Managing Markets for Health

Sustaining access to high-quality essential health services during the COVID-19 pandemic

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In response to COVID-19, governments are striving to increase their capacity to contain the outbreak and mitigate its health effects while sustaining provision of other essential health services. In developing countries, this requires a whole-of-society approach, mobilising all available resources in the health sector – whether these are in the public sector or the private sector. This course provides operational guidance for governments and their partners on how to achieve this.

Aims and Objectives

The Managing Markets 4 Health (MM4H) curriculum has been developed over a number of years by some of the world’s leading health systems experts. It was originally designed to enable governments and their development partners to accelerate progress towards Universal Health Coverage (UHC) (incorporating equity of access to safe, effective, and affordable care) through effective engagement with the private health sector. Now, in 2020, COVID-19 represents a major threat to these goals, and our curriculum has been redesigned to reflect this new reality. The learning content and activities set out in this course will help you understand how to sustain the path towards equitable, high-quality health care as you strive to contain and mitigate the impacts of the pandemic.

Our aim, therefore, is to demonstrate how effective management of markets for health products and services can help governments maintain progress towards Universal Health Coverage (UHC) in the context of the COVID-19 pandemic. UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be

BOX 1. What do we mean by the private health sector?

The private health sector is complex and heterogeneous. It encompasses all non-state actors involved in health service delivery, including for-profit and not-for-profit entities, providers in the formal and informal sectors, and domestic and international actors.
effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC comprises three key objectives:

1. **Access**: increased access to health services – everyone who needs services should have access to them, not only those who can pay for them.

2. **Quality**: quality of health services should be good enough to improve the health of those receiving them.

3. **Financial protection**: health services must be affordable to those who use them so that that households are protected from catastrophic or impoverishing costs.

Effective management of markets for health is required to maintain these objectives in both ‘normal times’ and in the context of an emergency or other ‘shock’ to the health system, such as the current COVID-19 pandemic. Proactive management is needed both to limit mortality and morbidity due to the disease, and to mitigate its impacts on access to other essential health products and services.¹

The learning content for this course is structured according to the Pathway to Impact (Figure 1.1 below) along which all effective market systems interventions must travel. The Pathway to Impact incorporates four key sets of actions:

**ACTION 1. Diagnosis**: the definition of local priorities, their origin in market systems constraints and weaknesses, and the root causes of these problems.

**ACTION 2. Design**: the ‘visioning’ of strategies and interventions to address the causes of prioritised problems – and thereby enhance access to affordable, high-quality health services and products.

**ACTION 3. Delivery**: the implementation of market systems strategies and interventions by government and its partners through collaboration with a diverse range of market players.

**ACTION 4. Detect**: the measurement of changes in the system that can be attributed to the intervention, and the approaches to taking mid-course corrections as needed.

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¹ World Health Organization 2020, Maintaining essential health services: operational guidance for the COVID-19 context, [https://www.who.int/publications-detail/10665-332240](https://www.who.int/publications-detail/10665-332240)
The Market Systems Framework

Underpinning each of these four sets of actions is the Market Systems Framework (Figure 1.2). This framework is used to organise our thinking about the institutional arrangements which collectively determine the performance of the market system in terms of our UHC goals. Specifically, this framework is used to:

- Ensure our focus is on achieving impact – i.e. what are the functions that need to be performed, and performed well, to achieve equitable access to high-quality health care?
- Emphasise the reality of pluralism in the health system – i.e. the ‘public-private mix’ that exists in most service areas, from hospital care to specialist services, diagnostics and laboratories, primary care, pharmaceutical supply, and drug sales.
- Clarify that interventions by government need to be structured so as to target the supporting functions and rules that drive behaviour in the market system – i.e. what are the problems; what functions are implicated in resolving them; who needs to perform these; who needs to pay for them; and how do we realise the necessary changes through our own actions?
- Demonstrate that the necessary changes are best defined in the local context (and cannot be imported as pre-packaged “solutions”) and must be domestically-driven, effective and sustainable.

The core function of a market system is to provide a ‘space’ in which transactions of a defined range of health products and services can occur. This space is influenced by a set of formal and informal rules and norms and a range of supporting functions.

The market system is a space in which transactions occur, and is influenced by formal and informal rules and norms and a range of supporting functions

These functions and rules determine behaviours and practices in the market, shape relationships between actors, provide information and knowledge, and generate incentives. Within the market system, a diverse range of public and private, formal and informal players, and their representative groups and associations, will be active.
It is this multi-function, multi-player assemblage that we understand as a health market system. It is comprised of:

1. **The core.** This describes the demand for all goods and services supplied in the market, and the range and scale of providers present in the market – including all state and non-state providers.

2. **Supporting functions.** These are the range of functions that fall outside of the core exchange of a market system – but significantly affect the behaviours, capabilities and incentives of ‘care-seekers’ and/or providers.

3. **Rules and norms.** These are the institutions that shape the operating environment for all market players, including care-seekers and providers. They determine who can participate in the market and under what conditions. Formal rules include laws and regulations issued by public authorities, in addition to rules issued by professional associations and industry bodies, e.g., industry standards or codes of conduct. Informal rules – generally a product of local culture and value systems and practices – are also relevant, both in their own terms and because they influence the extent to which formal rules are accepted.

These functions and rules support, shape, inform and enable interactions between care-seekers and providers. The root causes of performance problems will be found in terms of the presence and adequacy of these market attributes. From a generic (i.e.
non-market specific) point of view, important supporting functions in health market systems include attributes such as: information, coordination, skills and capacity, infrastructure and financing. Supporting functions are necessary for markets to work efficiently, ensuring that demand and supply meet, and transactions take place in a secure manner and at a low transaction cost. In weak market systems, functions and rules tend to be absent, or inadequate, or provided by the ‘wrong’ market player — e.g. a player that has too limited capacity, or an inappropriate set of incentives.

Many functions and rules can be provided via direct state action, or the actions of other market players, through specific ‘tools of government (a concept we consider in more detail in Chapter 3 of this course). However, in some cases, these are features of the socio-cultural environment (norms) in which the market is located, and these are not always directly amenable to change through actions of government or other market players.

The Strategic Logic Model

It is important to recognise that the objectives underpinning market systems interventions (as set out above) are not all at the same level; and that there are connections between them. It is important to set our goals in light of this. In simple form, the connections between market systems actions and our understanding of their likely impacts on population health are shown in Figure 1.3:

**FIGURE 1.3 From market systems actions to population health outcomes**

Minimisation of direct and indirect mortality and morbidity during and after the Covid-19 pandemic

...results from

increased equity of access to improved health care at prices that do not threaten household budgets

...which arises from

upgrading and improved performance of market systems for health products and services

...which provides the logical focus for

the most appropriate role of government and its partners in generating substantial and sustainable impact.
We can present these connections as a stylised *Strategic Logic Model* (SLM), as in Figure 1.4.

**FIGURE 1.4: A Strategic Logic Model for effective management of market systems**

The appropriate role(s) of government is to respond to key constraints and limitations in the health market system.

Well-governed health markets create conditions for enhanced access, quality and financial protection.

These goals are pre-requisites for achieving acceptable health outcomes – in ‘normal’ times and times of ‘crisis’.

The SLM is a ‘golden thread’ that runs throughout the Pathway to Impact utilised in this course. Indeed, this course can be viewed as providing practical guidance on how to operationalise the SLM in practice through effective usage of the Market Systems Framework. In the next chapter, we begin to show you how to do this.

**Governance of Mixed Health Systems**

The Pathway to Impact emphasises the important role that policymakers perform as *stewards* of the public-private mix (PPM) in the health system. Stewardship is often likened to ‘rowing instead of steering’. But this characterisation is not sufficiently detailed. According to the World Health Organization (WHO), effective stewardship of a mixed health system entails six key governance behaviours (see Figure 1.5). These behaviours also apply to managing health market systems – which are, in effect, constituent parts of the larger mixed health system. Indeed, according to the WHO, one should observe these governance behaviours throughout the Pathway to Impact.
The six governance behaviours help policymakers to align different interests in the private and public sectors, so that all market players can work together in strengthening a health system to deliver on UHC goals.

**Governance behaviours include:**

1. Setting strategic direction for all actors in the health system.
2. Collecting and using intelligence to create a common understanding of challenges to be addressed and facilitating information flow to enable sound policy/program decisions.
3. Applying tools of government that enable both public and private actors to perform their respective roles and responsibilities in market systems.
4. Building and sustaining cooperative relationships for coordinated and efficient implementation.
5. Creating institutional framework(s) that align public and private health actors.
6. Creating a culture of accountability to foster trust and performance (Travis, 2002) \(^2\) (WHO, 2019) \(^3\).

**Inclusive Processes**

Another ‘golden thread’ that runs throughout the Pathway to Impact is the concept of inclusive processes - which facilitate each set of actions in the Pathway to Impact. Achieving UHC requires a ‘whole-of-society’ approach in which government actors

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\(^3\) World Health Organization. 2020. Engaging the private health service delivery sector through governance in mixed health systems. The Advisory Group on the Governance of the Private Sector for UHC.
facilitate collaboration among multiple stakeholder groups. This approach calls upon policymakers to play a central role in which they orchestrate all stakeholders to fulfil their respective roles during each step of the Pathway to Impact. So:

- In **Diagnosis**, policymakers engage all relevant market players – in public, private, and civil society sectors – to inform the understanding of the targeted market system and to ensure the analysis reflects all relevant perspectives.

- In **Design**, policymakers involve multiple stakeholder groups to help assess the market’s capacity to implement the intended strategy, and to inform the approaches taken to implementation.

- In **Deliver**, policymakers orchestrate the market players to be included in or affected by the process of change, performing new activities to sustain public-private sector involvement throughout the implementation process.

- In **Detect**, policymakers need to step back to determine, in collaboration with other market players, to assess how the strategy is moving the market system in the ‘right’ direction, and to be flexible enough to make mid-course corrections as required.
Introduction

This course is designed to help governments and their partners realise a commitment to universal health coverage (UHC) through market systems action.

To do so, decision-makers need to:

- **build** a sound understanding of the market systems most relevant to issues of access, quality and financial protection,

- **identify** the extent to which these systems fail to achieve desired outcomes with respect to these goals, and

- **analyse** why these sources of underperformance exist.

As the WHO has argued (see Chapter 1), building an understanding between the sectors is a key component of effective governance. This relates to our goal in this chapter: to show how a clear (and shared) understanding of key market system challenges can be created, including through the collection and analysis of data.\(^1\)

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\(^1\) World Health Organization. 2020. Engaging the private health service delivery sector through governance in mixed health systems. The Advisory Group on the Governance of the Private Sector for UHC.
Market systems in health are complex. The diagnosis of performance problems is challenging and time-consuming. But is worth the effort! Getting the diagnostic process right is necessary for building strategies that ‘work’ – that do more than simply fight fires and address the underlying causes of persistent market system failures.

**Getting the diagnostic process right is necessary for ensuring interventions do more than ‘fight fires’**

The diagnostic process is NOT about defining strategies (that comes later). Nor is it a process of finding a ‘target’ for some pre-defined strategy or tool. It is about discovering where intervention by government will deliver the greatest benefit from a UHC perspective.

The diagnostic process proceeds in four steps:

1. **Selecting** the ‘right’ market system for intervention,
2. **Identifying** how the system is or isn’t working to achieve UHC goals,
3. **Specifying** the root causes of underperformance, and
4. **Prioritising** which root causes are to be tackled through intervention.

These provide the main structural components of this chapter.

**The Diagnostic Process**

**STEP 1: Selecting the right market system(s) for intervention**

The technical skills, organisational capabilities and financial resources needed to achieve UHC are all finite. This is especially so today, in the context of the COVID-19 pandemic, which has placed all of these resources under severe strain. Therefore, decision-makers have to prioritise – to select the market system(s) in which there is the greatest potential to achieve beneficial impact. Setting clear criteria for this selection makes decision-making about prioritisation more effective and transparent, leading to greater trust and understanding among stakeholders, including in the private sector and civil society.

Each market system considered for intervention should be assessed in terms of:

- **relevance** - its role in determining the ability of people to satisfy their essential care needs,
opportunities - the probability and potential benefits of delivering better performance, and

feasibility - the prospects for achieving better performance in practice given the resources of government.

Relevance of the market system

The first task in Step 1 is to consider which market systems are most relevant to government priorities with respect to people’s (in)ability to satisfy their essential health care needs. It is common for governments to define such priorities – for example, with respect to specific diseases or health themes – in national health policies, strategies and plans (NHPS). The content of NHPS reflects a high degree of consensus among local stakeholders about priorities for government intervention. Therefore, they describe a set of objectives that have local ‘buy-in’ and support – factors that are likely to prove important for successful delivery. As such, they provide an excellent starting point for considering the relevance of the market system(s) to be considered.

The overriding goal is to ensure that our interventions bring maximum benefit to as many people as possible in terms of the most severe and urgent challenges from a UHC perspective. Therefore, consideration of three concepts can help to define an understanding of how such goals can be addressed with respect to individual market systems:

- Scale. An assessment of the percentage of the population deemed to be at risk of and/or currently affected by a lack of access to affordable, high-quality essential health products and services in the market system.

- Severity. An examination of the market system in terms of its impact on UHC goals. For example, in the context of COVID-19, market systems for essential health products and services have been disrupted, increasing avoidable morbidity and mortality. Due to their actual or potential impact on such goals, high-priority market systems for intervention are likely to include those concerned with:

  - Essential preventative services for communicable diseases, particularly vaccinations,
  - Services related to reproductive health, including family planning, and maternal and neonatal care,
  - Care of vulnerable populations, such as young infants and older adults,
  - Supply chains for medications and products for management of chronic


diseases,

- Critical outpatient and inpatient therapies (including but not limited to those related to COVID-19), and
- Auxiliary services, such as diagnostic imaging, laboratory services, and blood bank services.

