

**A SCOPING STUDY OF
PUBLIC AND PRIVATE SECTOR DELIVERY OF
ESSENTIAL SERVICES**

Final study report - 21 October 2016

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Abbreviations and acronyms

AFD	Agence française de développement (France)
BMZ	Federal Ministry for Economic Cooperation and Development (Germany)
DAC	Development Assistance Committee
DCED	Donor Committee for Enterprise Development
DFI	Development finance institution
DFID	Department for International Development (United Kingdom)
DGIS	Directorate-General for International Cooperation (the Netherlands)
ECDPM	European Centre for Development and Policy Management
EIB	European Investment Bank
EU	European Union
EURODAD	European Network on Debt and Development
FP	Family planning
HiA	Health in Africa initiative
IADB	Inter-American Development Bank
IFC	International Finance Corporation
LMIC	Low and middle-income country
MDB	Multilateral development bank
MNCH	Maternal, newborn and child health
NGO	Non-governmental organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PPP	Public-private partnership
PSD	Private sector development
PSiH	Private Sector in Health
PSP	Private Sector Programme in Health (PSP, SIDA-funded)
sd	Sine die (no date)
SDG	Sustainable development goal
SHOPS Plus	Sustaining Health Outcomes through the Private Sector Plus
SIDA	Swedish International Development Cooperation Agency (Sweden)
SME	Small and medium-sized enterprise
SRHR	Sexual and reproductive health and rights
TB	Tuberculosis
UHC	Universal health coverage
UN	United Nations
UNDP	United National Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
USAID	United States Agency for International Development
USD	United States of America dollar
WHO	World Health Organisation

1 SCOPING STUDY

1.1 Study objectives

11.11.11, the coalition of NGOs, unions, movements and various solidarity groups in Flanders, requested a scoping study of the advantages and disadvantages of public or private delivery of essential services, particularly provision of healthcare and education. The findings of the scoping study inform the 2016 campaign “essential health services for every one”.

The study describes the **(dis)advantages of the increasing commercialisation and privatisation of essential services in terms of accessibility, appropriateness, affordability and sustainability of these services**. Furthermore, the study provides an analysis of the discourse of multilateral and bilateral development cooperation agencies and development finance institutions with regards to private sector involvement and gives examples of projects and countries where privatisation has occurred.

1.2 Study methodology

This scoping study is entirely based on a literature review. We performed a non-exhaustive search of publications in academic peer-reviewed journals, documents and grey literature (non-reviewed papers, reports), in different languages (English, French, Dutch, German, Spanish). Information and data collection was therefore primarily based on publicly available documents and sources found online.

The sources and websites consulted include:

- *Document libraries*: PubMed (bibliographic), ELDIS (development references), HEART (health and education resources);
- *International development cooperation agencies*: World Bank, International Finance Corporation (IFC), Asian Development Bank, African Development Bank, Inter-American Development Bank (IADB);
- *National/bilateral development cooperation agencies*: European Union, Directorate-general Development Cooperation and Humanitarian Aid (Belgium), Ministry of Foreign Affairs – development cooperation (DANIDA, Denmark), Agence française de développement (AFD, France), Federal Ministry for Economic Cooperation and Development (BMZ, Germany), Directorate-General for International Cooperation (DGIS, the Netherlands), Swedish International Development Cooperation Agency (SIDA, Sweden), Department for International Development (DFID, United Kingdom), United States Agency for International Development (USAID, United States of America), Department of Foreign Affairs and Trade (DFAT, Australia);
- *Organisations specialised in development cooperation*: Organisation for Economic Cooperation and Development (OECD), European Centre for Development and Policy Management (ECDPM), Oxfam, 11.11.11 (Belgium), European Network on Debt and Development (EURODAD), Centre for Global Development;

- *Thematic organisations for health:* World Health Organisation (WHO), and for education: United Nations Educational, Scientific and Cultural Organisation (UNESCO) and Global Partnership for Education;
- *Private sector websites:* Private Sector Programme in Health (PSP, SIDA-funded), Private Sector in Health (PSiH, a Health Systems Global thematic working group), Sustaining Health Outcomes through the Private Sector Plus project (SHOPS Plus, USAID-funded), Global Health Group's Private Sector Healthcare Initiative (based at University of California, San Francisco);
- Reference lists of key papers and reports.

The full reference list – split into general background documents, health-related and education-related documents – can be found in annex 1.

2 DEBATE BETWEEN PUBLIC AND PRIVATE INVOLVEMENT IN DELIVERY OF ESSENTIAL SERVICES

2.1 Controversy about public and private delivery of essential services

Access to both health and education is considered a basic human right. In most countries health and education services are therefore primarily delivered by the public sector, since the provision of these services – for free or at a fee that is not associated with the production or delivery cost – is traditionally seen as the role of the state. The public sector thus delivers public goods and services which a non-payer cannot be excluded from (such as street lighting), or which benefit all of society rather than just the individual who uses the service (education).¹

This study focuses on low and middle-income countries where – along with more traditional aid and public sector financing – **private sector investments increased, mainly because of state budget restrictions, limited public engagement and increased commercial opportunities in emerging markets for private investors.** The private sector includes all types of market players, from the self-employed in the informal economy, small, medium and large enterprises, to transnational companies, even to foundations or institutions that represent the business sector. The composition of the private sector differs from developed to developing countries, with almost half of private sector activity in developing countries taking place in the informal sector.

Involvement of the private sector in the delivery of essential services such as *health and education* has also increased over the years and across the world. Literature shows that there is quite some controversy around the contribution of the private sector in these sectors² and

¹ This description of the public sector and public goods and services can be found in the introduction of any handbook on economics.

² The divide is often seen as running parallel to neoliberal versus alterglobalist thinking.

that nuances are needed in the divide between opposite opinions of supporters and contestants of private sector involvement.³

Many believe that private investments are required to generate growth – but there are as many who believe that public investment is needed, e.g. in basic physical infrastructure, primary, advanced and vocational training, basic research, health and green investments as this leads to healthier people, higher productivity, and/or higher living standards. While growth is not an end in itself, it creates – according to the believers of private sector involvement – the necessary resources to support healthcare, education, and other public services. Tax revenues from the private sector are to be used by the government to reallocate and to guarantee access to essential services such as health, education, social security (FOD Buitenlandse Zaken 2014). In addition, the public sector is considered to have a critical role in supporting economic growth and private sector involvement (IFC 2011a). **The private sector is by those ‘believers’ considered as the engine of sustainable economic growth and job creation, but evidence is rarely provided.**

Many multilateral and bilateral development cooperation agencies believe that the private sector also contributes to **poverty reduction** (e.g. Australian Government DFAT 2015). In the context of development cooperation and against the background of decreasing aid budgets many of the international finance institutions and national development agencies follow the neoliberal thinking and consider the private sector as the ‘new kid on the block’ to guarantee extra resources and to achieve the sustainable development goals (SGDs) by 2030.

Apart from poverty reduction, job creation and inclusive and sustainable growth generation as benefits of private sector involvement, efficiency is often mentioned as the rationale for promoting private sector participation. A recent review by UNDP’s Global Centre for Public Service Excellence states that the debate between public and private provision is often opinionated but – based on rigorous literature – “finds **no conclusive evidence that one model of ownership (i.e. public, private or mixed) is intrinsically more efficient than the others**, irrespective of how efficiency is defined. Instead the literature suggests that the efficiency of service provision is dependent on the type of service (health, education, etc.) and other specific contextual factors (e.g. regulation, market competition)”, rather than on ownership (UNDP 2015).

Whereas literature comparing efficiency between public and private models often lacks rigour, the same review observes that sectoral literature, especially in health and education, is “more rigorous although often inconclusive” (UNDP 2015). For *health* the study concludes that there is no convincing evidence that either public or private health service delivery is more efficient, but within the private sector evidence shows that non-profit providers are more efficient than for-profit providers, most probably because “perverse incentives to over-treat in private for-profit hospitals drives down efficiency” (UNDP 2015). The review mentions that for *education*

³ Because of the combination of (i) low and middle-income countries on the one hand and (ii) private sector participation in service delivery on the other hand, it is difficult to distinguish between private sector involvement and the term ‘private sector development’ (PSD), particularly because most sources discuss the role of the private sector in the context of development (cooperation).

"greater efficiency in private provision has been attributed to lower pay, recruitment autonomy, and market-like conditions" (UNDP 2015).

Efficiency is not the focus of our study but is very much present in the discussion on public versus private sector provision of essential services. Our study attempts to add to the efficiency findings by studying aspects of accessibility, affordability, appropriateness and sustainability (see chapter 3).

Overall, our scoping study tends to affirm the above observations. While job creation, inclusive growth, poverty reduction and efficiency are mentioned continuously by believers of private sector participation, **evidence doesn't always come along, and when evidence is available it often lacks quantification**. Wordings such as 'it is likely that the private sector will generate growth', or 'private investments can lead to job creation', can also be reversed and said about public sector (if the state budget allows them to), so it often depends – again – on who wants to defend what.

2.2 Who advocates for increased private sector involvement?

Many multilateral and bilateral development cooperation agencies (European Commission, EU Member States, Australia, regional development banks) recommend private sector involvement in their current development strategies. **Private sector-led development** refers to this donor engagement with international or domestic for-profit and not-for-profit organisations to promote productive investment and activities in developing countries.⁴ These partnerships between donors and business are a trend in development cooperation. Annex 2 presents an overview of the trend towards more private sector development, a trend which we consider to be 'biased' because primarily advocated for by the (neoliberal) development cooperation agencies and development finance institutions.

In this context of private sector development multilateral and bilateral development cooperation agencies mainly concentrate on micro, small and medium-sized enterprises in sustainable energy, sustainable agriculture and agribusiness, digital and physical infrastructure, the green sectors, and **focus to a lesser extent on social sectors** such as healthcare and education. Annex 3 gives a non-exhaustive overview of the development cooperation agencies' priorities and focus on private sector development.

"One of the latest arguments development finance institutions and aid agencies use to justify their investments in the private sector is that by cooperating with the private sector they can leverage significantly more finance into their projects than development institutions could ever raise alone."

[Kwakkenbos and Romero 2013]

⁴ The term 'private sector-led development' may be more correct than 'private sector development', but to be in line with the terminology used most frequently in publications we stick to 'private sector development'.

2.3 Who adds critical opinions to the debate?

When pleading for universal healthcare and education for all, it may be better to turn the above reasoning of the rationale for private sector-led development upside down so that inclusive growth, job creation and poverty reduction may be encouraged by public instead of private sector development. If the public sector is fully engaged to deliver quality education and health services to the whole population (and gets sufficient resources to fund the sector), a healthier and more educated population would most likely lead to less economic poverty.⁵

A more critical opinion about private sector development comes from EURODAD, the European Network on Debt and Development, that warns that **although foreign direct investment by multinational companies is "sometimes necessary"** when a poor country lacks the technology, expertise or capital available to carry out a specific investment, **its impact on pro-poor and nationally owned development is not without controversy"** (EURODAD 2010).

