overall health system context.** What gaps exist in the health system and public sector that need to be addressed? Can the private health sector fill those gaps? Are there existing barriers (e.g., restrictive regulations, anti-private sector ideologies) that prevent private providers from filling those gaps, and could they be addressed through a more organized effort?
2. **Emerging opportunities and threats.** What new policies and programs are the government considering that would affect the health system? Will these proposals create new opportunities for private providers to increase their client volumes or access new sources of revenue? Will they create new burdens that inhibit the private sector's growth? What is the government's strategy for achieving UHC and does its vision include a role for private providers?

Understanding this context leads to the overarching motivation for organizing, a vision for the group to pursue, and a value proposition to use in recruiting members.

Principle 2: Strong, local leadership is a key to continued success

Operating a private health practice is a full-time job. Providers and their staff often have little time for outside activities, including participating in an organizing effort. Effective leaders therefore need to provide the focused energy and mobilize the necessary resources to catalyze and sustain organizing efforts over the long term.

In some cases, international donors have provided this leadership through technical and financial assistance that has sought to strengthen and organize private providers to increase the scale and impact of donor programs. As the Bidan Delima experience in Indonesia shows, donors are an important stakeholder, providing a large, dedicated source of resources to support an organizing effort's rapid start-up and growth. This pool of resources can reduce costs (e.g., lower membership fees) and increase benefits (e.g., access to donor-financed technical assistance), thereby attracting a larger membership and building momentum for the effort. However, as Bidan Delima also demonstrates, relying too heavily on donor leadership can jeopardize

sustainability when donor support ends and a group must transition to local financing. Bidan Delima has addressed some of these concerns by diversifying its funding sources and operating on a volunteer basis.

In the majority of the successful examples presented in this primer, providers themselves have driven the organizing process, including mobilizing the resources needed to support their efforts. This self-reliance is important for several reasons, the first of which concerns the sustainability of the effort. By relying on local resources from the start, providers in Germany, Japan, the Philippines, and Brazil have largely avoided the challenge of identifying and adopting the adequate alternative funding sources that Bidan Delima has had to repeatedly address. Self-reliance has also helped the groups link to well-connected and well-respected champions who could lend instant credibility and access to influential networks of stakeholders. JMA exemplifies this aspect. At two key points—its initial founding and during post-World War II reforms—JMA was led by presidents who were well positioned to prove the association's value to its members. President Shibasaburo's influence opened the door for private general practitioners to shape the new SHI program. President Takemi's political connections ensured that JMA members could continue to influence health policies in the reformed Japanese health system.

Principle 3: Target the membership base appropriately

Targeting the right membership is essential. With the exception of the KHF, all of the country examples focus on organizing a specific cadre rather than the private health sector at large. A narrow focus is a key factor for success. It helps preserve the clarity of the group's mission and brand for potential members. This clarity of vision helps the group select activities that will likely provide the greatest value to its members. Especially during early stages when resources are scarcer, attempting too many disparate activities to attract a wide range of members can prevent anything of value from getting done. Focusing on one cadre also limits the time and effort needed to identify and recruit potential members. That said, this approach tends to lead to activities that are best suited to needs of specific cadres and may not be optimal for the health system as a whole, which is why it is important for organizing efforts to take place across multiple cadres. These groups can then serve as a platform for addressing health system-wide issues, as KHF did.

As organizing efforts grow and mature, there are benefits and costs to increasing their scope and diversity. For example, if a provider network

expands its geographic footprint, the network can improve patient outcomes through increased access and referrals; however, the network's operational costs would also rise significantly. Associations and other groups focused on policy and dialogue can also risk diluting their voice by trying to address the various concerns of a broader membership base. The examples from Brazil and Germany show how providers can address these concerns. In Brazil, UNIMED's cooperatives are geographically focused on specific urban settings. While clients can receive care at all UNIMED facilities (thereby increasing access and strengthening referrals), each cooperative is able to focus on the specific health system challenges and opportunities in its area. In Germany, while the provider associations have a nationwide umbrella group to represent their interests in national policy-making processes, the foundation of this group is the state-level associations. This structure allows the providers to reflect the SHI funds' structure to better interact with them.

Principle 4: Determine organizing strategies based on end goals

Effective organizing strategies respond to the health system context—everything from the membership base to the organizational structure needed to leverage opportunities to achieve the promised benefits. The group's structure should therefore depend on the specific activities that it will undertake to achieve its goals. In Brazil, private doctors wanted greater control over their practices, so they adopted the cooperative model to allow physicians—and not nonclinical corporate interests—to direct their activities. In Japan, private general practitioners wanted a voice in the design of the new social insurance schemes, so they created a national association that would allow them to channel that input. In Indonesia, concerns about quality of care led stakeholders to create a social franchise that would impose quality standards as a condition of membership. In South Africa, private hospitals required significant capital investments to seize upon market opportunities created by the retrenchment of the public sector, so large corporate groups came to dominate. Of the various organizing models, professional associations and umbrella federations typically focus on strengthening the private sector's voice. Provider networks and associations tend to address quality and financing issues.

Private provider groups operate best when they contain a system of benefits and obligations that are balanced between the organization itself and the members. Depending on the purpose, benefits can include better payment terms like in Japan and Germany, access to clinical and nonclinical trainings like in the Philippines and Indonesia, and increased access to commodities, supplies, and technology like in South Africa. Obligations usually include fees to cover the group's administrative and management costs. As providers identify their key motivations for organizing, they should adopt strategies that will allow them to address their goals. Donors and their implementing partners can assist in these efforts by sharing global best practices and lessons learned from efforts in similar settings.

Principle 5: Monitor, learn, and adapt

As private provider groups grow and mature, their leaders need to understand how their activities continue to benefit their members and affect the larger health system. If conditions change and the principal motivating factor is no longer relevant, organizing efforts run the risk of becoming irrelevant to their members. In Japan, JMA began offering additional benefits to its members, including a pension program, to increase its appeal. In the Philippines, IMAP began running its own health facilities and supporting accreditation with the new national health insurance scheme. Additionally, it is equally important that stakeholders watch out for negative repercussions of organizing. In South Africa, while consolidation of the private hospital groups has led to a number of positive gains, it has also led to concerns about increased costs that have resulted in considerable political backlash. As the South African government finalizes plans for its new national health insurance proposal that is intended to reshape the health system, the private sector will have to adapt accordingly.

As these examples show, private provider groups should develop and implement strategies to monitor their effectiveness, learn what works and what does not, and adapt accordingly. Doing so provides an opportunity to remain relevant to its members and continue effectively pursuing its goals. In some cases, this adaptation requires providers to change their overall purpose for organizing, strategy, leadership, or main activities. Identifying and measuring clear metrics for their activities, monitoring developments in the larger health system context, and establishing an effective process to collect, analyze, and use this information are all essential to the group's long-term success.

Conclusion

The private sector is a key partner to support the achievement of Family Planning 2020, UHC, and other public health goals. For donors looking to implement private sector strategies, large and effective private provider groups are important partners in scaling up these interventions. This primer has provided an overview of the experience of six countries and identified five central principles that can guide providers, governments, and donors as they seek to engage with larger numbers of private providers. Working through the questions and issues presented in the five principles can help donors develop a blueprint for strong, sustainable, and effective provider networks and associations.



In 2016, the West African Private Health Federation was established, comprising 15 countries. Pictured here: Representatives from six West African countries sign a declaration in 2015, agreeing to form the federation.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Marie Stopes International, Population Services International, Praekelt.org, and William Davidson Institute at the University of Michigan.



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