- **Urgency.** Health priorities are – quite rightly – influenced by events requiring an urgent response. In the context of the COVID-19 pandemic, it is appropriate to prioritise interventions in the market system(s) most directly involved in containing and mitigating the associated health impacts.

### Opportunity to improve the market system

Market systems present different opportunities for achieving positive change. Some present more opportunities than others. For example, in some systems, providers of safe, effective services **exist**, but they are **inaccessible** to a proportion of the population. In this case, there is an opportunity to increase access and thereby serve our UHC goals.

In other systems, essential products and services may be accessible but of **low quality** - and there are technologies or new ways of working that could improve the quality of care. In this case, there is an opportunity to stimulate take up of new technologies and information by market players.

To underpin the analysis of opportunity, existing data on the market system will need to be sourced or collected. For example, data can be generated on the pattern of care-seeking and the availability of services to the population (see Appendix One for a comprehensive overview of data sources and data collection methods).

**To underpin the analysis of opportunity, data on the market system will need to be sourced or collected**

The research needs to examine **how patients seek care** (utilising population-based surveys of health care utilization, such as the DHS) and **what services are available** in all sectors (with data drawn from, for example, Service Availability Assessments, Private Sector Assessments, and government data and reports).

The analysis underpinned by such research will help to address key questions about the **trends** in the market (e.g. are access, quality and financial protection increasing or diminishing, and where in the system are the trends most promising/ most concerning?), as well as the existence of any spare or under-utilised capacity, or any misalignment between existing incentive structures and those consistent with our goals as policymakers.

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4 These methods are discussed in more detail in the appendix to this handbook.
Feasibility of improving the market system

There must be sufficient organisational capabilities (technical skills, levels of authority, and the ability to take decisions) within government to implement and achieve the intended changes.

In general, governments have limited organisational capabilities to intervene in market systems. However, systems vary in the demands they place on such capabilities. Two key considerations here include:

- **Complexity**: Does the government and its partners have the technical skills to define what change is needed in the system, and verify whether this is change is being delivered? Does it have the political authority to obtain a consensus on what good performance looks like, and to take actions that stimulate this in the system?

- **Reach**: Does the government have an understanding of the key dynamics of the system? If not, can this be developed? Is there a set of counterparties in the system with whom the government can consult and negotiate? If not, will this affect implementation of the intervention?

To illustrate these concepts, let’s take two examples of (very different) market systems.

First, consider the market system for acute inpatient services. This market tends to be very concentrated. There are typically few secondary and tertiary hospitals serving a given population. There are also information asymmetries between care-seekers and providers (e.g. it is difficult for the former to know from whom to seek treatment and/or whether they are being offered the safest and most efficacious form of treatment).

In principle, then, intervention in this market system is warranted. Concentration in supply means providers can charge high prices. Information asymmetry means they can under-invest in quality – and still stay in business. But is intervention feasible? How likely is it that we can improve the operation of this market system?

Such an intervention is likely to be challenging from a technical perspective. We will find it difficult to specify what good performance ‘looks like’ in the system. Even if we can do so, we might not have tools (e.g. regulatory or financing tools) to alter the incentive and accountability environment and stimulate better performance. The market power of incumbent providers means we might meet strong resistance. And we may not have access to the performance data needed to verify whether or not systemic changes have been achieved or are having the intended impacts. In short, intervention in this market may be very desirable, but not very feasible. The complexity of the market, set against the limited organisational capabilities of government, limits the potential for achieving sustainable change.

Second, consider the market system for medicines – especially those sold to poor people by informal, unqualified drug sellers. Here, for obvious reasons, there is a compelling
need for intervention – in the form of regulations that establish and enforce barriers to market entry and prohibit such sellers from remaining in the market. Governments with strong organisational capabilities can take various steps to specify and enforce the standards they want to see in this market system, leading to market exit by drug sellers – and, perhaps, an expansion of market share for qualified pharmacists.

This is all very desirable. So, again, intervention is warranted. But is it feasible? Where a market system is large and diffuse, the government’s understanding of it may be extremely limited. For instance, it might be difficult to discover (a) how many providers there are, (b) where they operate, (c) who they sell to, and (d) on what terms. Furthermore, there may be no credible intermediary entity with which government can consult, or negotiate with, to generate information for a feasible vision of improvement. In this context, whatever interventions are implemented ‘on paper’ might have limited impact ‘in practice’. The intervention will simply not ‘reach’ the sellers in terms of their behaviour in the market – and unsafe and/or ineffective medicines in the country will continue to be made available to the population by this group of sellers.

**FIGURE 2.2:** Assessment of the feasibility of intervention in (stylised) market systems

Figure 2.2 (above) provides a (stylised) representation of how these concepts can be used to organise our thinking about the feasibility of interventions. On the left-hand side of the diagram are market systems that government understands well – systems in which market players can easily be engaged (including through strong representative entities, with whom government has an active dialogue). However, the ‘product’ in this market is complex; and specifying desired outputs and outcomes is challenging. Even if these can be specified, enforcement is difficult – and costly. In contrast, on the right-hand side are market systems in which the ‘product’ is more straightforward. The government can specify desired outputs and outcomes quite easily. But these are more diffuse and disorganised market systems. The government has limited data on who the key market players are, where they operate, or how they are organised. There are no strong representative entities, and no existing dialogue structures on which to build.

In contrast to these examples, towards the middle of the diagram are market systems in which: (i) minimum standards for the ‘product’ can more readily be established and enforced, and (ii) government has a strong presence and understanding of what is taking place in these systems. All else being equal, the feasibility of stimulating better
performance will be greatest in these market systems, located towards the middle of the diagram (in which complexity is low and reach is high), and least for those on the extremes. Our argument here is NOT that intervention in the latter category of market systems should never be considered. However, it will be prudent to concentrate initial activities on the systems most amenable to intervention.

Once the key issues considered in Step 1 have been addressed (i.e. we understand the relevance of the market system being examined, and the opportunity for and feasibility of stimulating positive change in this system), the results of the analysis can be compiled in a simple operational tool as in Table 2.1 (below). The completed table will help us to make a logical decision about where to intervene and explain this decision to other internal and external stakeholders. However, it should be noted that this is still a preliminary analysis. No decisions have been taken yet on the strategy to be pursued, or the intervention areas to be advanced. Those decisions come later.

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<td>Relevance of the market system to the priorities defined in NHSPS</td>
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<td>% of population lacking access to affordable, high-quality care within this market</td>
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<td>Impacts of the lack of access on morbidity and mortality</td>
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<td>Importance regarding time-sensitive goals, such as outbreak response</td>
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<td>Potential for providing better access to goods and services available in the market</td>
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<td>Prospects for ensuring higher-quality care in facilities where patients seek care</td>
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<td>Opportunities to enhance financial protection against the costs of care</td>
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<td>These prospects/opportunities compare favourably with other market systems</td>
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<td>Government’s ability to define what it wants, and verify if this is being delivered</td>
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<td>Willingness and ability of market actors to adopt change in line with UHC</td>
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<td>Availability of counterpart(ies) with whom to consult, include, and negotiate</td>
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ILLUSTRATING STEP 1: A MINISTRY OF HEALTH RESPONDS TO THE COVID-19 OUTBREAK

Country X reported its first case of COVID-19 this week. Minimising the direct and indirect effects of the outbreak on population health has become the national priority. The Ministry of Health (MoH) recognises the scale, severity, and urgency of the threat. It is aware that the public sector has insufficient capacity to protect population health during the crisis, and that embracing a ‘whole of society’ approach to the outbreak response will be necessary. Fortunately, the Deputy Minister of Health has previously taken the MM4H course. She knows, therefore, that the first order of business is to discover which market systems are most relevant to the national response effort. She has identified two specific market systems in particular:

- **Diagnostics and laboratory services**: Ensuring equitable and rapid access to accurate testing will be essential for identifying new cases and reducing transmission through rapid isolation and contact tracing.

- **Treatment**: Ensuring equitable and rapid access to high-quality, affordable treatment will be necessary to limit mortality and improve post-infection morbidity. Two specific sub-systems are implicated here: primary care (for those with mild symptoms), and acute care (for those with more severe symptoms).

The Deputy Minister assembles a technical team within the MoH to help her diagnose the challenges in these market systems. The team is comprised of the Director General (DG) of the Federal Drug Administration (FDA), the DG of the Medical Services and Quality Assurance Department, the DG of the Health Finance Division, and staff from the Public Education Unit. The MoH already has a presence in the diagnostics and laboratory services sector and is a provider of primary care and acute care. However, the Deputy Minister is aware that there is also a large private sector in these market systems. Therefore, she invites the MoH Public Private Partnership (PPP) Advisor to join her team, hoping that he can help the technical team to better understand ‘who’s who’ in the private health sector in Country X.

The Deputy Minister is keen to ensure that capacity across the entire health system is effectively mobilised for the national response to COVID-19. Her technical team is assigned to conduct a rapid review of existing data, generated through recent Service Availability and Readiness Assessments, Private Sector Assessments and government reports undertaken as part of the National Health Sector Strategic Plan, to provide a snapshot of health care resources in all sectors. The review determines that there is substantial capacity in the private sector – and, given the disruption caused by the outbreak, much of this is likely to be under-utilised.

Therefore, the MoH team concludes that there is an opportunity – indeed, an imperative – to intervene in the relevant market systems.

However, it is clear to the technical team that the testing and treatment systems are not equally amenable to government intervention. The team can form a reasonably detailed view of what it will take, and what it will cost, to achieve equitable access to high-quality testing services for the population. It is less clear to them at this stage how to obtain similar
outcomes in the two treatment sub-systems. Having made this preliminary assessment of the relevance, opportunity and feasibility of intervention, the Deputy Minister asks her team to focus initial efforts on the diagnostics and laboratory services system, and to move to the next steps of the analytical process.

STEP 2: Identifying how the system is or isn’t working to achieve UHC goals

Having identified the market system(s) that will be targeted for intervention, Step 2 focuses on a description of the market system’s performance in terms of access, quality, and financial protection, and an explanation of this level of performance in terms of key market attributes and constraints.

Description

We start with the core of the market system – the main features of supply and demand. Key questions that relate to ‘the core’ include:

- **Access**: To what extent are relevant health products and services available to the population, and in the places that consumers would normally seek them?

- **Quality**: To what extent are relevant products and services safe and effective, and appropriate to the population concerned?

- **Financial protection**: To what extent are relevant products and services affordable to the population?

We then move on to identify the supporting functions and rules that determine the nature of interaction in ‘the core’. We can use the Market Systems Framework, introduced in Chapter 1, to make a graphical representation of the system in terms of functions and rules (see Figure 1.2 in the previous chapter for a stylised illustration of this). Note, however, that at this stage we are simply describing the functions and rules that are present in the market system and that determine current (under)performance at the time of the analysis. We are not yet providing an evaluation of these attributes.

Descriptive questions that relate to the functions and rules in the market system include:

- **What?** What supporting functions and rules have a significant bearing on the degree of access, quality and financial protection afforded by the system?

- **Who?** Who are the players (they may be private, public or other, large or small, formal or informal) that perform the functions or set the rules relevant to these aspects of market performance?
Evaluation

As we describe the market system’s supporting functions, rules, and players, we generate insights into the reasons for (under)performance. Questions about the nature of the supporting functions and rules are evaluative: they are seeking to understand the why of current (under)performance.

Evaluative questions about supporting functions may include the following:

- **Information (demand-side):** To what extent are consumers aware of the health products and services that are available, their costs and benefits, and where and from whom to access them?

- **Demand-side financing:** To what extent does financing exist to adequately support demand in the market, reduce financial barriers to access, and provide income for suppliers who offer products and services to the population(s)?

- **Supplies, skills and technology:** To what extent do providers have access to the supplies, skills and technologies needed to provide safe, effective, and affordable products and services to the population(s)?

- **Capital financing:** To what extent do suppliers have access to financing for capital investments and/or working capital to sustain their operations in times of cash-flow volatility?

Evaluative questions about the rules of the market system may include the following:

- **Standards/Guidelines:** To what extent do market players have guidance to help them perform their roles to national or international standards? Is the guidance adequate or are there gaps to be addressed? Is there a need for training programmes to ensure informed compliance?

- **Regulations:** To what extent are there rules sufficient to ensure health services and products meet minimum standards/ excessive regulations creating barriers to market entry?

- **Taxes/Tariffs:** To what extent are the structures of taxes, tariffs and other economic conditions sufficient to attract new actors and/or retain current actors in the market system?

- **Formal/informal norms:** To what extent is there sufficient trust between state and non-state actors to enable effective resolution of conflict and the creation of consensus?

The evaluation of supporting functions and rules will generate insights about the adequacy of these attributes, whether or not the ‘right’ market players are undertaking them, and whether some attributes are missing entirely. In other words, we can evaluate them in terms of whether they are:

- **Adequate or inadequate:** a function or rule is inadequate when it is performed by a market player that does not have the ‘right’ capacity to do it well. For instance,
a customs authority may lack the capacity to adequately enforce standards designed to restrict the import of fake medicines.

- **Well-matched or mismatched:** a function or rule may be performed by the ‘wrong’ player – one that has the wrong incentives to perform it well. For instance, public sector laboratories may have weak incentives to increase the volume of tests performed during an infectious disease outbreak.