The EURODAD report also shows how IFC fails to reach the poor and to prioritise development effectiveness as the overriding criteria when choosing projects in which to invest. In the period assessed (2008-2010) "less than one fifth of all IFC investments went to companies from the world's poorest countries, where credit is most scarce and borrowing costs are higher. Two thirds of the IFC's financial support went to companies based in the richest countries". In the same report EURODAD points to official aid effectiveness commitments stating that the private sector should also contribute to effective country-led development processes, but "IFC fails to show how it supports developing country ownership over their industrial and agricultural policies, investment policies and strategies, and the development of its financial and private sectors" (EURODAD 2010).

As criticised in a recent Oxfam report published for the SDGs' first anniversary "most international finance goes to countries with higher public spending" and although private finance through investments and remittances contribute to development, **"yet again, the problem is that the poorest countries are left behind"** (Oxfam 2016). The latter was also confirmed in a study of the Asian Development Bank, that showed "that many private operators were unable or unwilling to improve or expand services to low-income groups, at least in the short to medium term" (Asian Development Bank sd).

Thus there seems to be **missed opportunities in simultaneously encouraging private sector development and acting jointly for pro-poor development.** Kwakkenbos et al. nevertheless argue that – based on lessons learned from international finance institutions such as IFC and European Investment Bank (EIB) – "there is not enough focus on using development finance for the private sector in developing countries, which can provide much needed revenues for social policies and public goods" (Kwakkenbos and Romero 2013). But

⁵ As Sen rightly points out in his blog in The Guardian healthier and more educated people would be "leading to higher wages and larger rewards from more effective work, but also because universal health coverage makes it less likely that vulnerable, uninsured people would be made destitute by medical expenses far beyond their means" (Sen 2015).

when private sector investments are used for development purposes, Küblöck et al. warn that “consideration should also be given to which sectors or companies should be private at all and which responsibilities are best met by public providers” (Küblöck and Staritz 2013). This warning is important in our discussion about privatisation of basic services such as healthcare and education (see chapter 3).

"Apart from the private sector's considerable heterogeneity, when discussing private sector development, consideration should also be given to which sectors or companies should be private at all and which responsibilities are best met by public providers. After focusing on the privatisation of nearly all sectors in the 1990s, the view has gained ground again in recent years that the public sector does have an essential role to play in central infrastructure and services such as health and education."

[Küblöck and Staritz 2013]

Critical voices with regards to privatisation or commercialisation of health services and education come from various international, European and Belgian NGOs; e.g. Oxfam International, IBON International, CONCORD, 11.11.11 in Belgium, People's Health Movement, World Education, just to mention a few. These organisations demand that the rights to health and education are prioritised over the economic interests of a few and that governments safeguard that for-profit companies behave responsibly and transparent and don't compromise the interests of the poorest in developing countries. They therefore request that the government takes up its responsibility (and a sufficient share of the state budget) to provide equitable, affordable and high quality healthcare services and education.

3 (DIS)ADVANTAGES OF PUBLIC AND PRIVATE DELIVERY OF ESSENTIAL SERVICES

Note: The focus of this chapter on the discussion of advantages and disadvantages of private sector involvement rests primarily with for-profit private companies, but because evidence is not always strong, or does not always distinguish between different types of private organisations and forms of partnerships between public and private sector, other forms of private sector involvement will be discussed as well.

We refer to peer-reviewed articles – and to a much lesser extent grey literature – to make an evidence-based case for the role of public versus private sector involvement.

(Dis)advantages of private delivery of health and education services that exclusively refer to **private for-profit involvement** have been indicated in **bold** in the following text. Annexes four and five include more details about the focus of the studies and their definition of the 'private' service delivery for health and education respectively.

3.1 Health

► Private sector in health

The private sector in health is defined to include for-profit organisations, social enterprises sometimes referred to elsewhere as “not-for-profits”, non-profits including NGOs and faith-based organisations; and privately motivated individuals and groups of individuals” (IFC 2008). The heterogeneity of the private sector generates different challenges and opportunities, moreover because it is playing a growing role in health systems in low-income and middle-income countries. In some regions (e.g. Africa) the private sector accounts for half of healthcare provision.

In practice, it is not always easy to distinguish between the public and private sector and boundaries between the two can be blurred as healthcare providers or clinicians might work in both sectors, as Patouillard and colleagues (2007) remark. The definition of ‘the’ private sector differs and makes it difficult to compare and understand the different aspects of the private sector – including for-profit but also not-for-profit private providers.

Ample evidence exists nowadays about the advantages and disadvantages of either public or private healthcare provision. Several systematic reviews have compared public and private health services delivery, sometimes in specific areas such as maternal or antenatal care, focussing on the effectiveness of each

"Few issues provoke as much disagreement, even anger, as the question of the private sector's role in delivering healthcare. Supporting a contribution by the private health sector towards achieving the goal of universal health coverage is seen as a betrayal of public welfare by many critics."

[Horton and Clark 2016]

system, the quality of care provided, and accessibility. These reviews regularly cover the not-for-private sector. Findings about the for-profit sector are less documented - or publicly available. About the corporate commercial hospital sector e.g., which is growing rapidly, little is known (McPake and Hanson 2016).

Both the public and private sector provide healthcare services, but the controversy around their appropriate role in service delivery and health system strengthening in low and middle income countries gives rise to a constant debate, as evidenced in a PLoS Medicine 2008 publication and a recent Lancet series about universal health coverage (UHC) and private healthcare (Hanson et al. 2008, Horton and Clark 2016).

The PLoS Medicine debate contrasts the viewpoints of two groups of academicians with "there is no alternative to strengthening the public role in the health system" versus "we must engage the private sector to improve healthcare in low-income countries". The first group, being in favour of public sector involvement, argues that “the profit-making incentive dominant in much of the private sector is likely to be problematic for healthcare” and that “even where private services are low cost, they are not necessarily affordable” (Hanson et al. 2008). The second group explicitly states that “being pro-private sector does not imply being anti-public sector”

and claims that blending of the strengths and weaknesses of both sectors can produce optimal results, because “with a complicated problem such as improving healthcare under constrained resources, two heads are better than one”.⁶

Although both groups continue to defend their pro-public and pro-private standpoints respectively, **there is a common understanding that the public sector cannot be ignored in health service delivery and that there is a role for the private sector in improving the health of the world’s poorest.** Hence agreement about the necessity of a public-private mix prevails nowadays. Or as is concluded in one of the Lancet series contributions: “The main aim of government policies should be to encourage a public–private mix that ensures widespread availability of good quality, affordable care so that the health system meets the needs of the population as a whole” (McPake and Hanson 2016).

This conclusion is also shared by the Private Sector Healthcare Initiative at the University of California, San Francisco: “In developing countries and areas of limited healthcare access, private providers act on the front line and are often the only form of healthcare available.

“The private sector is increasingly hard to ignore, and the costs of ignoring it could be very high in public health terms. A range of devices exists for engagement, and experience with them has rapidly developed in recent years. The choice of appropriate approach will vary substantially, dependent on the health system failures being addressed, the nature of the health-care product or service, the type of provider, and the level of development of the country both in terms of income levels and health system organisation.”

[Montagu et al. 2016]

Although the private sector plays an increasingly important role in healthcare in developing countries, it remains a new area of study and innovation. When governments cannot provide widespread access to care, and traditional charity-focused NGOs can only offer limited or temporary solutions, the private sector presents an opportunity for sustainable scale-up of healthcare services alongside social and economic development.”⁷

One of the private sector-led development defenders is the International Finance Corporation, member of the World Bank Group. IFC strongly believes that private sector development is key because the public health sector in LMICs is often unable to respond adequately to the enormous health needs (amongst others because of public underspending on health) and because “private sector providers, including for-profit and social enterprises, fill an important medical need for poor and rural populations underserved by the public sector” (IFC 2008).

In 2008 IFC launched the Health in Africa initiative (HiA) to link governments in Sub-Saharan Africa with the private sector in order to improve the quality of healthcare (IFC 2013b). A mid-term evaluation of this Initiative in 2012 concludes that “HiA has had some significant successes, but its performance has been quite uneven and it has not delivered in some

⁶ Viewpoint by Smith R, Feachem R, Feachem NS, Perez Koehlmoos T, and Kinlaw H: ‘We Must Engage the Private Sector to Improve Healthcare in Low-Income Countries’, in Hanson K, Gilson L et al. 2008.

⁷ <http://www.globalhealthsciences.ucsf.edu/global-health-group/private-sector-healthcare-initiative-pshi/research/private-health-sector-markets>. Accessed September 14 2016.

important areas", in brief "HiA has not lived up to its expectations" (IFC 2012). Reasons for this conclusion are that the HiA activities were not focussed nor benefitted the underserved, that there was no detailed operational strategy nor M&E plan and that there were no synergies across the World Bank Group. An evaluation of the World Bank Group's support to improving effectiveness and outcomes for the poor in health and nutrition also finds that "IFC's health interventions have had limited social impact, although efforts to broaden those impacts are increasing" (World Bank 2009). IFC nevertheless claims in a 2013 study about jobs that IFC health projects have had some positive results for efficiency, governance, and affordability" (IFC 2013b). Based on the limited and sporadic information made publicly available by IFC, Oxfam largely confirms the findings of the 2012 mid-term evaluation of HiA that IFC's investments don't benefit the poor and underserved, but mainly benefit wealthier people in need of tertiary care: "Publicly available information shows that Health in Africa's investments to date have, in practice, predominantly been in expensive, high-end, urban hospitals offering tertiary care to African countries' wealthiest citizens and expatriates" (Oxfam 2014b).⁸

"Health in Africa's investments consistently prioritise urban hospitals despite the IFC's own research finding that less than 12 percent of households in the poorest wealth quintile access healthcare in hospitals, and despite Health in Africa's commitment to improve the availability of healthcare for rural populations."
[Oxfam 2014b]

IFC's priorities and examples of the work in emerging markets are available on their website.⁹ Some of the (most successful?) cases are published.¹⁰ The Centre for Health Market Innovations provides free access to the world's most comprehensive database of health market innovations; based on their database information about private for-profit health providers can be obtained.¹¹

► Evidence base

The role of the private sector in healthcare provision has been analysed and documented substantially, but often in the form of grey literature. "Currently, a large body of literature

⁸ In a forthcoming publication on 'Public-Private Partnerships in Health: World Bank Group Engagement in Health PPPs: An IEG Synthesis Report', the Independent Evaluation Group found weaknesses in sequencing, completeness of advice, monitoring and evaluation, and aftercare, despite the World Bank Group supporting countries that need its support the most. One of the key lessons of the synthesis report is that "pro-poor access and affordability need not only be systematically considered at the design stage; they should also be tracked to ensure that the poor actually benefit from PPPs". Source: Independent Evaluation Group of the World Bank, IFC and MIGA. 2016. Private Sector Development: Recent Lessons from Independent Evaluation – What works. Washington DC: IBRD/World Bank.

⁹ <http://www.ifc.org/health>

¹⁰ See 'resources' on the IFC Health webpage. Case studies include: NephroPlus, a provider network of kidney dialysis services across 15 states in India; Alliar, diagnostic and laboratory services in Brazil; Aier Eye Hospital in China; Fundación Cardiovascular, providers of tertiary level services in Colombia to hospitals as well as of telemedicine, training, manufacturing of hospital products, assembly of bioengineering equipment, and hospital management software among other areas; Apollo Hospitals Enterprise Limited, largest private integrated healthcare group in India.

¹¹ See <http://healthmarketinnovations.org/>. In 2013 CHMI published an overview of more than 220 programmes that harness private providers to deliver maternal, newborn, and child healthcare in low- and middle-income countries (Centre for Health Market Innovations 2013).

documents the role of private for-profit and not-for-profit sectors in the provision of health services and commodities for the poor in developing countries. Much of this documentation exists in the form of grey literature: programme reviews, programme evaluations and summaries of experience from donor-supported interventions that support NGOs and/or private sector delivery of health services” (Montagu et al. 2011).

Our literature review includes 74 documents from various sources and confirms the remaining debate about pros and contras of public or private – or any mix – sector involvement in health service delivery. Comparison of the findings is often problematic because the focus of the documents differs: e.g. on one subsector (MNCH), on one thematic area (family planning, TB), on one country, or because the definition of private sector differs (only for-profit, or the whole range from informal private sellers, over not-for-profit non-governmental organisations, to large private for-profit companies).

Table 1 describes the sources used intensively for this scoping study by type. Of the 74 sources, twenty exclusively address the private for-profit sector, including only one systematic review (see annex 4 for more details about the sources used).

Table 1: Sources used for the scoping study on health, by type

Type of source	Number of sources included	Range of year of publication	Main focus
Systematic reviews	7 °,^	2007-2016	Appropriateness (service delivery and quality of care)
Landscaping studies	22	2001-2016	Partnering with the private sector for improved health for the poor
Country studies	18	2004-2016	Role of the private sector in health service delivery
Regional studies	11	2008-2016	Role of the private sector in health service delivery
Case studies	16	2003-2016	Link with UHC; focus on MNCH (FP, SRHR)

Note:

° Sample size of all documents reviewed totals to 681. The different samples were not cross-checked for doubles, and the total number may therefore be overestimated.

^The overview of systematic reviews of the performance of private for-profit, private not-for-profit and public healthcare providers by Herrera et al. (2014) includes some of the six selected systematic reviews.

Not all sources are used to the same extent for this report. Highest significance is given to systematic reviews, because they apply a comprehensive and rigorous approach and use multiple sources.

The total sample of the six systematic reviews on public-private sector comparison in health includes more than 680 studies and documents, with their individual findings diligently synthesised into a couple of pages.

Country and case studies are included because of the exemplary value, but although they often describe success stories, lessons can be learned from them, if context is well taken into account. Regional studies are useful because they address challenges and opportunities which are very similar for all countries in the region (or continent). For the health sector we found many country and regional studies on Africa, mainly because of the Health in Africa Initiative of IFC which produced a set of private sector assessments, e.g. in Congo, Ghana, Kenya, Mali (IFC 2010a: Ghana; IFC 2010b: Mali; World Bank 2010: Kenya; IFC 2011b: Congo).

Tung and Bennett (2014) study whether **private for-profit health providers that provided more than 40,000 outpatient visits per year, or covered 15% or more of a particular type of service in their country** have the potential to reach the poor in low and middle income countries. The study's most challenging limitation is the availability of documentation from for-profit companies, which moreover was often not complete or had not been subject to fact checking or peer review. The authors therefore conclude that their findings "may be biased towards companies that had more documentation" (Tung and Bennett 2014). They identify only 10 large scale private for-profit providers, most of them active in urban and peri-urban settings in South Asia and providing specialised services.¹² **"The characteristics of the business models of these firms were found to be similar to non-profit providers studied by other analysts (such as Bhattacharya 2010). They pursued social rather than traditional marketing, partnerships with government, low cost/high volume services and cross-subsidisation between different market segments"** (Tung and Bennett 2014).

The recent helpdesk report of the Health and Education Advise and Resource Team (HEART 2016) gives a good and succinct overview of the variety of reviews that have been published recently, although sometimes with conflicting conclusions: "However, the evidence base is not robust (Yoong et al. 2010). Assessments of interventions tend not to be rigorous and do not provide firm conclusions (Montagu et al. 2016). There is generally mixed and sometimes directly conflicting evidence on all areas comparing private and public healthcare (Campbell et al. 2016; Rao 2016). No firm conclusions can be drawn on whether one is 'better' than another, as the results vary considerably by context. Evidence on the relative advantages of the private sector is largely inconclusive (Saksena et al. 2012) and more research is needed (Powell-Jackson et al. 2015). There is no evidence to support claims that the private sector is more efficient, accountable, or effective than the public sector (Basu et al. 2012). Policy implications are therefore unclear." (HEART 2016).

¹² The list of 10 companies discussed in the study of Tung and Bennett (2014) includes: CARE Hospitals (India); CEGIN (Argentina); Lifespring hospitals (India); Lumbini Eye Institute (Nepal); Queen 'Mamohato Memorial Hospital (Lesotho); Narayana Hrudayalaya Hospital (India); Vaatsalya Hospitals (India); Visualiza (chain of hospitals; Guatemala); Viva Sehat (India); Ziqitza (ambulance services; India). Seven of the ten initiatives identified are chains of clinics or hospitals, where a single company owns and operates multiple hospitals or clinics, based in different geographical areas. All of the hospital chains are based in India, except for the two eye care specialty chains – Visualiza in Guatemala and the Lumbini Institute in Nepal. The chains range in size. See table 1 in their study for more details about the companies.

The scoping study looked into four criteria:

1. accessibility (geographic, financial)
2. affordability (refer to equity)
3. appropriateness (quality of care, effectiveness, ...)
4. sustainability.

For each of those criteria table 2 summarises the advantages and disadvantages for which evidence is available.

Table 2: (Dis)advantages of private sector involvement in health service delivery

Criterion	Advantages of private sector	Disadvantages of private sector
Accessibility	<ul style="list-style-type: none"> ▪ Greater perceived accessibility [1] ° ▪ Shorter waiting times [2;3;7] ▪ Higher responsiveness and customer orientation (e.g. suitable opening hours, convenient locations) [6;8] ▪ Lower rich-poor and urban-rural disparities: for births [3] and treatment of childhood respiratory disease [3;7] ^ 	-
Affordability	<ul style="list-style-type: none"> ▪ Possibility of using cross-subsidisation (i.e. higher mark-ups for wealthier patients to subsidise care of the poor) [8] 	<ul style="list-style-type: none"> ▪ Higher levels of exclusion of poor people from primary care [4] ▪ Higher user fees [7]
Appropriateness	<ul style="list-style-type: none"> ▪ Higher perceived quality of services [1] ° ▪ Perceived continuity of care offered [1] ° ▪ Availability of drugs [1;6] ° ▪ Guaranteed confidentiality [2;3] ▪ Patient-centred staff attitude [2;3;6;7;8] 	<ul style="list-style-type: none"> ▪ Poor technical quality [5] ▪ Low or no standards/regulation [5;6;9] ▪ Unnecessary testing and treatment [7]
Sustainability	-	-

Notes:

The (dis)advantages indicated in bold refer explicitly to the private for-profit sector.

° No evidence provided for this statement, therefore we added 'perceived' to the advantages as these benefits seem to stem from IFC's perceptions and selling arguments in their publications.

^It is not clear from the publication whether these advantages apply to the whole private sector, independent of being for-profit, not-for-profit or faith-based.

Sources:

[1] IFC. 2015. Guide for Investors in Private Healthcare in Emerging Markets. Washington DC.

[2] Montagu D, Anglemeyer A, Tiwari M, Drasser K, Rutherford GW, Horvath T, Kennedy GE, Bero L, Shah N, Kinlaw HS. 2011. Private versus public strategies for health service provision for improving health outcomes in resource-limited settings: a systematic review. San Francisco, California: Global Health Sciences, University of California, San Francisco.

[3] HEART. 2016. Helpdesk Report: Comparative advantage of the private sector in delivery of health services. 15 June 2016.

- [4] Oxfam International. 2014. Investing for the Few - The IFC's Health in Africa initiative. Oxfam Briefing Note. September 2014. Prepared by Marriott A and Hamer J.
- [5] Patouillard E et al. 2007. Can working with the private for-profit sector improve utilisation of quality health services by the poor? A systematic review of the Literature. *International Journal for Equity in Health* 2007, 6:17.
- [6] Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. 2012. Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review. *PLoS Med* 9(6).
- [7] Yoong J, Burger N, Spreng C, Sood N. 2010. Private Sector Participation and Health System Performance in Sub-Saharan Africa. *PLoS ONE* 5(10).
- [8] Tung E and Bennett S. 2014. Private sector, for-profit health providers in low and middle income countries: can they reach the poor at scale? *Globalisation and Health* 2014 10:52.
- [9] Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? *Lancet* 2016; published online June 26. [http://dx.doi.org/10.1016/S0140-6736\(16\)30242-2](http://dx.doi.org/10.1016/S0140-6736(16)30242-2).

The analysis that follows aims at describing the advantages and disadvantages mentioned most frequently in the discussion of public versus private sector involvement in health and tries to balance between them by giving a voice to both visions (pro-public and pro-private).

► Accessibility

Greater accessibility is regularly highlighted as one of the major reasons to involve the private sector in health service delivery. Since many low and middle-income countries have limited state budgets to allocate to health service provision or have (too) low public spending on health¹³, participation of the private sector is highly appreciated, especially by patients. This is one of the arguments often cited by IFC: "The private sector in many countries is becoming patients' preferred choice because of greater accessibility, a higher perceived quality of services, the continuity of care it offers, and the availability of drugs" (IFC 2015).