- **Present or absent:** a function or rule may be missing because the necessary capacities and incentives are not in place – and hence no market player chooses to perform it. For instance, many private health providers complain about a lack of access to capital finance, which undermines their ability to invest in new equipment, enter into contracts for supplies, or retain staff in times of cash-flow shortfall. Banks are aware of the demand for credit, but cautious to enter into agreements with entities that have an uncertain revenue stream (e.g. during a pandemic).

Once the key questions concerned with step 2 have been addressed, the results of the analysis can be summarised in a simple operational tool (represented, using entirely illustrative attributes, in Table 2.2 below).

### TABLE 2.2: Results of the evaluation of supporting functions and rules in the market system

<table>
<thead>
<tr>
<th>Illustrative Attributes</th>
<th>Present</th>
<th>Adequate</th>
<th>Matched</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supporting Functions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information (demand-side)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information (supply-side)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies, skills, and technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital financing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rules and Norms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards/guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxes/tariffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal/informal norms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Even after evaluating the adequacy of supporting functions and rules in the market, we are still describing the symptoms of the problem at this stage. The aim of the above step is to understand how the system is currently not working in such a way as to allow UHC to be achieved. In the next step, Step 3, we need to go deeper, to identify the system-level constraints that represent the root causes of the problem.
A note on market segmentation

It should be recognised that, in many health market systems, there is a high degree of segmentation – i.e. different groups of consumers engage in transactions with different groups of providers, and these transactions take place in operating conditions that are specific to the segment. Our analysis needs to reflect this reality.

Therefore, when analysing key areas of underperformance in the market system, it is important to be aware of which segment the analysis refers to, i.e.:

1. **The ‘Served’**. This is a segment in which the smallest number of consumers – often affluent, urban residents – receive the health products or services being considered. They have relatively good access to high quality care, provided by competent and motivated players on terms that are affordable to them. Information, coordination and regulation are likely to be strong features of the system(s) in this segment.

   **Nature of supporting functions and rules**: information, coordination, and regulation are likely to be adequate, and performed by the ‘right’ players, in this market system.

2. **The ‘Underserved’**. In this segment, a larger number of consumers is present. They are often on low-to-middle incomes and live in peri-urban or larger rural settings. They have some access to care – but with less choice than those in the ‘Served’ market segment. The care they receive is generally of lower quality – while providers are certified to some level, their qualifications do not correspond to the full range of services they offer; and levels of staff motivation are generally low (staff absenteeism is a key feature).

   Providers are subject to some degree of regulatory oversight (at least regulations exist ‘on paper’), but weak enforcement means that regulations are not a key driver of performance in actual practice. Care is nonetheless considered acceptable (in terms of both quality and cost factors) in this segment.

   **Nature of supporting functions and rules**: low standards but inadequate regulation, limited coordination and poor information are likely to be strong features of this market system.

3. **The ‘Unserved’**. This segment may represent a large number of consumers. These people are often on low incomes and live in sparsely populated rural areas. They have limited formal education, live in information-scarce environments with poor connectivity, and limited infrastructure. They either have no access or, more likely, they have access to some range of low quality and unacceptable products and services, provided by low-competence and unmotivated providers. Such providers will often be small, informal – perhaps with some experience, but with no formal training or professional qualifications. Levels of staff motivation are generally low (e.g. staff absenteeism is a major feature). Costs of accessing better alternatives might be prohibitive and/or have catastrophic financial consequences for the poor.
Nature of supporting functions and rules: Low skills, low standards, unregulated operations, financial constraints, and strong influence of social rules and norms are key features of these market systems.

ILLUSTRATING STEP 2: ASSESSING THE MARKET SYSTEM FOR TESTING IN THE CONTEXT OF COVID-19

Returning to Country X, during a working dinner, the MoH technical team considers how the market system for testing is delivering on core goals, such as access, quality, and financial protection, during the COVID-19 outbreak. It begins by examining the nature of supply and demand in the system. It makes the following observations:

- Tests are currently accessible to a minority of the population – mostly affluent, urban residents (‘the served’) – that live close to public laboratories or can afford to pay ‘out of pocket’ for private testing.

- The FDA DG has confirmed that, in these segments of the market (comprising both public and private laboratories), services are of variable quality. However, he is confident, at least, that the results of tests undertaken by these diagnostic facilities are being routinely shared with the Surveillance Department.

- The majority of the population (‘the underserved’) does not have rapid access to reliable Covid-19 tests. In the public sector, there is limited supply. This can be expanded – but the technical constraints to this, in relation to space, staff and access to resources, mean that supply is likely to fall short of demand. As discussed in the earlier meeting, the private sector has substantial excess capacity for testing services, and this can be utilized. But the current price tag of $60-70 average per course of three tests is going to be too large a financial barrier for the majority of underserved people.

The team reflects on what it has learnt so far. On the demand side, it has found that market prices are limiting access to testing services; while on the supply side, there is excess capacity – but also variable quality. The Deputy Minister (after consulting her MM4H textbook!) asks the team to turn its attention to three additional questions:

1. What supporting functions and rules would need to be present for access and quality to be at the desired levels?

2. To what extent are these things currently present in the market system?

3. For those that are present, are they carried out at an adequate level of performance, and carried out by a market player well-motivated to do the task well?

These questions are not easily answered. Doing so requires good data – some of which needs to come from external actors. The MoH technical team therefore decides to consult the Executive Director (ED) of the country’s Private Health Care Federation, as well as the
EDs for the private hospital and private laboratory associations, to (a) confirm that the MoH’s initial analysis of the laboratory/diagnostic market system so far accords with reality (as it is perceived outside of government!); and (b) help address the answers to the questions above.

Having reflected on the private sector stakeholders’ inputs, the technical team summarises its current analysis of key gaps in the table below.

*Note: P stands for Present, Ad stands for Adequate, and M for well-matched*

<table>
<thead>
<tr>
<th>Attribute</th>
<th>P</th>
<th>Ad</th>
<th>M</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td></td>
<td>√</td>
<td></td>
<td>While accreditation services are available, they are high-cost, and too strict for most private laboratories. They are also voluntary - and take-up among labs is very limited.</td>
</tr>
<tr>
<td>Supplies, skills, technology</td>
<td></td>
<td>√</td>
<td></td>
<td>Public sector capacity is in effect fixed (due to stock-outs on reagents, scarce human resources, out-of-date equipment). Excess capacity is available in the private sector.</td>
</tr>
<tr>
<td>Information (supply and demand)</td>
<td></td>
<td>√</td>
<td></td>
<td>There is insufficient information for providers about what viral tests are appropriate for whom. Also, there is insufficient information for consumers about where to get a test.</td>
</tr>
<tr>
<td>Capital financing</td>
<td></td>
<td>√</td>
<td></td>
<td>There is a lack of access to capital financing (credit), which impedes the stability of private providers’ access to key supplies - testing kits and related laboratory materials.</td>
</tr>
<tr>
<td>Demand-side financing</td>
<td></td>
<td>√</td>
<td></td>
<td>There are no pooled funds for COVID-19 tests delivered outside of public facilities. Patients unable to access tests in public facilities pay ‘out-of-pocket’ in private sector.</td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td>√</td>
<td></td>
<td>At least some private sector laboratories and clinical facilities are reluctant to perform COVID-19 tests because clients will not seek services if there is a known positive case.</td>
</tr>
<tr>
<td>Regulations</td>
<td></td>
<td>√</td>
<td></td>
<td>Private laboratories and other providers of diagnostic services need clarity that they have regulatory approval for their participation in COVID-19 testing.</td>
</tr>
<tr>
<td>Taxes/Tariffs</td>
<td></td>
<td>√</td>
<td></td>
<td>Important taxes on, and customs processes for, essential diagnostic equipment and consumables have increased prices of these commodities and increased their scarcity.</td>
</tr>
<tr>
<td>Price regulation</td>
<td></td>
<td>√</td>
<td></td>
<td>There is no regulation of prices for tests, and these are known to vary – though average costs of £60-70 per course of tests is equal to 10% of average annual household income.</td>
</tr>
</tbody>
</table>
STEP 3: Identify the root causes of underperformance

In this step, we introduce practical guidance on ways to uncover the ‘root causes’ of underperformance. The main question we are asking here is this: Why and in what ways are important functions and rules in the market system absent or underperforming?

To address this question, we need to understand the cause-and-effect relationships underlying identified problems. Fortunately, there is an established technique for doing this – the ‘Five Whys’. As the name implies, the Five Whys technique involves asking ‘why’ up to five times when trying to understand a problem. The technique is based on the theory that the root of any problem in a complex system can be answered by asking up to 5 ‘why’ questions.

However, the number of ‘why’ questions is not definitive. The point is to keep asking ‘why’ until the analyst is sure that the underlying root cause of the problem has been found. Use of this technique is more effective when three key disciplines, as shown in Figure 2.3, are borne in mind.

![FIGURE 2.3: Disciplines for using the Five Why’s tool](image)

There are three key elements to effective use of this tool:

- Accurate and complete statements of identified problems
- Complete honesty in answering the questions
- The determination to get to the bottom of problems and resolve them

This approach promotes ‘thinking through questioning’ and can be adapted to the dimensions of almost any problem. Indeed, in their book, Getting Health Reform Right, Roberts et al (2008) suggested that it is always useful to conduct health policy analysis in this way because of the underlying complexity of health system challenges.6

Factors to consider when conducting a ‘Five Whys’ analysis include: incentives, capacity, and the existence of connected markets.

- Incentives. Incentives drive behaviour. When designing an intervention, it is important to consider and integrate these into the design. Incentives are shaped by attitudes towards risk and reward (e.g. losing or gaining money, status, reputation, opportunity, assets or resources). In health, incentives can be materially-oriented, socially/ruditionally-oriented, or purpose-oriented.

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Capacity. Assessing market players’ capacity to perform relevant functions and fulfil their assigned roles in a market system is as important as incentives. A policymaker can assess the capacity of individuals, groups and/or organizations in the system. Capacity can be technical, financial, strategic, personal or cultural.

Connected markets. The (under)performance in one market may be explained by variables in another market that is ‘connected’ to it. For example, health service providers may be unable to expand services into a new geographic area in where there is excess demand because they can’t access credit (a connected market). In this situation, it is useful to treat the connected market as a separate system from the target market and undertake a further diagnosis of its core functions.

Figure 2.4 illustrates an example of a ‘diagnostic journey’ used by Roberts et al to understand why higher than expected health care costs occurred in public hospitals in China. Their research revealed an unusually high prescription rate with respect to certain pharmaceuticals. Using the Five Whys approach, they identified a chain of explanations of why public hospitals prescribed certain drugs. It found that the ultimate ‘root cause’ was a change in staff compensation which influenced hospital physicians’ behaviour.

Note that an understanding of root causes does not by itself determine the right actions to take. We are not yet at the design stage (the focus of Chapter 3). Roberts et al. note that a range of options might be appropriate in response to identified root causes. They comment: “one could change hospital funding, the insurance system,
the price list, physician compensation schemes, or drug regulations” (Roberts et al 2008). Nonetheless, identifying the root causes of the problems is the first step toward devising a sound plan for the response.

Understanding root causes does not by itself determine the right policy actions to address the problem

This exercise is improved when applied by a team with a broad understanding of the problem. Therefore, consultation with all relevant stakeholders – if possible, across government, the private sector and civil society (where relevant) – can enrich the analysis.

There are up to five basic steps. First, the team should agree on a clear statement of “the problem”, reflecting the analysis undertaken in Step 2. It then proceeds by asking the first ‘why’: why is this problem taking place? There will probably be three or four plausible answers. Best practice is to record them all on a flip chart or whiteboard – or use index cards taped to a wall. Ask up to four more successive ‘whys’, repeating the process for every statement on the flip chart, whiteboard, or index cards. Post each answer near its ‘parent.’ The analysis team will identify the root cause when asking ‘why’ until this yields no further useful information.

ILLUSTRATING STEP 3: IDENTIFYING ROOT CAUSES OF CONSTRAINTS IN THE MARKET SYSTEM

Back in Country X, the MoH technical team reviews what it has discovered so far through its analysis. It now understands the pattern of supply and demand in the system, and the extent to which ‘supporting functions’ and ‘rules’ are present/absent, adequate/inadequate, and matched/mismatched. It summarises the main points of the analysis as follows:

1. There are some ‘high-capacity’ laboratories in the private sector, but these are not accessible to the majority of the population. Tests are too expensive for most people to purchase directly, and there is no subsidy from government (or reimbursement under insurance) to help cover the costs.

2. There is confusion among consumers about where and from whom to seek a test. Quality is variable – such that even patients with the ability to pay ‘out of pocket’ do not know who will provide the ‘best’ services; and some low-quality providers can therefore stay in business. Suppliers are also unclear on key regulations governing the provision of testing.
3. There is a risk that the supply of testing services in the private sector might be compromised by the socioeconomic impacts of the outbreak. In particular, the suspension of routine health services has reduced utilisation of diagnostic services and reduced providers’ revenues. There is limited access to working capital (to offset the temporary shortfall in revenues), placing at risk the ability of providers to retain staff and maintain access to the essential supplies needed for reliable testing.

The MoH technical team considers some of these constraints as relatively straightforward to understand and assess. Others, though, require deeper analysis - to understand underlying causes and not just ‘symptoms’. For example, a key question concerns the lack of financing to support access to testing. This is puzzling. After all, there is a national health insurance fund (NIHF), and the team would like to know why it is not ‘doing its job’ at such a critical time. The team decides to use the ‘five whys’ technique to understand the root causes of this problem.