Basu and colleagues (2012) conducted a systematic review of research studies investigating the performance of private and public sector delivery in low- and middle-income countries. Performance was assessed in terms of accessibility and responsiveness; quality; health outcomes; accountability, transparency and regulation; fairness and equity; and efficiency. They observed that few studies have investigated accessibility', i.e. the ability to access available services. Accessibility was determined by them as (i) availability (in terms of distance to facility and hours of service availability), (ii) timeliness of the service (measured by waiting times from presentation to initial evaluation and subsequent testing, results, and follow-up) and (iii) hospitality (assessed on basis of patient questionnaire responses regarding treatment of patients by the provider, and patient experiences when navigating the health system). They found that **in several countries patients in private sector facilities reported preferring the facilities because of shorter waiting periods, longer or more flexible opening hours, and better availability of staff**. For the other elements, the systematic review does "not support the claim that the private sector is usually more efficient,

¹³ Reference is made to the Abuja Declaration (2001) in which African Union countries set a target of allocating at least 15% of their annual budget to improve the health sector, a target met fifteen years later by only one country.

accountable, or medically effective than the public sector; however, the public sector appears frequently to lack timeliness and hospitality towards patients” (Basu et al. 2012).

Yoong et al. (2010) assessed the effect of private sector participation on health system performance in Sub-Saharan Africa by analysing self-reported measures of utilisation and equity in deliveries and treatment of childhood respiratory disease. They found a positive and significant correlation between private sector participation and better quality and greater access to healthcare facilities – whether for-profit, not-for-profit, faith-based – for deliveries and treatment services of childhood respiratory disease and they observed reduced disparities between rich and poor as well as urban and rural populations.

Accessibility – BASED ON REVIEW OF PRIVATE FOR-PROFIT COMPANIES THAT PROVIDE MORE THAN 40,000 OUTPATIENT VISITS PER YEAR, OR WHO COVER 15% OR MORE OF A PARTICULAR TYPE OF SERVICE IN THEIR COUNTRY

"This analysis showed that most for-profit companies reaching our measure of scale are based in urban and peri-urban areas in South Asia, and that there are very few of them. Since most companies follow the Bottom of Pyramid model of low-cost, high-volume services, it makes sense that the companies are based in areas with high population density. Further the mix of incomes means that they can cross-subsidise between patients. Even so, many of the for-profit companies we examined used charitable arms or partnerships with the government to expand their services to the poor."

[Tung and Bennett 2014]

► **Affordability**

With respect to affordability, Yoong et al. (2010) highlight that some countries in Sub-Saharan Africa continue to charge for services in public facilities, but they refer to the 2008 WHO Health Report to show that there is no systematic evidence on whether user fees in the public sector are lower than in the private sector user fees. A recent OXFAM report refers to Koivusalo and Mackintosh (2004)¹⁴ who based their findings that "higher levels of private sector participation in primary healthcare have been associated with higher levels of exclusion of poor people from treatment and care" on data from 44 low- and middle-income countries (Oxfam 2014b).

With regards to affordability of health service delivery in low and middle-income countries it is relevant to discuss equity and the efforts of the healthcare providers to act pro-poor. The systematic review by Patouillard et al. (2007) assessed working with private for-profit providers in low and middle-income countries and focused on interventions to improve utilisation of healthcare by the poor such as social marketing, pre-packaging drugs, provision of vouchers, contracting out services, franchising, regulation and accreditation. While some of the studies showed an increase in the utilisation of services and improvement in the quality of care due to private sector involvement, the review was not able to explain what services were utilised by the poor and who provided these services. **It was nonetheless evident that many interventions have "worked successfully in poor communities and positive equity**

¹⁴ See: Koivusalo M and Mackintosh M. 2004. 'Health Systems and Commercialisation: In Search of Good Sense'.

impacts can be inferred from interventions that work with types of providers predominantly used by poor people” (Patouillard et al. 2007).

Basu et al. (2012) confirm that both public and private sectors create financial barriers to care and their systematic review highlights a limited and poor-quality evidence base regarding the comparative performance of the two systems.”

Affordability – BASED ON REVIEW OF PRIVATE FOR-PROFIT COMPANIES THAT PROVIDE MORE THAN 40,000 OUTPATIENT VISITS PER YEAR, OR WHO COVER 15% OR MORE OF A PARTICULAR TYPE OF SERVICE IN THEIR COUNTRY

"Many of the companies studied reach the poor through cross-subsidisation that is using higher mark-ups on wealthier patients to partly subsidise care for poorer patients. CARE states that 70% of its patients are subsidised to varying degrees or do not pay; NH up to 60%; Ziqitza, 20%; and Lumbini, 12%. This information was not available for Visualiza, CEGIN or LifeSpring. NH prints daily profit and loss statements in order to know in real time the balance that they need to strike. Free procedures will be postponed in order to ensure that the company maintains a healthy bottom line.

Some of the companies, do not use cross-subsidies, but instead, because of their locations they end up serving low income populations. For example, Queen Mamohato Memorial Hospital has 395 general ward beds and 35 private ones, but the private rooms are used to generate profits for Netcare rather than to extend care. Vaatsalya recognises that its prices are still out of reach for the poorest quintile, but it would not be able to expand or survive if it were to reduce its prices further. Similarly, Viva Sehat does not offer tiered pricing, though there is not documentation describing why.

[Tung and Bennett 2014; details about the above-mentioned companies can be found in table 1 of their study]

► **Appropriateness**

Appropriateness (in terms of quality of care and effectiveness) is often mentioned as the main reason for patients to choose private healthcare. Elements mentioned above, such as shorter waiting times, responsiveness of the healthcare providers, are often cited, as well as higher perceived quality, greater sensitivity to patient needs, and greater confidentiality.

Basu et al. (2012) highlight that private patients prefer private healthcare facilities because of shorter waiting times, greater flexibility of opening hours, and better staff availability (see above, under accessibility).

Private healthcare provision can be poor in terms of technical quality of care and potentially harmful, sometimes because the private sector is not regulated (Patouillard et al. 2007). A review by Berendes et al. (2011) evaluated 80 field-based studies that compared service quality in ambulatory public and private healthcare clinics and found that private outpatient clinics often had better drug supplies and responsiveness than public clinics. But the authors add that governments tend not to pay attention to or invest resources in the private sector, resulting in weak quality of care and low standards. They found no

difference between the public and private sectors for patient satisfaction or competence, although formal private services appeared to be more patient-centred than public health services (Berendes et al. 2011).

Montagu et al. (2011) conducted a meta-analysis of 21 studies exploring the impact of healthcare type and mortality which revealed that "patients in a private healthcare setting are less likely to die than patients in a public healthcare setting" and "patients in a private healthcare facility are more likely to have unsuccessfully completed TB treatment than patients in a public healthcare facility". A recent study by Montagu et al. (2016) concluded that **evidence about the effect of the private for-profit sector on clinical quality, coverage, equity, and cost-effectiveness is inadequate**. They also state that "banning the private sector where demand for services is high and capacity to regulate imperfect is very unlikely to succeed, and use of statutory regulation to constrain private providers is inadequate, especially in low-income countries".

Wiysonge et al. (2016) assessed the role of public stewardship of private for-profit healthcare providers in low and middle income countries. **The studies identified suggested that training (e.g. in Kenya and Indonesia) or educational visits (e.g. Thailand and Vietnam) probably improve the quality of healthcare services but that enhanced regulation (e.g. Lao PDR) may make little or no difference to quality of care.**

The USAID-funded SHOPS project firmly announces that "investing in the private sector improves the delivery of health services, strengthens the health system, and results in better health outcomes", and gives examples from Nigeria and Paraguay (USAID 2014).

An assessment of the private health sector in Nigeria conducted by the SHOPS Project confirms that "lack of access to credit, financing, and business development support services continues to impede private providers from expanding and improving the quality of their services" (SHOPS Project 2012). The assessment shows that contraceptive supply was a challenge, despite the private sector filling the gap left by the public sector through national social marketing and recommends – amongst others – to create an enabling policy environment for the private sector. The SHOPS project has then stepped in to enable "private providers to access finance and business training, increasing their ability to expand their businesses and improve services. Working with USAID's Development Credit Authority, SHOPS brokered a partial risk guarantee with Diamond Bank. This resulted in a newly developed loan product for private health care businesses that offer reproductive health, family planning, and maternal and child health products and services" (USAID 2014). Recent data on the effects of this initiative on private for-profit sector involvement were not found.

A more recent publication of the SHOPS Project of six macro-level assessments of the private sector in West Africa (i.e. in Burkina Faso, Cameroon, Ivory Coast, Mauritania, Niger and Togo) also points at the weak regulation of the private health sector. The six countries share the same "regulatory characteristics: poor enforcement of laws regarding non-compliant private health facilities; lack of incentives to develop private health facilities in rural areas; outdated, inadequate, and poorly enforced inspection standards; and poor private sector reporting, including disease surveillance" (SHOPS Project 2015). The regional recommendations of this

multi-country assessment therefore include the development of a regional private sector alliance, in collaboration with the West Africa Health Organisation, “to advocate for the development of standards across West Africa for private sector engagement, reporting, and disease surveillance. Each country, in turn, could develop its national private health sector strategy to increase the private sector’s role in health care delivery” (SHOPS Project 2015).

Appropriateness – BASED ON SYSTEMATIC REVIEW OF PRIVATE FOR-PROFIT HEALTH PROVIDERS

*"This focus on whether the poor benefit is particularly important as programmes which work with private for-profit providers might be expected a priori to be pro-rich, since they generally require out-of-pocket payment (except in the case of a 100% value voucher). Available data indicate that **poor people make significant use of the private sector, and that the quality of services they receive is at best variable**. While a case can be made, therefore, for using public funds to work with for-profit providers, there is a need for much stronger evidence that such interventions can lead to health improvements for poor people."*

[Patouillard et al. 2007]

► Sustainability

Sustainability is hardly referred to in the documents consulted. Although sustainability is one of five main evaluation criteria in development cooperation (see OECD DAC criteria) it seems to be neglected in the discussion of private sector development. This may be due to the fact that evaluations after finalisation of the development cooperation interventions do not frequently occur.¹⁵

In the context of sustainability and as an example of IFC’s highlighted advantages of private sector involvement such as increased accessibility, high quality healthcare services and continuity of care (see table 1) we refer to the Queen ‘Mamohato Memorial Hospital in Lesotho which was built through a PPP, with IFC as technical advisor¹⁶. The PPP between the Government of Lesotho and the Tsepong consortium¹⁷ aimed at replacing the aging plant and equipment from the national referral hospital (Queen Elizabeth II Hospital) in Maseru and at extending and upgrading the network of urban filter clinics which, together with the hospital, provided publicly-funded healthcare services in the greater Maseru district, and referral services for the country. Another purpose of the PPP was to engage the private sector to ensure that the new health facilities would function effectively and become an integrated

¹⁵ This is confirmed by an ex-post evaluation study of the sustainability of Belgian development cooperation interventions in Benin and Bolivia. See: Dienst Bijzondere Evaluatie / DBE (2016), Ex-post evaluatie van de duurzaamheid van de Belgische gouvernementele samenwerking, Wat na afloop van onze ontwikkelingssamenwerking? FOD Buitenlandse Zaken, Buitenlandse Handel en Ontwikkelingssamenwerking, Brussel.