The Deputy Minister starts with the first question, “Why does the patient bear the direct costs of COVID-19 tests?” (the First ‘why’). The Health Finance Division DG quickly provides the answer – the National Health Insurance Fund (NHIF) is refusing to reimburse patients for such tests. The Director General asks a follow-up question, “Why has the NHIF taken this decision?” (the Second ‘why’). The Health Finance Division DG makes a quick telephone call to the President of the NHIF to find out more. The President points out that the NHIF is short of funds and is concerned that the COVID-19 crisis could exhaust its reserves, placing at risk enrollees’ access to all other essential health services.

The NHIF President goes on to explain why the Fund’s reserves are so low (the Third ‘why’), noting that the government decided two years ago to reduce its allocation to the NHIF, leaving the Fund largely dependent on individual contributions. The FDA Director General asks why this is such a big deal (the Fourth ‘why’). Patiently, the NHIF President explains that, while the government’s decision had seemed reasonable in the context of the relatively buoyant economy of 2018, in the current context (one of global economic recession created by the COVID-19 pandemic), this was causing serious problems. In particular, the growing shift from formal to informal employment (and to unemployment) in the country, meant that the number of people making contributions was rapidly diminishing.

This also implies, the technical team is careful to note, that there are many fewer people with coverage under the NHIF scheme – or indeed, coverage of any kind at all. Whatever strategy and portfolio of interventions the technical team ultimately arrives at, it is going to need to address this crucial dimension of the problem head-on.
STEP 4: **Prioritise which root causes to tackle through intervention**

The purpose of the preceding analysis is to generate information for decision making. Now, the guidance in this section focuses on how to transition from **diagnosis to design**. Moving through steps 1-3 is a process of engaging, learning, reflecting, questioning, and consensus-building. As you move from step to step, you explore and explain problems, and you learn a great deal about the related stakeholders through these processes. Two forms of information emerge that will prove critical for informing the focus and design of our strategies and interventions. These are:

- **Incentives**: Reform is a change process. Understanding who will gain, or lose, from interventions, how this might happen, and how it might be avoided, if feasible and desirable, are critical.

- **Capacities**: Resources are finite. This includes various forms of capacity – including **technical** (the knowledge and ability to execute actions to a desired standard), **financial** (the money to execute actions), **physical** (the structures, assets, and human resources to execute actions), **strategic** (the vision, governance and networks to perform appropriate roles in a system) and **personal and cultural** (the ethos, attitudes and the extent of leadership/buy-in to shape effective performance).

For example, the process of populating the operational tool outlined in Table 2.2 (above) will reveal which supporting functions and rules are absent, inadequate, or mismatched. Where the problem is a mismatch, this suggests a problem with **incentives**. The function is being provided by a market player with motivations that are mis-aligned with our goals in some way. The choices we will make in the Design stage will have to wrestle with this lack of alignment. In contrast, where the problem is one of inadequacy, this problem likely relates to **capacity**. Again, this will shape how and in what way we will intervene in the targeted market system – to address a lack of technical, financial, physical, strategic or cultural resources in some part of the market system.

**A note on capacity.** Is capacity missing? If so, can it be built – and how? These issues are explored in guidance by Harvard University economists Lant Pritchett and Matt Andrews in their work on Problem-Driven-Iterative-Adaptation (PDIA). PDIA is strongly aligned with the guidance offered in this chapter; including the Five Whys technique – its diagnostic ‘centrepiece’. It too is predicated on the first principles notion of ‘defining local solutions to address local problems’. PDIA offers useful guidance for those seeking to transition from **diagnosis to design**, through considering various incentive and capacity factors. We do not present this as a core part of the MM4H curriculum. But we include it here as we believe it may be useful for some course participants.

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7 More on their approach can be found here: [https://bsc.cid.harvard.edu/about](https://bsc.cid.harvard.edu/about)
PDIA uses a heuristic to assess the ‘space for change’ which is implicated by three factors that the authors ascribe as (and see Figure 2.5):

1. **Authority**: refers to the support needed for reform or policy change or to build the organisational capabilities required for these. The concept may refer to political, legal, organizational, or personal authority. Some changes require more authority than others, and it is always important to assess the extent of authority that one already has — and any authority lacunae that need to be closed.

2. **Acceptance**: relates to the extent to which those who will be affected by the reform or policy change accept the need for change and the implications of that change. Different types of change require different levels of acceptance (from narrow or broad groups and at different depths) and the key is to recognise what acceptance exists and what gaps need to be closed to foster reform.

3. **Ability**: focuses on the practical side of reform or policy change, and the need for time, money, skills and the like to initiate any kind of intervention. It is important to ask what abilities exist and what gaps need to be closed.

Through this process, we can establish a selection of potential market systems in which intervention appears to be merited. We can then establish a rank order of these in terms of priorities. As shown in the diagram below (Figure 2.5), the alignment / confluence of the combination of these three factors defines the ‘change space’ for reform with respect to each identified root cause (from the ‘five whys’ analysis). Specifically, in the figure shown:

- **A and B**: there is sufficient overlap of factors to give a degree of confidence that there is space for change.

- **C and D**: there is not sufficient overlap of all three factors which would indicate there is no sufficient space for change; at this point in time and in relation to this specific problem at least.

Stakeholder analysis of this form is particularly useful to in form the prioritisation, sequencing and momentum considerations referred to earlier in the guidance.
ILLUSTRATING STEP 4: TAKING STOCK OF THE RESULTS OF THE DIAGNOSTIC PROCESS

By this point, the MoH technical team has developed a clear diagnosis of (i) what is going wrong at the ‘core’ of the market system (i.e. lack of access to high-quality testing services) and (ii) how the current set of ‘supporting functions’ and ‘rules’ are shaping performance. The team has also analysed the root causes of some of the most fundamental and complex problems underpinning the constraints in the market (illustrated with reference to the NHIF above). Now, the team takes stock of its findings before determining how to move forward.

It has already begun to work in a more inclusive way, breaking down silos and engaging relevant stakeholders in the diagnostic analysis. The Private Health Care Federation, and their counterparts in the Private Hospital and Private Lab Associations, have been consulted to build a fuller understanding of market conditions in these sectors. In addition, the President of APAX, an umbrella association of civil society organisations, has been invited to discuss
what un/underserved population groups’ know about testing – when to seek testing, from whom, and at what price - and what happens afterwards for those found to be positive.

The knowledge gained from these conversations has confirmed the existence of a set of key challenges relating to both the demand and the supply sides of the market system. In the former case, consumers lack access to testing in the public sector due to constrained capacity (staff, space and supplies). They lack rapid access to testing in the private sector due to financial barriers – they are unable to pay the market price of $60-70. Patients also lack the information needed to assess which providers provide reliable tests. In the latter case, there is confusion over regulations - including, most importantly, who can legally perform COVID-19 tests! And private diagnostic facilities and labs, like many healthcare businesses, are struggling to meet payroll and other operating expenditures due to the socio-economic impacts of the pandemic. They lack access to working capital to smooth out variations in monthly cash-flows, which could quickly undermine their capacity.

The technical team admits that it cannot address all of these constraints immediately. For example, taxes and tariffs are leading to higher prices and scarcity of testing supplies. In addition, high (and variable) prices suggest a need for economic regulation. But these problems will require long, drawn out negotiations with different arms of government, and possibly other stakeholders, to resolve. The MoH team believes it has neither the technical skills nor the political authority to deliver change on these areas on an urgent timescale.

Overall, by the end of Step 4, the MoH technical team feels that it has done sufficient analysis to understand where its priorities lie, and to transition from the diagnosis of problems to the design of a targeted strategy. The goodwill it has generated through consultation, and the adoption of a systematic and transparent approach to the diagnostic process, will be helpful as it moves from analysis to action. Indeed, the team has a renewed sense of hope. It feels confident that, by continuing to work in partnership with others, it will build an effective response to this crisis.
Additional Considerations

This chapter has focused on the assessment of market system performance and the diagnosis of the symptoms and underlying causes of (under)performance. We have not yet begun to consider the strategy for addressing these causes (to be covered in Chapter 3), nor how we will implement this (Chapter 4). However, we would like to leave you with three key factors to consider in the diagnostic phase.

- **Baselines and targets.** At different levels of the diagnostic process a huge amount of important information – raw data on and insights about the market system – will have been collected. These will have helped to build an understanding of the factors that determine performance – especially as the analysis moved from ‘symptoms’ to ‘root causes’. These have also helped us to think beyond the technical challenges facing us – the ‘what’ – but also about the stakeholders – the ‘who’ – and the incentives and capacities we will have to bear in mind as we transition to the design and delivery stages – the ‘how’. This process of defining what is now (baselines), and what could be (targets), is central to the challenge of setting baselines, agreeing targets, and defining indicators.

- **Diagnostic work does not stop after diagnostic phase.** As a final point, good diagnostic work is going to be needed throughout the life cycle of the market systems intervention. It is a recurrent process. Policymakers will need to embrace new data as it emerges, test and modify assumptions, measure progress and actively look to specify unintended consequences (good or bad!) as the intervention proceeds through the Pathway to Impact.

**FIGURE 2.6: Summary of the Diagnostic Process**

- **STEP 1:** Assess the relevance of the market system to UHC, and the opportunity for and feasibility of improvement.
- **STEP 2:** Identify the supporting functions and rules needed for the market system to perform well. Understand how well these are performing in practice.
- **STEP 3:** Identify and evaluate the underlying reasons for these supporting functions and rules not being performed well.
- **STEP 4:** Prioritise among the market system problems to be addressed.
Including outside voices and perspectives is important. Experience in managing health markets demonstrates how limited information on the private health sector’s interests, incentives and perspectives can hamper government’s capacity to understand why health market systems are underperforming, and how they can change. Data is often insufficient for a number of reasons, including:

- Ministries of Health do not always collect basic data on the size and scope of non-state care providers,
- there is no standard or consensus on what data on the private health sector should be collected, and
- there is no framework and/or mechanism to communicate regularly with and exchange information between the public and private sectors.

Given the absence of data, it is critical not only to invest in additional data collection (see Appendix 1) but to also consult with and engage relevant actors – especially private health sector providers – to integrate their perspectives in the development of realistic strategies to address the limitations of markets and the root causes of these.
Introduction

The diagnostic process has identified how and why the market system to be targeted is not working from the point of view of ensuring access, quality and financial protection to the relevant population(s). Our task now is to design a strategy that addresses the causes of the market system constraints we have identified.

The design stage embodies three of the ‘governance behaviours’ noted in Chapter 1 (see Figure 3.1)\(^1\):

- **deliver strategy** by facilitating agreement among key market players on the ‘vision of change’ for the relevant market system and articulating all market players’ roles and responsibilities to implement interventions;
- designing interventions that **align all relevant market players and reorganize structures/systems** to achieve this ‘vision of change’; and
- **enable all market players** – by building their capacity and/or adapting the incentive and accountability environments in which they operate – to perform their respective roles in the future.

\(^1\) 2020. *Engaging the private health service delivery sector through governance in mixed health systems*. The Advisory Group on the Governance of the Private Sector for UHC. The Health Systems Governance and Financing Department, World Health Organization.
The design process is advanced in four steps namely:

1. Summarising findings in relation to the ‘current picture’,
2. Developing a realistic picture of how the system will work after intervention,
3. Analysing the feasibility of our visions of the future, and
4. Deciding on the specific portfolio of interventions needed to bring about the vision

These steps provide the main structural components of this chapter.

The Design Process

STEP 1: Summarize findings on the ‘Current Picture’

In this step, we will review our understanding of how the targeted market system is functioning at present. During the diagnostic process, we will have generated key insights into:

- the supporting functions and rules that are needed to promote UHC objectives in the system,
- the extent to which these attributes are actually present in the system, and, for those that are present...
- the extent to which these are performed at the ‘right’ level and by the ‘right’ market player.

During the design process, we draw on our diagnostic findings to answer additional questions about the core of the market

During the design process, we will draw on these findings again. Now, we will use them to answer additional questions about the core of the market, and the supporting functions and rules that are either shaping the market system today, or are needed to shape the market in future, in accordance with our UHC objectives. The analysis begins by asking two key questions about the functions and rules in the market system:

- Which market player, if any, performs the function or rule? (who does?)
- Which market player, if any, pays for the function or rule to be performed? (who pays?)
Having addressed these questions, our analysis can be presented in a simple operational tool, as outlined in Table 3.1 below. This summarise the analysis of who does? and who pays? and ensure that our vision of the future is fully informed by the main findings of the diagnosis process.

**TABLE 3.1: THE CURRENT PICTURE: Analysis of the state of institutional arrangements in the market system**

<table>
<thead>
<tr>
<th>Who currently does?</th>
<th>Who currently pays?</th>
<th>Absent, adequate, mismatch?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Market</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting Functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ILLUSTRATING STEP 1: SUMMARISING FINDINGS ON THE ‘CURRENT PICTURE’**

Back in *Country X*, the MoH technical team is ready to craft a vision of the future. The crux of the problem is that, while there are many high-capacity diagnostic facilities and laboratories in the private sector, these are inaccessible to the majority of the population - ‘the underserved’. The analysis of ‘supporting functions’ and ‘rules’ has highlighted what is absent, inadequate and mismatched in the market system. On the demand side, constraints on pre-paid and pooled funds are of central importance, as is the general lack of information – confusion about *when to seek a test, from whom, and what the terms will be*. On the supply-side, there are key regulatory gaps - including, crucially, a lack of guidance on *appropriate testing standards and protocols* - and the private sector lacks access to working capital impeding its ability to access crucial supplies. While this is not a complete account of all that is going wrong in the market system (and other things have been picked up in the diagnostic process), the team concludes that these are the most important factors determining the diagnostics and laboratory services market system’s performance.