¹⁶ “The IFC has consistently highlighted its own role as transaction advisor to the Government of Lesotho for the health PPP, for which it earned a ‘success’ fee of approximately \$720,000 when the contract between the government and Tsepong was signed” (Oxfam 2014a).

¹⁷ A consortium of Netcare, a private South African health care provider, and several Lesotho-owned businesses.

healthcare network for more efficient, higher quality care and expanded access to services for the population.

An IFC-commissioned study of health indicators and patient outcomes shows improvements between baseline and endline study¹⁸, with delivery of new and high-quality services at the Queen 'Mamohato Memorial Hospital. The endline results confirm improved patient outcomes: a 10% decrease of maternal mortality, "a 41% reduction in the overall death rate, a 65% reduction in paediatric pneumonia death rate, and a 22% decline in the rate of stillbirths compared to baseline" (Vian et al. 2013). The same study notes less accessibility due to waiting times at the filter clinics and reduced affordability for lower-income patients due to the additional transport costs to reach the new hospital (Vian et al. 2013; Oxfam 2014a).

While these performance improvements were the rationale for this public-private partnership, the PPP also anticipated to generate better health outcomes at the same level of public expenditure. However, a critical analysis by Oxfam International draws attention to the cost escalation which puts burden on the Government of Lesotho and the country's taxpayers and points at "a dangerous diversion of scarce public funds from primary healthcare services in rural areas, where three-quarters of the population live" (Oxfam 2014a).¹⁹ The study is in support of other international evidence that suggests that health PPPs are likely to be high risk and costly and fail to achieve universal (Nikolic and Maikisch 2006; World Bank 2007; DG SANCO 2008; IBON 2016; Byiers et al. 2016).²⁰

3.2 Education

► Private sector in education

While public delivery represents the norm at the basic education level in most developed and developing countries, private sector plays an important role in the provision of education, often through the 'traditional' model of privately operated or financed schools. Private schools usually refer to schools controlled and/or managed by non-state providers, whether for-profit, non-profit, commercial, non-government, faith-based or community-based organisations.

"In the past, some have argued that development assistance agencies should limit assistance to public school sector. Others have argued that the public sector is inadequate and in many ways has failed in its ambitions to provide a minimum quality for every child. [Heyneman and Stern 2013]"

Private funding and delivery of education services are often perceived as a threat to state authority, rather than complementary. "In the case of for-profit institutions, the profit motive is often viewed as incongruent with the vision of education as a social rather than

¹⁸ Baseline study covers April 2006 – March 2007 and the endline study covers the period January – December 2012.

¹⁹ The Oxfam briefing note also states that IFC should be held accountable for the poor technical advice given to the Government of Lesotho.

²⁰ See section five of the Oxfam briefing note for more international evidence (Oxfam 2014a).

commercial good. Because of this, governments across the East Asian and Pacific region have been reluctant to recognise explicitly the role played by the private sector in their legislation or in education plans and strategies developed across the region. Some governments have banned the existence of private schools or have limited the number of schools that can be established" (UNICEF EAPRO and ADB 2011).

A study by Ernst & Young explores the role that the private sector can play in implementing the Right to Education Act which was enacted in 2009 in India. Based on various opinions and analysis of different programmes and initiatives, the study concludes that the primary responsibility for providing quality education to all children lies with the government. Involvement of the private sector or non-state actors can be in the form of sharing existing knowledge and skills, by undertaking capacity development of management, organisational and leadership skills, and thereby improving the quality of education, but they can never take the lead, because "public-private partnerships in 'socially good' sectors should be undertaken by the public sector" (Ernst & Young 2012).

The Academy for Educational Development already **advocated a decade ago for private sector involvement to reach Education for All** because "among the many skills and resources business brings are expertise in managing people and resources, conducting strategic planning, performing needs assessments, allocating resources, analysing markets, using incentives, anticipating demand, and creating new opportunities" (Ingram et al. 2006).

Since the 1990s UNESCO has given priority to Education for All. Bertsch and colleagues (2005) notice challenges shared by all partnerships in education, but argued that "there may be some important opportunities for UNESCO, as chief advocate for education around the world, to make contributions to improving and streamlining corporate-public partnerships". In 2007 UNESCO together with the World Economic Forum launched the Partnerships for Education programme which aims to create a global coalition for multi-stakeholder partnerships, including the private sector (Draxler 2007).

A World Bank study examines *public-private partnerships* in which the government guides policy and provides financing while contracting out private providers to supply services, ranging from the construction, management, or maintenance of infrastructure to the provision of education services and operations, as in voucher schemes or charter schools; the study shows how PPPs can facilitate service delivery and lead to additional financing for the education sector as well as expand equitable access and improve learning outcomes (Patrinos et al. 2009).

An international literature review by CfBT Education Trust in 2008 looks at public-private partnerships at basic education level and concluded that a "strong regulatory framework, flexibility in provision and good quality assurance are fundamental for PPPs to work well" (LaRocque 2008).

"The main rationale for Public-Private Partnership (PPP) programmes is the potential role of the private sector for expanding equitable access and improving learning outcomes."

[Al-Tarawneh 2012]

In a study on the dynamics of private sector support for education in Latin America, AED admits that "while PPPs can bring new ideas for problem solving, innovation, and resources to education, they also bring challenges and tensions" (USAID and AED 2008). Despite challenges, other reviewers confirm that PPPs contribute to improving learning outcomes and access to education in LMICs but also acknowledge that they are "unable to explain why PPPs appear to have worked in some contexts but not in others" (Snilstveit et al. 2015).

"Based on the mixed results regarding the quality of outputs relative to public schools, as well as the degree to which non-government schools accommodate low-income students, it is difficult to point to an exemplary initiative or model that effectively maximises both of these criteria. This is not to say that non-government schooling has not expanded access to basic schooling or that promising approaches have not been developed. Each of the case study countries provides some evidence of non-government schooling initiatives or models that, if implemented correctly, could be used to assist countries in meeting their Education for All goals. It is assumed that the context of origin is an important criterion of success and that transferring that elsewhere involves risk.

[Heyneman and Stern 2013]

Like for the health sector the International Finance Corporation invests in the private for-profit sector. It is the largest multilateral investor in private education in emerging markets to "complement the offering of the public sector and to create more opportunities for children, youth, and working adults".²¹

► Evidence base

Table 3 describes the 19 sources used for this scoping study on education. Compared to private sector involvement in health, less evidence is available or less lessons have been documented with respect to education.

The impact evaluation of Lewis and Patrinos (2012) confirms that documentation is limited and that there is an urgent need for more impact evaluations "to create a rigorous evidence base in order to inform policy".

Of the nineteen sources consulted, nine exclusively address the private for-profit sector, including two systematic reviews (see annex 5 for more details about the sources used).

²¹ Examples of IFC's investments in private education projects are available from http://www.ifc.org/wps/wcm/connect/Industry_EXT_Content/IFC_External_Corporate_Site/Industries/Health+and+Education/EducationSector/EducationRegulatingPrivateEducation/. Accessed online 3 October 2016.

Table 3: Sources used for the scoping study on education, by type

Type of source	Number of sources included	Range of year of publication	Main focus
Reviews[^]	6 [°]	2008-2015	Impact of private schools on improving learning outcomes and access to education
Landscaping studies	5	2005-2011	Role of PPPs on improving learning outcomes and access to education
Country/case studies	6	2011-2016	Impact of private schools and PPPs on access and affordability
Regional studies	2	2008; 2011	Appropriateness of PPPs in education

Notes:

[^]Includes four systematic reviews, one literature review and one impact evaluation.

[°] Sample size of all documents reviewed totals to 172. The different samples were not cross-checked for doubles, and the total number may therefore be overestimated. One review was very comprehensive and synthesises the findings of 238 studies evaluating the effects of a range of different education programmes in 52 LMICs; we only included the studies which focused specifically on public-private partnerships in education.

Comparable to health above, the scoping study of private sector involvement in education looks into four criteria²²:

1. accessibility (geographic, financial)
2. affordability (school fees)
3. appropriateness (quality of teaching, learning outcomes, ...)
4. sustainability.

Table 4 summarises for each of those four criteria the advantages and disadvantages of private sector involvement for which evidence is available in the studies selected.

Table 4: (Dis)advantages of private sector involvement in education

Criterion	Advantages of private sector	Disadvantages of private sector
Accessibility	<ul style="list-style-type: none"> ▪ Improved enrolment rates amongst boys and girls [1; Pakistan] ▪ Reduced gender inequality when public schools cannot close the gap [2; Pakistan] [^] ▪ Improved school choice [3] 	<ul style="list-style-type: none"> ▪ No geographically reach of the poor [5] ▪ No equal reach of boys and girls [5]
Affordability	-	<ul style="list-style-type: none"> ▪ More expensive in terms of both school fees and hidden costs such as uniforms and books [5] [°]

²² Another set of criteria often used is the 4A framework (availability, accessibility, acceptability and adaptability) developed by former UN Special Rapporteur on the Right to Education Act 6, Katarina Tomasevski.

Criterion	Advantages of private sector	Disadvantages of private sector
Appropriateness	<ul style="list-style-type: none"> ▪ Better schooling inputs (teachers, classrooms and blackboards) [1] ▪ Provision at a lower unit cost by low-cost private schools [4] ▪ Improved learning outcomes (higher levels of teacher presence, more teaching activity) [5] ▪ Lower cost of education delivery (often due to lower salaries) [5] 	<ul style="list-style-type: none"> ▪ Lack of trust from public sector [6]
Sustainability	-	<ul style="list-style-type: none"> ▪ Lack of sustainability and accountability in partnerships [6]

Notes:

The (dis)advantages indicated in bold refer explicitly to the private for-profit sector.

^ This is primarily applicable in the case of low-fee private schools.

° But this is contested in the publication of Heyneman and Stern (2013) who mention that “public schools are not always free—and not always less expensive than low-cost private schooling options”.