The team summarises its findings as follows:
### Core Market

| Diagnostics and laboratory services | Private diagnostic centres/laboratories | Consumers (out-of-pocket payments) | **Inadequate**: Private providers have no incentive to serve the majority as they are unable to pay. |

### Supporting Functions

<table>
<thead>
<tr>
<th>Demand-side financing</th>
<th>NHIF</th>
<th>Enrolees (subsidiary role for government)</th>
<th><strong>Inadequate</strong>: The NHIF benefits package does not include testing services for COVID-19.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information (supply)</td>
<td>Ministry of Health</td>
<td>Ministry of Health</td>
<td><strong>Inadequate</strong>: Private providers lack awareness of appropriate testing standards and protocols.</td>
</tr>
<tr>
<td>Information (demand)</td>
<td>Ministry of Health</td>
<td>Ministry of Health</td>
<td><strong>Mismatch</strong>: Patients unsure about when to seek a test, where to get one, and at what price.</td>
</tr>
<tr>
<td>Accreditation</td>
<td>-</td>
<td>-</td>
<td><strong>Absent</strong>: No process to assure providers’ quality with respect to standards/protocols.</td>
</tr>
<tr>
<td>Capital financing</td>
<td>-</td>
<td>-</td>
<td><strong>Inadequate</strong>: Lack of access to working capital is impeding access to equipment/supplies.</td>
</tr>
</tbody>
</table>

### Rules

| Regulations | Ministry of Health | Ministry of Health | **Inadequate**: Private providers need clarity that they are legally authorized to ‘do’ testing. |

In addition, in Step 3 of the diagnostic process, the team undertook a ‘root cause analysis’ to examine why patients bear the direct costs of COVID-19 tests (such that most choose to forego tests altogether). The analysis found that the NHIF is refusing to reimburse patients for testing – and this is due to the fact that the government’s own allocation to the NHIF has reduced over time, leaving the Fund reliant on contributions from a shrinking pool of individual enrollees. The Deputy Minister reminds her team that, as its analysis moves from ‘taking stock of the current picture’ to ‘developing a new picture of the future’, this underlying set of demand-side financing challenges will need to be borne in mind.
STEP 2: Develop a realistic picture of how the system will work after intervention

Our focus in this step is on identifying how the necessary supporting functions and rules will be put in place (where absent) or improved (where inadequate). This means considering which market players can best perform these functions and rules.

There are three important factors for us to consider when deciding which functions and rules will be put in place and who will perform them:

1. The nature of the market system.
2. The history (past actions) and momentum (present and planned actions) of players within the system.
3. Innovation from elsewhere. Changes that have occurred outside the system, but which might inform analysis of the feasibility of change within it.

Nature of the market system

In the previous chapter, we noted that different market systems vary in their complexity. We argued that this is an important factor in considering the feasibility of an intervention in the context of governments’ organisational capabilities. The concept of complexity is linked to two characteristics of markets: transaction costs and externalities.

Complexity is linked to two characteristics of markets: transaction costs and externalities

Transaction costs are the costs of participating in market systems. Note that the term ‘costs’ does not necessarily mean financial costs. It relates to any scarce resource – for example, effort, attention, time – that raises barriers for suppliers (actual or potential) to address demand in the market. Common transaction costs include:

- **Search and information costs**: in some market systems, it is difficult for buyers and sellers to find out about each other and enter the most mutually-beneficial trades. For example, on the ‘buyer’ side of the market, it is often difficult to know what to buy or from whom. Buyers may end up accessing the wrong things (i.e. those that will not best satisfy their needs) from the wrong seller (e.g. those that will not provide what is needed at the best price). In this type of system, information functions and/or intermediation functions such as accreditation, which signals the competence of sellers, can help to reduce transaction costs and enable more mutually beneficial trades to take place.

- **Bargaining costs**: in some market systems, there are barriers to buyers and sellers reaching an acceptable deal (e.g. because of unequal power relations).
Functions that rebalance power and reduce the scope for bargaining – e.g. through aggregation, collective representation, coordination, standards or regulation of price, quantity or quality of goods and services – are therefore important.

- **Enforcement costs**: some market systems are prone to a lack of trust between buyers and sellers (e.g. because of unfamiliarity or unequal information between buyers and sellers). In some cases, for instance, demand for health products and services may be ‘induced’ by sellers, potentially exposing buyers to both adverse health outcomes and financial risk. In such systems, functions that support good relationships to develop, or functions that establish assurance, guarantees, or rights of redress are critical for the market to function well.

**Externalities** in market systems occur when the actions of one player can affect many. For example, it may be ‘rational’ for a private physician not to notify public health authorities of a new case of tuberculosis (perhaps this will reduce costs in terms of effort, attention and time, and may also please the patient, who prefers to keep information on his or her health status confidential). However, this failure to notify will have negative impacts on disease surveillance and thus population health. To restrict negative outcomes or to ensure favourable outcomes for the many rather than the few, regulation, coordination and compensatory functions may be necessary. Externalities thus increase the need for the government to take action – to intervene in the market system.

**History, momentum and the scope for innovation from elsewhere**

In addition, there are other characteristics of a market system that should be considered when conceptualizing the vision of a well-performing market system. These include **history, momentum** and **innovation from elsewhere**. Let’s look at these one by one.

**History**. The past can provide insight into the capacity and incentives of market players, and therefore the potential for change in their behaviours and performance levels. We need to consider if there is anything in the system’s history that leads us to believe that a revised set of functions and a re-alignment of market players is or is not feasible:

- **We need to consider if anything in a system’s history might make revision or re-alignment unfeasible**
  - Do certain players adhere strongly to long-established roles or norms? This might signal a resistance to change or affect how other players in the system view the player in question.
Do certain players hold positions of entrenched power or influence? If so, might they act as potential ‘blockers’ or ‘facilitators’ (in either case, these are players we definitely need to have ‘on board’)?

**Momentum.** Understanding trends and developments in a market system can also help us to analyse its potential for change. We might ask, for example, if there are any clear trends or events within the system that indicate that change is or is not feasible. For instance, on the demand side, are consumers becoming more or less sophisticated in their choices of what to buy and from whom; and are they becoming more or less demanding, shopping around more or less for needed health products and services? On the supply side, are there new entrants in the market, signs of new innovations and product lines, and pro-quality investments – or not?

**Innovations from elsewhere.** Innovations in comparable contexts can inform our understanding of what is possible in the market system being targeted. Contexts can be considered comparable when they concern a similar market system (e.g. a market system for a product or service of similar complexity), type of function (e.g. accreditation or contracting) and socio-economic situation (e.g. a country with a similar socio-economic and health system structure to our own). We might ask, for example, if there is any evidence of positive innovations in comparable contexts which might provide a source of inspiration for our own plans in the targeted system.

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**Innovations in comparable contexts can inform our understanding of what is possible**

Having considered the nature of the market system, its history and momentum, and analysed the potential relevance of experiences in comparable contexts, we should have a clearer sense of **who can do what we need to have done** and what kinds of financing arrangements they need to have in place to perform those tasks. The results of this analysis can be summarised in a simple operational tool, as shown in Table 3.2 below.
### TABLE 3.2: The Future Picture: what do we need; who will do it; who will pay for it?

<table>
<thead>
<tr>
<th>Core Market</th>
<th>Who will do?</th>
<th>Who will pay?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ILLUSTRATING STEP 2: DEVELOPING A REALISTIC VISION OF THE FUTURE

Back in **Country X**, the MoH technical team is working on two visions of the future based on the summary of findings so far, implemented in Step 1.

1. **The government increases its allocation to the NHIF pool.** Increased public funds will enable the NHIF to expand coverage for COVID-19 testing and give enrollees access to free testing services in the private sector. The team acknowledges that the Ministry of Finance may be reluctant to approve this option. Yet, high-level government officials – particularly in the Prime Minister’s office – may be persuaded by a new World Bank modelling study showing the likely economic consequences of failing to control the outbreak. In addition, these high-level officials may be comforted by auditors’ forecast of tax receipts from a new ‘sin tax’, approved earlier in the year and earmarked for the NHIF. Expanding coverage under NHIF would achieve both **pragmatic goals** (addressing the need for rapid action by working through an existing mechanism) and **strategic goals** (enhancing public confidence in the NHIF by demonstrating its benefits at a critical time for the country).

2. **The government works with a development partner to co-fund a voucher programme.** A voucher programme would focus on providing free access to testing in the private sector for **targeted groups** (such as the poor, those without formal employment and the elderly, which are vulnerable to severe disease.) The Ministry of Finance is more likely to approve this scenario because it will require lower government spending (due to the more targeted approach, and the use of ‘off-budget’ donor funds). Setting up a credible voucher programme takes time; but the MoH would not have to start from scratch. It can ‘piggyback’ on its long-established voucher programme for critical maternal health services. Additional factors to consider under this scenario include the
risks of (a) negatively impacting the NHIF’s public reputation and (b) undermining the long-term sustainability of the intervention (donor support will be short-term). Both consequences would be a blow to Country’s X long term goal to achieve UHC, since the government is banking on NHIF as the centrepiece of this process. All agree that these costs will needs to be mitigated if the team selects this scenario.

Under scenarios (1) and (2), the new, stable, public funding stream will enhance private providers’ ability to access to capital financing for working capital. However, for either option to work – especially in relation to service quality – other key ‘supporting functions’ and ‘rules’ will need to be put in place, or strengthened. For example, the National Institute for Public Health (NIPH) has long been responsible for ensuring the quality of both public and private sector diagnostic services. But in practice, its inspections have focused on the public sector, and it has limited presence in or understanding of the private sector. The NIPH will need additional funds, from the MoH, to enhance its reach and impact – to (a) ensure that private providers have systems in place for specimen collection, laboratory analysis and case reporting according to regulations, and (b) accredit those that meet the required standards. Accreditation plays an important role in both visions of the future, as this will determine providers’ eligibility for reimbursement under these scenarios.

In addition, consumers will need better information (and fast) on when to seek a test, where to obtain one and how they will be reimbursed for the costs. Civil Society Organizations (CSOs) are well-placed to reach the target population groups. However, the team believes that eligible private providers are best-placed to pay the costs of commercially marketing their services towards NHIF enrollees/ voucher-holders in the targeted groups. So, they will work with CSOs to deliver the necessary information to the relevant communities. After all, these providers have strong motivations to increase their market share – especially given their ongoing cash-flow problems in the context of the economic disruption caused by the outbreak.

The team summarises its thoughts so far as to what the future market system for expanded COVID-19 testing could look like under the two scenarios:
## Scenario 1 vs Scenario 2: Who does? Who pays?

<table>
<thead>
<tr>
<th>Core Market</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostics and laboratory services</td>
<td>Private providers</td>
<td>Government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supporting Functions</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance</td>
<td>NHIF</td>
<td>Government (pays to offset losses due to COVID-19)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Vouchers</td>
<td>-</td>
<td>Government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Government and development partner</td>
</tr>
<tr>
<td>Information (supply-side)</td>
<td>National Institute for Public Health (NIPH)</td>
<td>Ministry of Health (MoH)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NIPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MoH</td>
</tr>
<tr>
<td>Information (demand-side)</td>
<td>CSOs/Media</td>
<td>Private providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSOs/Media</td>
</tr>
<tr>
<td>Accreditation</td>
<td>NIPH</td>
<td>MoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NIPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MoH</td>
</tr>
<tr>
<td>Capital financing</td>
<td>Banks</td>
<td>Private providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Banks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rules</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulations</td>
<td>NIPH</td>
<td>MoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NIPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MoH</td>
</tr>
</tbody>
</table>
STEP 3: Analyse the feasibility of our visions of the future

Once we have developed a clear vision of what the future market system needs to look like to achieve UHC goals, we need to address two key questions:

1. what actions do the identified market players need to take for the vision to be realised?
2. how feasible is it that these actions can be adequately performed by these players?

We begin by considering what the government and its partners can do to directly influence the structure and behaviour of the market system.

The tools of government

In the public policy literature, mechanisms used by governments to influence the behaviour of individuals and organisations in a market system are called tools of government. A range of such tools are commonly used in health market systems. These fall into three broad categories.

Mechanisms used by governments to influence behaviour of individuals and organisations in a market system are called ‘tools of government’

First, there are financing tools. These include demand-side instruments such as insurance provision and voucher payments, and supply-side instruments such as contracts, grants and loans. They are used to increase or re-shape the demand for and/or the supply of health products and services.

Second, there are regulatory tools. These are used to encourage or constrain behaviours. They may be focused on who gets to provide services (licensing, certification of qualifications, accreditation), or the terms on which transaction take place (directly through price regulation, or indirectly through capping of profits or anti-trust rules).

Finally, there are information tools. These may be used, on the supply side, to shape what is made available in the market and how, or, on the demand side, to shape what is demanded in the market, from whom and/or on what terms.

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Tools of government are the main mechanisms through which policymakers can alter the institutional arrangements in market systems. They can be deployed to provide supporting functions and rules directly. However, the government and its partners cannot and should not do everything. Technical and financial resources are finite – therefore, there are some things they cannot do. There are other things that governments can do, but inadequately. Where direct provision is not feasible, or not desirable, we need to encourage or enable other players to do these things.

The government and its partners cannot and should not do everything

Fortunately, having completed steps 1 and 2 of the design phases, we will have developed a good understanding of the organisational capacities of the relevant state agency (e.g. an MoH) to deliver the desired functions and rules, and that of other market players. Therefore, we are going to use the ‘will-skill’ framework (Figure 3.3) to help us identify the willingness and ability of market players to play the roles assigned to them; and what kinds of support to provide where there is a deficiency.