Sources:

- [1] HDRC and UKAid. 2011. Helpdesk Report: Public-Private Partnerships in Education (Pakistan). 19 July 2011. Prepared by Shanti Mahendra.
- [2] Heyneman SP and Stern JMB. 2013. Low cost private schools for the poor: what public policy is appropriate? International Journal of Educational Development. <http://dx.doi.org/10.1016/j.ijedudev.2013.01.002>.
- [3] Snilstveit B, Stevenson J, Phillips D, Vojtkova M, Gallagher E, Schmidt T, Jobse H, Geelen M, Pastorello M, and Evers J. 2015. Interventions for improving learning outcomes and access to education in low and middle income countries: a systematic review, 3ie Final Review. London: International Initiative for Impact Evaluation (3ie).
- [4] Barakat S, Hardman F, Rohwerder B, Rzeszut K. 2014. The evidence for the sustainable scale-up of low-cost private schools in South West Asia. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
- [5] Day Ashley L, Mcloughlin C, Aslam M, Engel J, Wales J, Rawal S, Batley R, Kingdon G, Nicolai S, Rose P. 2014. The role and impact of private schools in developing countries: a rigorous review of the evidence. Final report. Education Rigorous Literature Review. Department for International Development.
- [6] Bertsch T, Bouchet R, Godrecka J, Kärkkäinen K, Malzy T, Zuckerman L. 2005. Corporate sector involvement in Education for All: Partnerships with corporate involvement for the improvement of basic education, gender equality, and adult literacy in developing countries. Report for UNESCO. Paris: UNESCO.

► Accessibility

In terms of accessibility, many see advantage in increased competition between public and private providers of education and most likely resulting improved education quality (Snilstveit et al. 2015). Others applaud the involvement of private sector partners into the national

schooling system as it leads to an increased number of school providers, expanded access to education²³ and improved school choice (Patrinos et al. 2008). The same authors claim that increasing the private sector's role in education through PPPs can also have several benefits over traditional public delivery of education, such as "including greater efficiency, increased choice, and wider access to government services, particularly for people who are poorly served by traditional schools" (Patrinos et al. 2008).

The review of Day Ashley and colleagues about the role and impact of private schools in developing countries (2014)²⁴ concludes that **evidence is ambiguous about whether private schools geographically reach the poor and whether private schools are equally accessed by boys and girls.**

Accessibility – BASED ON SYSTEMATIC REVIEW OF PRIVATE SCHOOLS IN DEVELOPING COUNTRIES

"Although private schools are continuing to focus on urban areas, they are also becoming increasingly prevalent in rural areas; but research cautions against assuming this means they are reaching the poor".

"Several studies indicate that girls are less likely than boys to be enrolled in private schools, but this finding is context specific with some findings ambiguous on the issue and a minority of studies finding that private schools reduce the gender gap in certain contexts".

[Day Ashley et al. 2014]

► Affordability

The systematic review by Day Ashley and colleagues (2014) shows that **private schools can be more expensive in terms of both school fees and hidden costs such as uniforms and books, which may cause inequitable access to quality education by excluding the poorest families** as shown by Barakat and colleagues (2014)²⁵.

²³ This benefit is also mentioned by IFC when it announced in July 2016 to invest in the South African private education company ADvTECH to support the "expansion of education and skills development in Sub-Saharan Africa". According to ADvTECH its expansion plans will increase its schools and tertiary education programmes and lead to "better educational access for at least 30.000 additional students, many of whom would not otherwise have had the opportunity to access quality education or vocational training. It will also provide new learning options for students leaving high school." See: <http://ifcextapps.ifc.org/ifcext/pressroom/ifcpressroom.nsf/0/AE186B3CA3F36C0285257FF600446EBC>. Accessed online 4 October 2016.

²⁴ The review by Day Ashley et al. did not include studies that did not explicitly define their focus as private schools. However, motivation for operating private schools such as profit/non-profit, income, influence was not used as a defining parameter because "school owners of any description may express their motivations as a combination of competing commitments to philanthropy, corporate social responsibility and business interests".

²⁵ The review by Barakat et al. focused on private schools that "are not solely dependent on outside financial assistance in the long term, or, if they are currently dependent on such assistance, have a clearly defined plan to become self-sustaining within a specified time".

But even in the public sector affordability can be a barrier. A study by Akaguri (2013) confirms that fee-free public education in Ghana led to the elimination of payments such as tuition, exams and extra classes fees, but noted that "other direct costs such as feeding and school uniform consume a large part of the household expenditure on education for the poor". Also Heyneman and Stern (2013) mention that "public schools are not always free – and not always less expensive than low-cost private schooling options". **In Latin America and the Caribbean, countries such as Peru, Dominican Republic, Honduras, Paraguay, Mexico, and Ecuador have shown that affordable non-government schools for low-income students can be viable options** (Heyneman and Stern 2013).

Affordability - INDIA

"During the discourse on education, when it comes to private players, the reference point is usually corporate players or their corporate foundations. While in reality, there are several non-state players that engage with the education sector in many meaningful ways. NGOs, international and corporate foundations, and private trusts and societies that have set up schools are also playing a vital role. By not including other non-state players in the discourse, there is a risk of not making a distinction between private participation and privatisation, which takes the debate to a different trajectory. It is perhaps for this reason that PPP in education has not found wide acceptance, because it is perceived that it can make education unaffordable for disadvantaged sections of society."

[Ernst & Young 2012]

► Appropriateness

In her dissertation Conn (2014) identifies effective education interventions in Sub-Saharan Africa. Because some intervention types may be susceptible to the "private school advantage"²⁶, she limits the discussion of private schools to two countries cases, i.e. Kenya and Nigeria. These studies find that private schools in both countries have a large advantage and significant effect over government schools. However, it is "unclear if this degree of private school advantage would be equivalent in other countries" (Conn 2014).

Parents often perceive private schools to be of higher quality than public schools, as is the case in Ghana, Kenya, Tanzania and Pakistan: "Citing issues such as poor national examination scores, over-crowding, high teacher absenteeism, and unengaged teachers, parents often worked to scrape together small amounts of money so they could remove their children from the public school system. This is a common thread throughout the research in nearly every country with a thriving low-cost private education sector" (Heyneman and Stern 2013).

The study of Barakat and colleagues (2014) confirms that **low-cost private schools in South West Asia have advantages "in terms of filling gaps in provision at a lower unit cost", but that scaling up of low-cost private schools should involve careful consideration of challenges and weaknesses (such as weak governance, corruption and lack of security) and the wider political economy of fragile states.**

²⁶ In many countries private schools may be perceived to be of higher quality but "this 'advantage' may say more about the current quality of public schools in general equilibrium than about the effectiveness of private institutions" concludes Conn.

Most studies in our sample focus on *public-private partnerships* and reiterate that private provision of public education services can produce several real benefits because of the added value of bringing business thinking into the public sector. Benefits of this business thinking may include competition in the market for education, autonomy in school management, improved standards through contracts, risk-sharing between government and providers (Lewis and Patrinos 2012). Or as formulated by Al-Tarawneh (2012) when discussing the role of public-private partnerships in education in Jordan: "Governments benefit from public-private partnerships by gaining access to corporate expertise and experience in management, strategic planning, innovative problem solving, labour market expertise, skills development, efficient delivery of goods and services, product development, and logistical support".

Snilstveit and colleagues (2015) reviewed 13 studies that evaluated the effect of PPPs on education outcomes in LMICs and conclude that overall outcomes were better for children attending PPP schools as compared to those that do not, but that there is a large amount of variability for all outcomes, so that caution is needed when discussing public-private partnerships in education. The mixed evidence on learning outcomes is also confirmed by some of the country studies analysed, e.g. in Pakistan and Afghanistan (Barakat et al. 2014; HDRC and UKAid 2011).

Appropriateness – PAKISTAN & AFGHANISTAN

"In contexts like Pakistan and Afghanistan, where the government's legitimacy is low, service delivery is the cornerstone of rebuilding or strengthening the state. While provision through private schools sponsored by donors, international organisations and NGOs may quickly scale-up education access, particularly in remote rural areas, in the mid to long term, this strategy could undermine the credibility of an already weak central government, by reinforcing the idea that families cannot depend on the government for education. In the long term, the impact is a continued weak state."
[Barakat et al. 2014]

► Sustainability

Based on our literature review we conclude that attention of the private sector for sustainability is limited. The only study that discusses sustainability thoroughly is the systematic review by Barakat and colleagues (2014) on scaling up low-cost private schools in South West Asia. The authors confirm that **there is "lack of engagement in the literature about sustainability", but they were able to summarise the factors affecting the sustainability of low-cost private schools as follows:**

- Long-term sustainability is affected by the school's ability to maintain enrolment, its location, low wages for teachers to keep fees low, and whether the school was responding to a community need;
- Rural schools were more difficult to sustain in the long-term due to higher levels of poverty, fewer schoolchildren to support continued enrolment and difficulties attracting teachers to remote locations;
- Negative responses to education, especially for girls, in more conservative rural areas can also impact on the enrolment needed for long-term sustainability;

- When government schools became more attractive to parents, they moved their children from the private schools, as the appeal of private education was based on the perception/reality of their having a higher quality in comparison to the often poor quality government schools.

Bertsch and colleagues (2005) consider **the lack of confidence amongst different stakeholders as the main obstacle to partnership initiation and sustainability**: “governments are often sceptical about the involvement of for-profit corporations in education, while corporations doubt governments’ accountability. In addition, both government and business can distrust NGOs’ competency to mount long-term, sustainable programmes, which is problematic since NGOs are often responsible for the program content. The lack of understanding of potential mutual gains to be made through partnerships accounts, in large part, for their failure”.

4 CONCLUSIONS

What are our main observations?

There is a large base of documents on private sector involvement, especially in the context of private sector-led development, but when it comes to quantifiable conclusions, there is less evidence. Even the evidence available often leads to inconclusive results as pointed out by several systematic reviews.

In both sectors, i.e. health and education, there is a common understanding that the public sector has to be strengthened in service provision and that there is a role for the private sector in improving the health of the world’s poorest and increasing access to education for all.

The main problem with the evidence available is the definition of the private sector (more so for health than for education). Most of the documents found discuss the private sector in a broad sense, including for-profit and not-for-profit private organisations, which makes it difficult to distil conclusions which apply to the for-profit private sector only.

What are the main findings of this scoping study in terms of the four criteria analysed?

Accessibility can be increased with participation of the private sector. In the *health sector* the increased access is largely evidenced through shorter waiting times thanks to expanded healthcare supply and through higher responsiveness of the private sector to patients’ requests. Private for-profit healthcare providers seem to prefer urban and peri-urban settings where they rather reach middle and upper class patients, and hence in terms of geographical and financial accessibility the private sector doesn’t benefit the rural areas nor the poor people. There are nevertheless examples of large-scale for-profit companies that can cross-subsidise between patients because of their high volumes and mix of income. For *education* the

involvement of private sector partners into the schooling system can lead to an increased number of school providers, expanded access to education and improved school choice.

Affordability can be a barrier in both sectors, but there is no systematic evidence found on whether user fees in the public health sector are lower than in the private health sector. However, many of the for-profit companies tend to deliver specialised or tertiary care services which are usually not affordable to the poor population. Inequitable access to *education* results from school fees and hidden school-related costs – even in the fee-free public schools or in the low-cost private schools.

Advantages in terms of **appropriateness** are merely seen in the supply-side aspects of the private sector. Benefits of the private health sector are the continuity of the care provided, higher availability of drugs, and patient-centred staff attitude. Patients often perceive the quality of the services to be higher, but studies confirm that technical quality in the private sector can be low, often because regulation and accountability are lacking. For education the benefits are the and better schooling inputs (e.g. teachers, classrooms and blackboards) and improved learning outcomes (e.g. higher levels of teacher presence, more teaching activity).

Of the four criteria assessed, **sustainability** is almost never highlighted as an important element pro-private sector involvement.

Based on the above findings we are convinced that both public and private sectors have their role in the sustainable development discourse: while the private sector can invest in profit-making activities, the public sector has to provide universal access to quality public services like health and education.

► **Conclusion for health:** In a Lancet Series on the perils and possibilities of the private health sector several pros and cons have been discussed. The Series concludes that “perhaps the best option available to governments is to identify incentives to encourage private health providers to change their behaviour, making equity and quality more important measures of success, while addressing the dangers of an often predatory corporate health sector” (Horton and Clark 2016).

► **Conclusion for education:** Governments have to pay attention to develop and implement policies that are pro-poor and ensure that there are no costs to the poorest households since this is the only way all children will enjoy a full cycle of basic education as mandated by commitments to Education for All.

5 RECOMMENDATIONS FOR 11.11.11

Evidence about the advantages and disadvantages of public versus private delivery of essential services for health and education is available but mainly remains a discourse between pro-public and pro-private believers. We therefore build primarily on systematic reviews for this scoping study because they apply a comprehensive and rigorous approach and use multiple

sources. But comparing the systematic review findings and drawing conclusions in terms of the four criteria of this scoping study is also challenging because most of their findings depend very much on factors such as country context and the (sub)sector analysed. Most probably a more in-depth search of the advantages and disadvantages of for-profit private sector involvement could come from individual country assessments, rather than from cross-country comparative studies that intend to find overall conclusions.

Several country and case studies are presented in most of the documents consulted and some have been added to this study report as examples but their effect on affordability, accessibility, appropriateness and certainly sustainability may need to be analysed further as the purpose of the reports referring to them is not always focussed on those four criteria.

6 ANNEXES

6.1 Annex 1: List of documents consulted

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6.2 Annex 2: Biased trend towards more private sector development

The movement towards private sector development has been invigorated by three changes: "First, aid budgets are being squeezed by most donors. In 2011 Official Development Assistance (ODA) from EU Member States fell for the first time since 2007 from 0.44 % to 0.42 % of GNI (gross national income). This percentage lies far from the UN target of 0.7 %. Second, private capital flows to developing countries have recovered substantially since their collapse in 2007. While they are still below pre-crises levels, private flows are steadily rising. Third, public development finance is increasingly channelled towards the private sector" (Kwakkenbos and Romero 2013.). OECD data show that 96 billion USD of aid²⁷ worldwide was allocated in support of leveraging private sector investment in developing countries (OECD 2016).²⁸

The growing consensus on the importance of private sector development in development programming is also reflected in the key texts and recommendations from international conferences in the field of private sector development.²⁹ "Similarly, recent donor strategies emphasise direct assistance to business where public and private interests overlap and often commit an increasing proportion of the development budget to such approaches". Many multilateral and bilateral development cooperation agencies (European Commission, EU Member States, Australia, regional development banks) recommend private sector involvement in their current development strategies. Annex 3 gives a non-exhaustive overview of their priorities and focus in private sector development.

The belief among bilateral development agencies and international financial institutions that private sector is essential in development and economic growth is strong. In the 2011 Busan declaration the development partners explicitly "recognise the central role of the private sector in advancing innovation, creating wealth, income and jobs, mobilising domestic resources and in turn contributing to poverty reduction".³⁰

One of the strongest advocates for private sector participation is the International Finance Corporation, a member of the World Bank Group who considers itself the largest global development institution focusing exclusively on the private sector in developing countries. IFC argues that private sector investments (often through international finance institutions) generated impact, additionality, and demonstration effects, as can be learned from examples in infrastructure, financial systems, agribusiness, SMEs, inclusive business models, and the investment climate. IFC considers the private sector to be critical to development, but calls

²⁷ Including aid, as well as non-concessional loans provided by bilateral and multilateral donors.

²⁸ See <http://www.euractiv.com/section/development-policy/news/weds-oxfam-questions-blending-financing-in-sdg-delivery/>. Accessed online 14 September 2016.

²⁹ Private sector development is discussed in various development cooperation policies, e.g. the DAC guidelines on the role of development cooperation in private sector development (1995); Private Sector Development Strategy – Directions for the World Bank Group', World Bank (2002); the UN Conference on Development Finance (Monterrey, 2002); the UN Conference on Sustainable Development (Johannesburg, 2002); the Paris Declaration on Aid Effectiveness (Paris, 2005); the Accra Agenda for Action (Accra, 2008); and the Busan partnership for effective development co-operation (Busan, 2011).

³⁰ Busan Partnership for Effective Development Co-Operation Fourth High Level Forum on Aid Effectiveness, Busan, Republic of Korea, 29 November-1 December 2011.

upon the public sector to provide public health and education services and “to create a supporting environment to boost economic growth and the private sector” (IFC 2011a).

While IFC mentions poverty reduction as element of its plead for more private sector development, the World Bank Independent Evaluation Group concluded in 2011 that it is not yet “clear what poverty means within the IFC context or how its interventions reach and affect the poor” and recommends that IFC “can more fully exploit the vast potential for poverty orientation in its growth supporting activities” (IEG 2011).

In a joint report of 31 multilateral and bilateral development finance institutions, IFC reiterates the importance of development through private sector partners, because they “provide critical capital, knowledge, and partnerships; help manage risks; and catalyse the participation of others. They support the kind of entrepreneurial initiatives that help developing countries achieve sustainable economic growth” (IFC 2011a). As summarised recently by the Donor Committee for Enterprise Development (DCED), the overview of member agency development strategies³¹ shows that most DCED member agencies have the fight against poverty as their priority goal, and that they all consider economic growth and private sector development as key drivers for ending poverty.

A recent IEG evaluation assessed the relevance, effectiveness, and social value of the World Bank Group interventions in its support to investment climate reforms to increase the ability of private firms to grow, create jobs, and reduce poverty. Analysis showed that the World Bank Group members, including IFC, had been successful in improving the investment climate by enacting a number of laws, streamlining of processes and time, or simple cost savings for private firms. “However, the impact on investments, jobs, business formation, and growth and the social value of regulatory reforms—that is, their implications for inclusion and shared prosperity as reflected in results—had not been properly included in the design of reforms and assessment of their impact. Instead, Bank Group support focused predominantly on reducing costs to businesses” (IEG 2016b; IEG 2016c).

In the context of private sector development, public-private partnerships (PPPs) are increasingly promoted by development cooperation agencies and development finance institutions (DFI). Nevertheless, there is limited information regarding donors’ spending on PPP investments. “OECD highlights several problems related to donors’ reporting systems, resulting in poor transparency. Some major institutions do not report their private sector activities separately, and several members fail to provide descriptive information regarding their DFI programmes and activities. From the figures that are available, 60 percent of PPP investments are targeted to upper-middle income countries (Byiers et al. 2016). In the same document Byiers et al. summarise that “the two concerns raised most frequently regarding development PPPs are additionality and transparency. The first concern is about defining, ensuring and measuring the additional impact that is being achieved due to the public finance

³¹ For an overview of the individual private sector development policies of international development agencies that are member of Donor Committee for Enterprise Development (DCED) or for a summary: see <http://www.enterprise-development.org/agency-strategies-and-coordination/individual-agency-psd-policies/>. Accessed online 26 July 2026.

component. The latter relates to the availability of reliable information on the negotiation, the design, the implementation and the results of PPPs" (Byies et al. 2016).

Another critical source is EURODAD in their recent study on public-private partnerships and their impact on sustainable development: "PPPs are, in most cases, the most expensive method of financing, significantly increasing the cost to the public purse. PPPs are typically very complex to negotiate and implement and all too often entail higher construction and transaction costs than public works. PPPs are a very risky way of financing for public institutions. The evidence of impact on efficiency is very limited and weak. PPPs face important challenges when it comes to reducing poverty and inequality, while avoiding negative impacts on the environment" (EURODAD 2015).

6.3 Annex 3: Development partner priorities in private sector development

Non-exhaustive list of bilateral and multilateral development cooperation agencies and development finance institutions encouraging private sector involvement.

Development partner	Priority sector(s)	Strategy	Reference documents
European Union	Mainly on micro, small and medium-sized enterprises in <ul style="list-style-type: none"> sustainable energy, sustainable agriculture and agribusiness, digital and physical infrastructure, the green sectors, the social sectors 	"will look for new ways of harnessing the potential of the private sector as a financing partner, implementing agent, advisor or intermediary to achieve more effective and efficient delivery of EU support, not only in the field of local private sector development, but also in other areas of EU development cooperation such as sustainable energy, sustainable agriculture and agribusiness, digital and physical infrastructure, and the green and social sectors"	<i>European Commission. 2014. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: A Stronger Role of the Private Sector in Achieving Inclusive and Sustainable Growth in Developing Countries. Brussels, 13.5.2014. COM(2014) 263 final.</i>
Belgium	Mainly on micro, small and medium-sized enterprises in <ul style="list-style-type: none"> agriculture infrastructure renewable energy natural resources services (financial, ICT) 	"supports strategies that are conducive to create, restore, modernise, diversify and strengthen the structures of micro, small and medium-sized enterprises in developing countries through supply of financial and non-financial services"	<i>Federale Overheidsdienst Buitenlandse Zaken, Buitenlandse Handel en Ontwikkelingssamenwerking – Directie-Generaal Ontwikkelingssamenwerking. 2014. Strategienota: De Belgische ontwikkelingssamenwerking en de lokale privésector: ondersteuning van een duurzame, menselijke ontwikkeling.</i>
Germany	Mainly on micro, small and medium-sized enterprises in the formal and informal sectors	"geared to helping partner countries put in place an enabling political, legal and administrative environment for private investment and to establish competitive and sustainable economic structures"	<i>BMZ. 2013. Sector Strategy on Private Sector Development, BMZ Strategy Paper 9/2013e. BMZ. 2011. Forms of Development Cooperation involving the Private Sector. BMZ Strategy Paper 05/2011e.</i>