- **High will, low skill scenario:** In this case, the market player has strong incentives to play the role but lacks the capacity to do this effectively. Support will need to be focused on strengthening the capacity of the player to operate outside their ‘comfort zone’ – through advice, training or mentoring.
Low will, high skill scenario: In this case, the market player has strong capacity to play the role but lacks the incentives to do so. Support will need to focus on ensuring alignment in incentives with our goals – e.g. through changes to financing arrangements, and/or the enforcement of regulations.

Low will, low skill scenario: In this case, the market player lacks both the incentives and the capacity to play the role. Such a player may not be worth the investment but in a ‘thin’ market such a partner may be the only option. We will need to recognise the risk associated with providing intensive support necessary to address both lack of incentives and capacity.

High will, high skill scenario: If, as in this case, the market player possesses both the required incentives and the capacity to play the role, then their current inaction might be caused by dysfunction elsewhere. For example, market entry might be hindered by too strict a regulatory environment, or a lack of accreditation which means that competent providers are crowded out by others.

Understanding incentives. A key element of the “skill/will” analysis is understanding each market player’s incentives. Incentives are shaped by attitudes towards risk and reward. There are three types of incentives that directly influence a market actor’s performance:

- Material – based on a desire to get something or not lose it, (i.e. losing or gaining money, market share, property or operational autonomy)
- Social – based on the need to belong to, or not be rejected by, a wider collective (i.e. peer acceptance, status, reputation); and
- **Purpose** - based on a personal desire to achieve a goal (i.e. win elective office, be promoted, support a political cause).

Our ability to shape a health market system depends on how well our market interventions take account of incentives.

Our ability to shape a health market system depends on how well our market interventions take account of incentives

As a final task, we bring all our understanding of the ‘five factors’ that can ‘make’ or ‘break’ our vision of a well-performing health market system (see Table 3.3). After completing this analysis, we can begin to design the specific actions to be taken by government to help each market player overcome its challenges – which will ultimately lead to changes in their behaviour and attitudes, enabling them to fulfil their respective roles in the future vision.

**TABLE 3.3: ‘Five Factors’**

| Nature of market |  |
| History & momentum |  |
| Innovation from elsewhere |  |
| Incentives |  |
| Capacity |  |

**ILLUSTRATING STEP 3: ANALYSING THE FEASIBILITY OF OUR TWO ‘VISIONS OF THE FUTURE’**

Back in *Country X*, the MoH technical team has some new information to consider. The Health Finance DG informs other team members that, while there will be an increase in funding for the NHIF, this will not be sufficient to finance free testing in the private sector. Given the new demands on the Fund due to the pandemic, such an expansion of the benefits package will not be possible at this time. Hence, scenario (1) is not feasible. The MoH team reluctantly decides to focus its attention on scenario (2). It carefully evaluates the ‘pros’ and ‘cons’ of this scenario by analysing it against five factors: (i) the nature of the market, (ii) its history and momentum, (iii) the insights provided by innovations in comparable contexts, (iv) the incentives and (v) the capacities of the players implicated in the vision of the future. The team summarises its evaluation of the five factors as follows:
THE DESIRABILITY AND FEASIBILITY OF SCENARIO 2: Consideration of the ‘Five Factors’

| Nature of market | Patients have limited understanding of when they should seek a test or from whom, suggesting that information and intermediation will be key. The Scenario 2 ‘vision of the future’ identified the absence or inadequacy of information and accreditation as two constraints. Few patients can afford the $60-70 market price for the recommended course of three tests. The voucher payment will address this financial barrier directly for targeted groups. |
| History & momentum | Private laboratories and diagnostic centres with the capacity to deliver COVID-19 tests have a track record of abiding by relevant regulations as enforced by NIHP licensing and inspection. These labs traditionally serve the relatively wealthy in society and are used to providing services to discerning (and often demanding) consumers. These facts provide some comfort that ‘fast-track’ accreditation may be sufficient to avoid negative consequences – in terms of testing, analysis and reporting – and sustain quality in many facilities. |
| Innovation from elsewhere | The MoH has positive experience with voucher programmes (see below). The team also knows that vouchers can be effective demand-side solutions when accompanied with tools of government that strengthen the information and regulatory environment. Based on experiences with vouchers, as well as anecdotal evidence from other countries that have utilised private lab capacity for COVID-19 testing, the MoH technical team believes there is a good chance of realising its future vision. Also, the team acknowledges that when the $1 test currently in prototype becomes widely available, the MoH can then terminate the voucher programme\(^3\). |
| Incentives | Given the pandemic’s impact on the cash flows of most private healthcare businesses, and their limited access to working capital, private laboratories/diagnostic centres with strong capacity to perform COVID-19 testing are likely to be highly motivated to serve new patients and thereby capture voucher values. There is also a willingness to ‘contract’ CSOs to provide consumers with accurate information on when and where to seek a test. |
| Capacity | The MoH can quickly put in place a voucher programme based on its existing maternal health voucher scheme. However, it is questionable as to whether the government can afford to finance this programme on its own. A bilateral donor has indicated it is not willing to pay for vouchers for the whole population - but it is willing to fund vouchers for certain vulnerable population groups. In addition, on the supply-side, private providers generally have good equipment and staff and – with the stable income stream provided by the voucher receipts, and new sources of capital financing – should have increased access to consumables and other inputs, as necessary. |

The technical team reviews its analysis a final time and agrees that scenario (2) is imperfect but worth pursuing. There is a strong chance that the strategy, if effectively delivered (see next chapter), will:

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\(^3\) NOTE: we assume here that the MoH is aware that the WHO is engaging with stakeholders on the development of a new ‘game changing’ $1 self-administered test.
increase access to high-quality, affordable tests among the targeted groups by removing financial barriers,

increase target population group’s awareness of the availability and location of qualified private testing sites,

ensure testing services are provided to voucher holders on equitable terms,

ensure only quality COVID-19 tests are available,

assure only licensed private facilities conduct and analyze COVID-19 tests for voucher holders,

increase eligible private providers’ knowledge of quality guidelines for COVID-19 testing, and

improve private laboratories/diagnostic center’s case reporting to public health agencies.

STEP 4: Elaborate a more detailed strategic framework for the market system

We have now developed a realistic vision of the way the market system will work in future and outlined the focus of the interventions to be pursued. We can now elaborate the strategic framework for this system (see Figure 3.4). At this stage, we need to add in more detail to the logic linking our programme’s main set of interventions to system-level change(s) and our programme’s UHC goals. The key questions to ask are:

- Are the links between each level of the strategic framework realistic? As Chapter 1 explained, the strategic framework must lay out realistic causal links, making plausible connections between the main interventions and the chain of results expected at output, outcome and impact levels (to use log-frame terminology).

- Are changes at the system-level elaborated precisely? What we depict in the strategic framework must describe a changed behaviour and/or practice within the market system. The aim is to provide an unambiguous, concise description of the anticipated change and therefore a basis for measuring and communicating that change to programme stakeholders.

Our strategic framework for the market system does not require exhaustive detail about each activity and output. But it should be sufficiently detailed to be informative and to enable appropriate indicators of expected results to be assigned for measurement purposes (see the Detect chapter).
ILLUSTRATING STEP 4: PLUGGING THE STRATEGY INTO THE STRATEGIC LOGIC MODEL

Before moving to the delivery stage, the technical team considers whether the strategy will deliver on its ultimate goals – i.e. to control the spread of COVID-19 and minimise the direct and indirect effects of this on population health. The team sets out the main intervention foci, the key mechanisms through which these will lead to market system change, and expected outcomes in terms of UHC objectives (access, quality and financial protection).

FIGURE 3.4: Strategic logic model

Mitigate spread of COVID-19 and minimize impact on essential health services

Increased access to and use of affordable, quality testing among target groups

Changes in the market system for diagnostics and laboratory services

- Supply of high-quality C-19 lab tests increased
- Number of accredited private labs increased
- Private labs understanding and awareness of new regulatory rules and guidelines increased
- National Institute for Public Health (NIPH) accreditation rules simplified and operational
- Economic barrier removed from target population to access COVID-19 lab tests
- Increased understanding and willingness of target population groups to use private C-19 lab testing services
- CSOs provider target populations critical information on C-19 tests and effectively market private lab C-19 testing services
- Vouchers issued to target population groups

Intervention

Create incentives for high-capacity private providers to deliver quality COVID-19 tests and strengthen demand among target population groups to seek COVID-19 tests
The team checks to see if the connections between these concepts appear plausible and illustrates them in a strategic logic model framework (see Figure 3.4 above).

Having completed this exercise, the Deputy Minister thanks her team – and advises everyone to take a break and head home for a much-needed rest. She, meanwhile, will go to see the Minister of Health to present the team’s key findings, and secure political support for acting on these via the favoured strategy and set of interventions.

Each market system that your programme works in will require an elaborated strategic logic model. You might find it useful to engage relevant market players to integrate their perspective on proposed market system changes and their feasibility. Each intervention within each market system will also require its own results chain. It may also be useful to develop these intervention-level results chains in consultation with some (or perhaps all) of the other relevant market players – but note that these will often need to be revised afterwards, when your intervention activities, and their results, become clearer.
Introduction

By this point in the Pathway to Impact, we have:

- **diagnosed** how and why the targeted market system is failing to achieve UHC objectives (of access, quality and financial protection), and

- **designed** a strategy for delivering change in the market system that responds to those constraints and weaknesses.

Now, in the Deliver chapter, we will turn our attention to implementing the strategy. In essence, we have decided **what to do**. Now, we need to understand **how to do it**.

We have decided what to do. In ‘deliver’, we turn our attention to understanding how to do it

Each intervention proposed as part of the strategy will have an impact on the market system – and the strategy overall is likely to have a material impact. This implies risk – the potential for change to lead to both intended and unintended outcomes. We need to recognise this risk and take steps to mitigate it. One important way of doing so is to ensure that an **inclusive policy process** is adopted – one that (i) generates accurate information about the capacities, incentives, attitudes, motivations, and...
relationships of all market system players implicated in the strategy, and (ii) leverages this information to align market system players around the intended vision of the future.

Building an appropriate interpersonal environment (i.e. the software of the process of market systems action) is just as important as getting the technical content right (i.e. the hardware of the process). Although we deal with the software of market systems analysis and action in this chapter, it is apparent that the inclusive policy process should – indeed must – have been initiated at the start of the Pathway to Impact.

In the Diagnose phase, we will have laid the foundations for the inclusive policy process by understanding the range of public and private actors in the targeted market system – and consulting them to generate needed data and findings in relation to core market system constraints and weaknesses. During the Design phase, we will have mobilised many of these critical stakeholders to gain their perspectives in order to develop information on key variables – capacity, incentives, etc – that are fundamental to the specification of the market system strategy.

Now, during the Deliver phase, we will build on this emerging and the inclusive policy process by formalizing a structure and process by which a policy maker can orchestrate all the partners to implement the market strategy. In this chapter, the reader is introduced to:

- A new governance ‘style’ for inclusive implementation processes,
- The skills needed for this new way of governing the public–private mix in the market system; and
- Steps and tasks to manage an inclusive implementation process.

**New Roles and Responsibilities**

**Governance of mixed health systems – a new way of doing business**

The Pathway to Impact emphasizes the important role that policymakers perform as stewards of the public–private mix (PPM) in the market system. Stewardship is often likened to ‘rowing’ instead of ‘steering’. But this characterization is not sufficiently detailed. What does a policymaker do on a day-to-day basis when frontline activities, like service delivery or supply chain management, are partly if not wholly carried out by private sector actors?

According to the World Health Organisation, effective stewardship of a mixed health system entails six key governance behaviours presented in the Introduction chapter and a common theme through each chapter. (see Figure 4.2). These governance behaviours also apply to managing health market systems that are a microcosm of the larger mixed health sector. Governance behaviours include: i) setting strategic direction for all actors in the health system, ii) collecting and using intelligence to create
a common understanding of challenges to be addressed and facilitating information flow to enable sound policy/programme decisions, iii) applying tools of governance that enable both public and private health actors to perform their respective roles and responsibilities, iv) building and sustaining cooperative relationships for coordinated and efficient implementation, v) creating institutional framework(s) that align public and private health actors, and vi) creating a culture of accountability to foster trust and performance.¹

The old governance style – exclusive – compared to the new governance style – inclusive

Across different countries, we observe different ‘governance styles. On one side, one can observe what is classified as an ‘exclusive’ regime in which the health ministry is the central policy actor (see Figure 4.1). The health policy processes and functions focus exclusively on health ministry delivery activities. Management of a health ministry is hierarchical and mostly focuses on administrative processes to control the network of public health facilities. Common policy functions are carried out with little to no engagement of external actors in the private or civil society sectors.

On the other side, an ‘inclusive’ governance style acknowledges that the health system is comprised of multiple public and private stakeholders that need to work together to achieve a common purpose. The Ministry of Health has a holistic view of the sector and plays a central but facilitative role. An inclusive approach is based on fostering relationships between the relevant market actors – one of the six governance behaviours – to work effectively together to achieve the ‘vision of change’ in the selected health market system (see Figure 4.2). Common governance functions include various forms of consultation, information sharing and negotiation across sectors.

In many LMICs, however, we observe a governance style that falls between these two extremes – the ‘selective’ governance style. Selective governance is like exclusive governance in one sense – both focus policy processes and functions on mainly on health ministry activities. However, in this governance style, a limited number of private market players tend to be included in the governance process – where they can assist in filling health system gaps and/or address specific, short-term priorities. Table 4.1 provides an overview of the different governance styles.

**TABLE 4.1: Characteristics of exclusive and inclusive governance styles**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Exclusive Style</th>
<th>Inclusive Style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>Hierarchy</td>
<td>Network</td>
</tr>
<tr>
<td>Relationships</td>
<td>Public vs private</td>
<td>Public plus private</td>
</tr>
<tr>
<td>Decision-making style</td>
<td>Command and control</td>
<td>Negotiation and persuasion</td>
</tr>
<tr>
<td>Skill set</td>
<td>Administration skills</td>
<td>Enablement/facilitation skills</td>
</tr>
</tbody>
</table>

Source: Salaman, L. 2002

There are many benefits to an inclusive governance style. First, the challenges confronting a health sector are complex, requiring diverse perspectives and expertise to solve them. Governance functions – such as policy design and implementation – can benefit from involving different perspectives and expertise critical. In contrast, excluding key stakeholders can be counterproductive. Second, an inclusive governance style allows for greater flexibility and responsiveness in policy design and implementation, especially in matters related to policy challenges that extend beyond the public sector delivery system.
In many cases, non-profit and for-profit providers are already engaged in providing the desired services to at least part of the population. In these market segments, they have established relationships with the communities they serve, and are closer to beneficiaries so they can respond more quickly and adapt as needed when government decides to expand access to, or otherwise shape the behaviours of, this sector through use of the Tools of Government. In this context, an inclusive governance style can potentially strengthen government capacity to solve problems, improve access to health services, improve customer satisfaction, and enhance capacity to innovate.

An inclusive governance style is not without its challenges. First, it involves sharing power, compromising on objectives, and ‘letting go’. Second, it is difficult to work across government agencies and non-state groups because these stakeholders can have different incentives and motivations from those held by a health ministry. Reconciling a health ministry’s bottom line - **political accountability to ensure the public interest** - with diverse and sometimes incompatible partner interests often creates conflict which is messy to manage. Third, an inclusive governance style also exposes a the Ministry of Health to greater political risk because the ministry is no longer in complete control of its implementing partners. Finally, policymakers are reluctant to embrace this governance approach because it is very different than their training and experience.

### New roles needed for the inclusive governance style

Delivering on a more inclusive governance style requires Ministry of Health officials and technical managers to take on a more ‘market facilitative’ approach. In this new governance style, **relationships matter** - within the Ministry of Health, among multiple government agencies and across the diverse non-government actors in health. In some instances, the relationship can be as simple as a contract manager and contracted providers. In others, it can be as complex as shared stewardship functions such as the co-regulation of private health providers through an independent professional health associations and/or co-assurance of clinical quality through a third-party actor.

Building and maintaining these complex relationships requires a policymaker to assume new competencies such as becoming politically astute, an effective communicator, a skilled negotiator, an honest broker, and capable manager of conflict. With these new competencies, Box 4.1 illustrates the type of facilitation tasks a policymaker facilitating an inclusive governance regime has to perform on a day-to-day basis. To perform these tasks well, a policymaker has to be:

**BOX 4.1: Facilitation tasks**

- Educate
- Inform
- Study
- Convene
- Connect
- Network
- Mediate
- Mentor
- Persuade
- Train
- Finance
Politically astute. An effective policymaker develops a ‘sixth sense’ – political acumen – based on political knowledge and experience combined with “practical wisdom”. Political acumen allows a health ministry official to develop judgement based on instincts with regards to the desirability and feasibility of different policy options or interventions. This political sensibility is honed by continually scanning the policy and political landscape to understand the five factors (see Design) that can make or break a strategy and/or market intervention: (i) understanding key public and private actors’ interests, motivations and ideologies (Incentive), (ii) assessing feasibility and ability to implement market interventions (Capacity), (iii) evolution of health market systems and trends to predict feasibility of change (History and Momentum), (iv) the specific characteristics of a health market system (Nature of Markets), and (v) impact of introduction of new technologies and innovations (Innovation). Political acumen can help a policymaker weigh the trade-offs and benefits of different market interventions.

Active listener / Effective communicator. A successful policymaker needs to become an excellent communicator with non-government partners from radically different organisational cultures to enable meaningful exchanges. Communication skills should focus on (i) raising awareness among private sector and civil society partners to foster support; (ii) facilitating two-way interactions between partners to send signals and model desired behavior and norms; and (iii) being an active listener who can provide constructive feedback and fine-tune understanding and interpretation of other perspectives. Skillful communication can increase support for the market system strategy’s goal, build trust among public and private partners, and foster cooperation.

Honest broker. The inclusive governance style requires a policymaker to take off his/her ‘institutional hat’ and become an honest broker representing the wider public interest. An honest broker strikes a balance between being tolerant and being tough with all partners and can ‘read’ the mood of the group, learning when to give the partners space to work through a disagreement or when to give them direction. Lastly, a policymaker needs to encourage on-going quality conversations between public and private partners. Creative conversation is a powerful tool to build transparency and trust and can influence the effectiveness of the public-private collaboration.
Skilled and persuasive negotiator. In working with non-government (private health sector and civil society) groups, a policymaker can no longer ‘dictate’ what to do and how to do it. As a result, a policymaker needs to learn how to find common ground among different actors with different norms, organisational mandates and cultures as well as competing interests, and to negotiate, persuade and find the right inducements to persuade and ‘nudge’ all partners to work together towards a common goal.

Capable manager of conflict. A certain amount of friction is inevitable when you bring together different organisations with distinct backgrounds to work collaboratively on a common task. It is therefore essential for a policymaker to learn how to manage conflict appropriately and constructively. A policymaker must be constantly ‘tuned in’ to his / her partner’s view and be prepared to intervene through discussion and negotiation to resolve emerging conflicts before they become obstructive. It can be difficult to be ‘objective’ and fair-minded all the time but a policymaker needs to learn how to act as a ‘good faith’ broker and not take sides with one partner over another.

Invest in staff

One of the key factors to consider when designing a market system strategy is the extent of government capacity to implement the tools of government. In fact, governments and development partners invest considerable resources to building health ministry technical skills to deliver quality health services and manage complex health systems. Yet a policymaker’s job becomes more complicated and challenging under an inclusive governance style. Few LMIC governments recognise and value these new roles, much less invest in building ministry staff skills needed to perform them.

Managing an Inclusive Process

The capacity needed to manage the inclusive process is the ‘software’ needed to deliver the Pathway to Impact. To manage implementation of a market system strategy effectively, a policymaker needs to orchestrate all the partners – public and private alike – so they can play their part and fulfil their respective roles during implementation.

‘Relationship brokering’ is an ability often compared to the skills of the world’s best symphony conductors

As noted earlier, this calls for ‘relationship brokering’, an ability often compared to the skills possessed by some of the world’s best symphony conductors. A conductor’s job
is to lead a group of musicians to perform their part in sync and on time, so that, collectively they produce a piece of music rather than a loud, discordant noise. The conductor needs to orchestrate the process by setting the tempo and communicating how the musical score is to be interpreted. The conductor is an enabler not a doer – his/her skills can make or break the quality of performance, but the music is not produced by the conductor. Leaders in a collaborative effort need to play a similar role, as an enabler of action and impact through performing a series of three discrete steps during implementation. These are described in steps 1–3 below.

**STEP 1: Establish the ‘architecture’ for an inclusive implementation process**

**TASK 1.1: Identify a core group of champions** to drive an inclusive implementation process. The core group of champions should include public and private sector representatives relevant to the prioritized health market system, for example the lab market system for COVID-19 testing.

A core group of champions should include relevant public and private sector representatives

This core group of champions often evolves into a leadership team managing the inclusive implementation process.

**TASK 1.2: Select an appropriate mechanism to serve as the basis of the process.**

Key attributes of a collaborative structure include:

- **Agile organisational structure.** Some argue that an informal structure can be beneficial, e.g. partners can ‘test the waters’ without committing to one specific path or another when the different parties hold conflicting visions of the goal of the process or when building trust is a priority. However, others argue that a formal structure is needed to create a ‘level playing field’ between the public and private sector representatives participating in the collaboration, and to send a positive signal to private sector actors that the public sector is committed to working with them on an ongoing basis. There is no consensus on a ‘one-size-fits-all’ approach for a successful collaborative structure. Table 4.2 offers the pros and cons of the key options available.
TABLE 4.2: Alternative Structures for Inclusive Implementation Process

<table>
<thead>
<tr>
<th>Design characteristic</th>
<th>TYPE OF STRUCTURE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Informal/Self-governance</td>
<td>Lead Organisation</td>
<td>Administration Organisation</td>
</tr>
<tr>
<td>Organisational form</td>
<td>No administrative entity. All partners manage governance structure</td>
<td>Health ministry or equivalent health authority</td>
<td>Partners create a distinct, independent entity to manage collaboration. Hire a secretariat</td>
</tr>
<tr>
<td>Optimal # of partners</td>
<td>Few</td>
<td>Many</td>
<td>Many</td>
</tr>
<tr>
<td>Locus of decision-making</td>
<td>Decentralized</td>
<td>Centralized</td>
<td>Shared</td>
</tr>
<tr>
<td>Advantages</td>
<td>Large number of diverse partners</td>
<td>Clear lines of accountability</td>
<td>Strategic involvement of key stakeholders</td>
</tr>
<tr>
<td></td>
<td>Strong commitment level</td>
<td>Highly efficient</td>
<td>Efficient day-to-day management</td>
</tr>
<tr>
<td></td>
<td>Easy to form</td>
<td>Clear direction</td>
<td>Likely to be sustainable over time</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Can be unwieldy to manage</td>
<td>Excludes many partners</td>
<td>More complex and rigid</td>
</tr>
<tr>
<td></td>
<td>Difficult to establish consensus</td>
<td>May be dominated by lead organisation</td>
<td>May result in perceptions of unjust hierarchy</td>
</tr>
<tr>
<td></td>
<td>Hard to establish ownership of process</td>
<td>May fail to create shared commitment</td>
<td>High admin costs</td>
</tr>
</tbody>
</table>

Source: MM4H, 2018. Table 1.1

- **Balanced representation.** The structure of the process should also embody the values of the inclusive process (see Box 4.2). Key principles include:

  - **Shared leadership:** An inclusive process is not directed by one sector and/or organisation. Sharing leadership can be achieved by each sector occupying one of the leadership positions (Chair, Vice-Chair and Secretary) and rotating these positions between sectors.

  - **Transparency:** Private sector leaders will see opportunities arising from direct access to government officials and donors in the inclusive process. The criteria for participation should be clear and publicly available, allowing all potential private sector partners to express their interests in participation and to avoid the pitfall of ‘cherry picking’.

**BOX 4.2: Leadership team should:**

- Be comprised of influential leaders, decision-makers and executives
- Represent all relevant stakeholder groups
- Be balanced across key stakeholder groups
- Be as small as possible
- Have a clear policy on substitution for the leader when s/he cannot participate
Joint decision-making. The public and private sector participants need to define what constitutes consensus (e.g. 100%, 66%, 51%).

Conflict resolution mechanism. A critical task for the collaboration is to ensure that conflict is handled appropriately and constructively. Although stakeholders are generally committed to achieving a common purpose and collaborative actions as proposed in the market strategy, conflict is inevitable. It is therefore important to minimize the occurrence of conflict and to resolve it swiftly and successfully. Of course, sometimes conflict may contribute to innovative solutions by clarifying the choices and trade-offs that the partners face. However, the existence of frequent conflict among partner organisations will undermine trust – a critical factor needed for public-private collaboration. A policymaker, along with other champions in the core leadership team, have an important role to play in resolving conflict and must continuously ‘tune in’ to the view of participants and be prepared to intervene through discussions and negotiation. To do this effectively, the core leadership team must be able to remove his/her ‘institutional hat’ to become objective and fair-minded while supporting the vision and purpose of the collaborative.

Legitimacy management. For any collaborative effort to be credible, it must have legitimacy. Legitimacy is conferred externally and is based on reputation and success. And unlike formal organisations with a clear mandate, an inclusive process is less readily understood and identifiable. The leadership team must manage both internal and external legitimacy. Externally, an inclusive implementation process must be able to attract and retain key partner organisations, generate good publicity and convince outside groups that the public-private collaboration is viable and will effect change that will address and resolve health market challenges. Internally, the leadership team must be able to maintain legitimacy of the collaborative’s purpose among the public and private partners by encouraging and supporting interactions, providing needed resources and ensuring partner organisations act and think like they are part of the larger effort. Managing legitimacy requires engaging and communicating regularly with partners as well as external groups external to build support and recognition.

For a collaborative effort to be credible it needs legitimacy – which is conferred externally based on reputation and success

Organisational funding and staffing. To develop traction, dedicated capacity is required to support the day-to-day work of an inclusive process and help move the agenda forward. The number of staff depends on the breadth of the issues, complexity of the collaborative structure and available funding. In many cases,
this capacity exists within a single organisation, but the responsibility to contribute can be shared across partner organisations. Unfortunately, it is often difficult to obtain funds for this type of activity because governments and development partners do not understand the benefits of an inclusive process. It may be perceived as overhead and not programme work, and its impact is indirect where lines of accountability are unclear. Justification for the cost associated with supporting an inclusive process include: (i) funding individual programs have so far proved unsuccessful in solving large scale complex problems; (ii) the cost of providing logistical and administrative support is minimal; and (iii) the cost savings resulting from the streamlining of multiple partners’ actions towards a common goal more than offsets the investment in the collaborative structure.

**TASK 1.3: Ensure all the right organisations are involved.** As part of mobilizing partners, the leadership team conducts a combination of social network analysis and stakeholder analysis to identify and select stakeholders to participate as partners in the process. The analysis focuses on: (i) determining stakeholders’ perspectives on priority market system; (ii) gauging their interest and willingness to collaborate with others to implement the market interventions; and (iii) assessing their ability to contribute to and fully collaborate in the market system strategy process. A stakeholder analysis can quickly evaluate a wide range of stakeholder groups – both internal and external to government – that may have a stake in the priority market system. Table 4.3 provides an example of the range of stakeholder groups to involve.