Development partner	Priority sector(s)	Strategy	Reference documents
Sweden	Sweden commends its "efforts to promote the private sector for the purpose of achieving certain societal objectives" and therefore private sector development is not limited to a sector in a conventional sense, but encompasses agriculture, manufacturing and services, including trade, and increasingly also infrastructure and social services.	Private sector as "an engine of improved economic growth; a means to generate the required domestic resources for investments in human resource development through health, infrastructure and education; a potential provider of some of these essential services; a direct partner in trade and technology transfers".	<i>SIDA. 2003. Making Markets Work for the Poor - Challenges to Sida's Support to Private Sector Development. October 2003. Provisional edition. Stockholm.</i>
World Bank		"The World Bank defines PSD not as a sector, but as a cross-cutting issue. It is about 'a way of doing things', that can have relevance for any sector such as energy or agriculture."	<i>World Bank. Private sector development strategy 2002.</i>
Inter-American Development Bank		"Recognising the contribution that micro, small, and medium businesses can bring to a country's economy, the IDB Group invests in its success. It works with financial institutions throughout Latin America and the Caribbean to expand access to credit for small businesses, helping unleash their potential to grow, create jobs, and innovate"	<i>Inter-American Development Bank. Private Sector with Purpose: Stories of Development. Washington DC.</i>
African Development Bank		The African Development Bank justifies the need for private sector development because "recent research shows that a dollar of AfDB money invested in the continent brings in an additional six from the private sector".	<i>African Development Bank Group. 2013. Supporting the Transformation of the Private Sector in Africa - Private Sector Development Strategy, 2013-2017.</i>

6.4 Annex 4: Details of the sources used for the scoping study on health, by type

Except for the reviews, only the sources that focus specifically on for-profit provision are listed in the table below.

Type of source	Reference	Year of publication	Focus	Definition of 'private'
Reviews (n=2/7) ^	Patouillard et al.	2007	Systematic review (based on sample of 52 publications and documents meeting the inclusion criteria); Private for-profit; Low and middle income countries	Looks at eight areas of intervention involving the government or NGOs working with the private for-profit sector: social marketing, use of vouchers, pre-packaging of drugs, franchising, training, regulation, accreditation and contracting-out
	Montagu et al. (Health Policy & Planning)	2016	Systematic review (based on sample of 343 publications and documents); Private for-profit; Developing countries	Examines five models of intervention with private markets for care: commodity social marketing, social franchising, contracting, accreditation and vouchers
	Herrera et al.	2014	Overview of systematic reviews (based on sample of 15 publications meeting the inclusion criteria); Private for-profit, private not-for-profit and public sector; Global	3 types of ownership: public, private not-for-profit and private for-profit
	Basu et al.	2012	Systematic review (based on sample of 102 publications and documents meeting the inclusion criteria); Private for-profit & not-for-profit; Low and middle income countries	Performance of the private health sector; Private providers are heterogeneous, consisting of formal for-profit entities such as independent hospitals, informal entities that may include unlicensed providers, and non-profit and non-governmental organisations

Type of source	Reference	Year of publication	Focus	Definition of 'private'
	Berendes et al.	2011	Systematic review (based on sample of 80 publications and documents meeting the inclusion criteria); Private for-profit & private not-for-profit; Low and middle income countries	"Private" refers to 'all organisations and individuals working outside the direct control of the state'. "Private for-profit providers" included individuals or groups of practitioners in privately owned clinics, hospitals, and pharmacies that operate on a for-profit. 'Private not-for-profit providers' included practitioners in facilities that operate on a non-profit basis, such as various (missionary or non-missionary) NGOs and private voluntary organisations.
	Montagu et al.	2011	Systematic review (based on sample of 21 publications and documents meeting the inclusion criteria); Private for-profit & private not-for-profit; Low and middle income countries	Private healthcare institutions include non-profit or religious institutions; Private providers (institutions or individuals) are distinguished in economic terms from the public sector by their ownership characteristic: profits or losses accrue to the owner, rather than to the government or society
	Whyle and Olivier	2016	Systematic review (based on sample of 68 publications and documents meeting the inclusion criteria); PPP; Region: Southern Africa	Private sector includes international donors, non-governmental organisations, for-profit providers and traditional healers
Landscaping studies (n=8/22) ^	Smith et al.	2001	Private for-profit; Developing countries	Private sector providers who operate on a for-profit basis, primarily in poorer countries, and who directly interact with service users, supplying them with healthcare services or products

Type of source	Reference	Year of publication	Focus	Definition of 'private'
	World Bank	2009	Private for-profit; Developing countries	Refers to World Bank strategy on private sector development, and IFC's investments in health
	Oxfam International	2009	Private for-profit; Developing countries	Examines arguments made in favour of increased private for-profit provision of health services as a means of scaling-up to achieve healthcare for all.
	IFC (Private Healthcare - Creating Opportunity in Emerging Markets)	2015	Private for-profit; Low and middle income countries	IFC investments in for-profit companies in the health sector, especially in emerging markets
	IFC (Guide for Investors in Private Healthcare in Emerging Markets)	2015	Private for-profit; Low and middle income countries	IFC investments in for-profit companies in the health sector, especially in emerging markets
	IFC	2016	Private for-profit; Low and middle income countries	IFC investments in for-profit companies in the health sector, especially in emerging markets
	Tung and Bennett	2014	Private for-profit; Low and middle income countries	Focuses on private for-profit companies that provided more than 40,000 outpatient visits per year, or who covered 15% or more of a particular type of service in their country
	Wiysonge	2016	Private for-profit; Low and middle income countries	Looks at public stewardship (i.e. regulation, training, or coordination) of the private for-profit health sector
Country studies (n=0/17) ^	(no country studies that exclusively address private for-profit; usually the whole private sector is assessed)			
Regional studies (n=5/11) ^	R4D Institute and The Rockefeller Foundation	2008	Private for-profit; Region: Africa	Private sector in health supply chains

Type of source	Reference	Year of publication	Focus	Definition of 'private'
	OXFAM International (Investing for the Few)	2014	Private for-profit; Region: Africa	IFC investments in for-profit companies in the health sector in the context of the Health in Africa initiative
	IFC	2013	Private for-profit; Region: Africa	IFC investments in for-profit companies in the health sector in the context of the Health in Africa initiative
	IFC	2012	Private for-profit; Region: Africa	IFC investments in for-profit companies in the health sector in the context of the Health in Africa initiative
	Doherty	2015	Private for-profit; Region: East & Southern Africa	Overview of legislation governing the for-profit private health sector
Case studies (n=5/16) ^	Montagu et al. (Lancet)	2016	Private for-profit; Case: UHC Low and middle income countries	Interventions that encourage private providers to improve quality and coverage (while advancing their financial interests) such as social marketing, social franchising, vouchers, and contracting
	Every Woman Every Child (Report on Private Sector Engagement Activities)	2015	Private for-profit; MNCH Low and middle income countries	Overview of activities implemented by the United Nations Foundation in support of private sector engagement in Every Woman Every Child (EWEC)
	Every Woman Every Child (Ultimate Investment in the Future Profiles of Corporate Engagement ...)	2015	Private for-profit; MNCH Low and middle income countries	Overview of 48 corporations that support the EWEC programme
	Every Woman Every Child (Business Approaches to Advancing Women's, Children's and Adolescents' Health)	2016	Private for-profit; MNCH Low and middle income countries	Overview of business approaches to improve MNCH

Type of source	Reference	Year of publication	Focus	Definition of 'private'
	Centre for Health Market Innovations	2013	Private for-profit; MNCH Low and middle income countries	More than 220 programmes that harness private providers to deliver maternal, newborn and child healthcare

Note:

^The first number refers to the private for-profit studies; the second number to the total number of studies per type of course.

6.5 Annex 5: Details of the sources used for the scoping study on education, by type

Type of source	Reference	Year of publication	Focus	Definition of 'private'
Reviews (n=6)	Day Ashley et al.	2014	Systematic review; Private for-profit; Developing countries	Profit was not a defining parameter but authors assume that studies included refer to for-profit private sector although not possible to check if all are low fee
	Barakat et al.	2014	Systematic review; Private for-profit; Region: South & West Asia	Non-state actors which are financially sustainable or have perspective of becoming self-sustaining within a specified time
	Lewis and Patrinos	2012	Review of impact evaluations; Private for-profit and not-for-profit; Global	No clear distinction between private for-profit and not-for-profit
	Conn	2014	Systematic review of impact evaluations; Effective educational interventions with an impact on student learning; Region: Sub-Saharan Africa	Private schools are not included in the sample but discussed briefly as they are not the 'educational interventions' that the author looks for
	Snilstveit et al.	2015	Systematic review; PPP; Low and middle income countries	Partnerships with private sector include for-profit and not-for-profit organisations
	LaRocque	2008	Literature review; PPP; Global	Partnerships with private sector include for-profit and not-for-profit organisations
Landscaping studies (n=5)	Lewis and Patrinos	2011	Private for-profit involvement in education; Global	Private schools (no subsidies); private funded schools; private contracted schools; private management schools; market-contracted schools
	Patrinos et al.	2009	PPP; Global	Three types of education services and operations (vouchers, subsidies, private management of schools) and private finance initiatives for school construction

Type of source	Reference	Year of publication	Focus	Definition of 'private'
	Draxler	2007	PPP; Global	Partnerships includes business (for-profit) and civil society (not-for-profit)
	Ingram et al.	2006	PPP; Global	Private refers to business
	Bertsch et al.	2005	PPP; Developing countries	Corporate involvement
Country/case studies (n=6)	Akaguri	2013	Private for-profit Country: Ghana	Low-fee private schools
	Heyneman and Stern	2013	Private for-profit Countries: Jamaica, Kenya, Tanzania, Ghana, Indonesia and Pakistan	Low-fee private schools; Use the term "non-government schools" due to the connotation that "private" often has with regard to being elite and/or for-profit
	Ernst & Young	2012	Private for-profit Country: India	Corporate social responsibility
	HDRC and UKAid	2011	PPP Country: Pakistan	Private sector includes for-profit and not-for-profit
	Al-Tarawneh	2012	PPP Country: Jordan	Private sector includes for-profit and not-for-profit
	GPOBA	2016	Public and private Output-based approach (subsidies dependent on output) Country: Vietnam	Semi-private and private upper secondary and professional secondary schools; no definition of 'private'
Regional studies (n=2)	UNICEF EAPRO and ADB	2011	PPP; Region: East Africa and Pacific	Doesn't distinguish between for-profit and not-for-profit private schools
	USAID and AED	2008	PPP; Region: Latin America	Includes for-profit private schools