**TABLE 4.3: Range of public and private actors in health system**

<table>
<thead>
<tr>
<th>Category</th>
<th>Stakeholder Group</th>
</tr>
</thead>
</table>
| **Government**      | › Office of the Prime Minister  
› Parliament  
› Ministry of Health (regulatory agencies)  
› Ministry of Finance |
| **Private Sector**  | › Private healthcare businesses  
› Faith-based organisations  
› Local/Intl non-government organisations |
| **Development partner** | › UN agencies  
› Bi- and multi-lateral agencies |
| **Civil Society**   | › Health policy research groups, think tanks  
› Press and media figures |
|                     | › Ministry of Education  
› Ministry of Local Government  
› National/Social Health Insurance Agency  
› Professional associations  
› Healthcare industry representative groups  
› Foundations  
› Consumer and health advocacy groups  
› Universities  
› Trade unions |
**TASK 1.4: Establish norms and practices through consensus.** Once the relevant stakeholders have been identified, the first order of business is to align interests, create group norms and agree on the collaboration’s purpose to build trust, mutual understanding, and shared values. At the onset, participants with diverse worldviews, interests and motivations may hold different visions of priority health market or have a specific purpose for participating in the inclusive implementation process. Sharing knowledge about each other, building relationships, and learning new skills during the early stages will help to achieve strategic alignment (see Box 4.3). Regular and frequent contact through meetings, joint projects and other professional events also fosters social learning about each other.

Over time, implementation partners will start to trust, respect, and reciprocate with each other, building a strong foundation for collective learning and action to implement the market strategy.

During this initial stage, it is also important to establish the rules of engagement – group norms – on how the partner organisations will work together. In some cases, the working relationships are already dictated by policy and/or regulations (e.g. contractual relationships, quality regulations, etc). In other cases, the relationships are not prescribed and can be determined by the group. Box 4.4 lists examples of normative behaviour in working together in an inclusive policy process.
STEP 2: Establish the overall direction of the inclusive process

TASK 2.1: Action planning. Most public and private health sector groups in LMICs are familiar with the steps needed to develop an action plan. The challenge is how to develop an action plan that serves as the driver for mutually reinforcing activities (e.g. market interventions). An action plan describes the various pathways (e.g. system level changes) to achieve the priority market system's goal and objectives. Equally importantly, an action plan aligns both public and private partners’ resources (e.g. political, financial, physical, etc.) to carry out the proposed interventions in a market system strategy.

The power of collaboration comes not from the number of participants but from the coordination of their activities

The power of collaboration comes not from the number of participants but from the coordination of their activities. Mutually reinforcing activities ensure that public and private partners’ efforts and activities are aligned towards achieving a common agenda and shared goals. In this case, the common agenda and shared goals are embodied in the market strategy and portfolio of market interventions. Designing mutually reinforcing activities entails: i) building upon existing partner activities and discouraging duplication; ii) distributing activities that leverage each partner’s existing skills, passion and expertise; iii) using data to create a culture of learning and adaptation among all partners; and iv) using data to determine which interventions to scale or stop (more on this in the last step of the Pathway – Detect).
ILLUSTRATING STEP 1: LAYING THE FOUNDATION FOR INCLUSIVE IMPLEMENTATION

The Deputy Minister debriefs the Minister of Health on the technical team’s diagnostic analysis and strategy to enhance testing capacity through engagement of private providers. She explains that the team’s systematic and transparent approach to diagnosis and design have helped to foster trust and ‘buy-in’ among all the key stakeholders – in government, the private sector and civil society. The Deputy Minister admits that there have been some heated discussions. But by the end of multiple meetings, all the stakeholders at the table had been honest and realistic about their capacity to deliver on the favoured testing strategy.

She recommends that the MoH should build on this platform for effective public-private dialogue (PPD) as the technical team moves to transition from design to delivery. She also points out the need to strengthen the PPD platform in various ways, including: (i) expanding the number of private health sector stakeholders involved, to include ‘front-line’ voices, as well as business representative groups; (ii) adding more CSOs and NGOs to ensure proper community representation, (iii) formalizing the MoH technical team to become a ‘standing committee’, fully integrated into the President’s National COVID-19 Emergency Response, including private sector and CSO representation within this; and (iv) appointing additional MoH staff to provide logistical and communication support.

The Minister of Health agrees to all these recommendations.

With this ‘green light’, the Deputy Minister pulls in two junior staff members - one from her office and another from the national drug administration (NDA) - to get organised for the next phases of delivery. As a first step, the Deputy Minister reconvenes the MoH technical team to give them an update on the debriefing with the Minister of Health and to discuss the transition from small team deliberation to incorporation within the National COVID-19 Strategy.

Together, the MoH technical team and its private sector contacts map out an action plan, including: i) identifying new stakeholders to incorporate into the PPD planning process, ii) reaching out and orienting the new stakeholder groups, iii) meeting with the National COVID-19 Strategy’s Executive Director, iv) convening a kick-off meeting, and v) collecting data on the private providers’ ability to fill some of the key information gaps. The junior health ministry staff quickly get to work to set up the necessary meetings. At the conclusion of this planning meeting, the Deputy Minister has the Executive Director of Country X Private Healthcare Federation and the President of APAX join her for a meeting at the temporary offices of the COVID-19 National Response Team.

The Deputy Minister’s first stop is a meeting with the Response Team’s Executive Director. At this meeting, she presents the technical team’s recommendations to enhance free access to diagnostic testing for targeted groups using a voucher-and-accreditation scheme. Duly impressed by the systematic, transparent and inclusive approach the team has undertaken thus far, the Executive Director immediately welcomes them to join her larger team. They will now act as one of several ‘Pillars’ within the response (the ‘Testing Pillar’), and she asks them to work with the other ‘Pillar Team Leaders’ to fully integrate into the structures and processes of the National COVID-19 Strategy.
Each senior staff member within the Testing Pillar is assigned responsibility to reach out to at least one new stakeholder group to secure their commitment and orient them to the task at hand. The Deputy Minister knows that understanding and buy-in from these stakeholders will be important for effective implementation of what is now becoming known as the ‘Testing Pillar Strategy’. The Deputy Minister finalizes an agenda to kick-off the consultative planning process and convenes a meeting to constitute the Testing Pillar of the national response effort. At this meeting, the stakeholders elect the Testing Pillar’s future leadership, which includes representation from across public, private and civil society stakeholders, and agree on key group norms and ways of working.

While the public and private sector stakeholders work together to develop the action plans, they are continuously ‘stress testing’ how each market intervention will affect the market. The first level of the stress test ensures the proposed action plans for a market intervention are consistent with the health priorities identified in Diagnose, support market strategy goals and objectives in Design, and do no harm (e.g. do not distort) the intended health market system (see Figure 4.3). The second level focuses on whether the market interventions use facilitation levers (e.g. attitudes, incentives, buy-in, relationships, and capacity) to ‘nudge’ market actors and behaviours.

**FIGURE 4.3: Market facilitation**

- Are the interventions consistent with health priorities?
- Market strategy?
- Will the intentions ‘do no harm’?

Priorities (Diagnose) → Strategy (Design) → Guidance for consistency between practice and objectives → Market Actors and Functions

Do the interventions use market facilitation levers?

(Incentives, attitudes, buy-in, relationships, capacity)

Market Distortion → Facilitation always has the potential to change markets → Market Development
**TASK 2.2: Establish Shared Metrics**. Agreement on a common agenda is illusory without agreement on how ‘success’ will be measured and reported. Collecting data and measuring results consistently on a short list of indicators across all partner organisations yields many benefits: (i) ensures data quality, (ii) tracks progress toward a shared goal, (iii) enables coordination and collaboration, (iv) holds partners accountable to their commitments, (v) offers opportunity to learn and course correct; and (vi) catalyses action. In addition to defining the shared metrics, the partners establish the mechanics to track the collaboration’s progress as well as implementation of the intervention (see DETECT for more details).

**BOX 4.7: Shared metrics**
- Enables all players to work toward the same goal and measure the same things
- Prompts cross-sector alignment between government and non-state sectors as essential partners
- Enables organisations to actively coordinate their action and share lessons learned

**ILLUSTRATING STEP 2 (A). MAPPING THE SLM TO AN ACTION PLAN**

During the second half of the Testing Pillar kick-off meeting, the Pillar members focus on the business of **planning**. Given the urgency of the situation, the group agrees to an intensive planning process over the course of three weeks, starting with the kick-off meeting. They organise the planning tasks as follows.

<table>
<thead>
<tr>
<th>Week One</th>
<th>Week Two</th>
<th>Week Three</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning Session #1:</strong></td>
<td><strong>Technical Session #4:</strong> Junior staff members present on intl/regional</td>
<td><strong>Working Sessions:</strong> Finalise draft plans for each intervention. Prepare</td>
</tr>
<tr>
<td>Get organised.</td>
<td>best practices on COVID testing.</td>
<td>slide deck.</td>
</tr>
<tr>
<td><strong>Planning Session #2:</strong></td>
<td><strong>Working Sessions:</strong> Meet multiple times. Include partner organisations’</td>
<td><strong>Technical Session #5:</strong> Group meets to reconcile and coordinate different</td>
</tr>
<tr>
<td>Finalise the SLM as planning</td>
<td>experts in working groups.</td>
<td>interventions. Prepare presentation.</td>
</tr>
<tr>
<td>framework and form teams based on key intervention areas.</td>
<td><strong>Homework:</strong> Finalize data collection. Include this in intervention design.</td>
<td><strong>Debrief COVID National Response Team:</strong> Testing Pillar leadership present action plan.</td>
</tr>
<tr>
<td><strong>Technical Session #3:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft shared metrics underpinning the SLM.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Homework:</strong> Collect missing data.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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The Testing Pillar team frame their action plan on their vision of change in this priority health market as reflected in the Strategic Logic Model (SLM).

The SLM also drives the group’s decision on the number and technical focus of the relevant teams. They form the Technical Working Groups (TWGs), and assign a lead agency to coordinate each one as follows: (i) voucher programme implementation and consumer/provider information (MoH), (ii) accreditation (of voucher-eligible providers) and quality assurance (MoH), and (iii) community mobilization (CSOs). The Pillar leadership team will supervise the TWGs and solve problems as they arise. The junior staff will provide logistical support for all the TWGs and maintain / share the materials among all the TWG to ensure coordination and synergies between interventions.

Mitigate spread of COVID-19 and minimize impact on essential health services

Increased access to and use of affordable, quality testing among target groups

Changes in the market system for diagnostics and laboratory services

- Supply of high-quality COVID-19 lab tests increased
- Number of accredited private labs increased
- Private labs understanding and awareness of new regulatory rules and guidelines increased
- National Institute for Public Health (NIPH) accreditation rules simplified and operational
- Economic barriers removed from target population to access COVID-19 lab tests
- Increased understanding and willingness of target population groups to use private COVID-19 lab testing services
- CSOs provides target populations with critical information on COVID-19 tests and effectively market private lab COVID-19 testing services
- Vouchers issued to target population groups

Intervention

Create incentives for high-capacity private providers to deliver quality COVID-19 tests and strengthen demand among target population groups to seek COVID-19 tests
ILLUSTRATING STEP 2 (B). REACHING AGREEMENT ON ‘SUCCESS’

During the design stage, the MoH technical team had agreed on what success ‘looks like’ in the diagnostic and laboratory market system. The Pillar teams now refine their definition of success. Returning to the SLM, they define this as “increased access to affordable, high-quality tests among target population groups”. They return to the prior analysis completed in the design stage to ensure that the Testing Pillar’s strategy is fully aligned with UHC core goals. The Pillar teams then carefully review and finalise the related performance objectives, discuss the indicators and possible sources of data, and formulate assignments in terms of which teams and team members will be responsible for collecting the data for each indicator.

<table>
<thead>
<tr>
<th>UHC Goal</th>
<th>Specific performance objectives</th>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased access to quality, affordable tests</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Consumer awareness of available and location of qualified test sites increased</td>
<td>MOH, CSOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td># of testing sites to at least double</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Massive campaign to increase consumer awareness and knowledge</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only quality COVID-19 tests are available</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Only accredited labs conduct/ analyze tests</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Consumer awareness of qualified public and private labs increased</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td>Private labs knowledge of quality guidelines for testing increased</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td>Private labs case reporting improved</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>Private labs access to essential equipment and consumables increased</td>
<td></td>
</tr>
<tr>
<td><strong>Affordable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tests are affordable</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>No OOP for target groups</td>
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</tbody>
</table>
STEP 3: Enable partners to realise capacity and commitment

Orchestrating both public and private partners in a collaborative effort entails working tirelessly both in the public eye and behind the scenes to establish collective ownership, to balance the tension between coordination and accountability, and to negotiate compromises and defuse potentially contentious issues. Below are activities that help realise each partner’s potential.

Task 3.1: Manage public and private partners’ commitment. Now that all the implementing partners have agreed upon the vision and overall direction of the collective action embodied in the market strategy, the ‘orchestra leader’ (in this case the leadership team) needs to safeguard each partner’s commitment to ensure the collective goals are attainable. Specifically, it is important the leadership team institutionalizes all partners’ relationships and commitments to the action plan so that the collaboration is not dependent on personal ties or single individuals. In managing commitment, it is important to recognize that not all partner organisations will be equally committed to the collaborative effort (Millward et al, 2006).

Orchestrating public and private partners entails establishing collective ownership, balancing coordination and accountability and negotiating compromises

Most implementing partners have multiple programs, of which only a few may be related to the goal of the collective effort. In fact, a single organisation may be involved in several different collaborative initiatives. The leadership team’s role is to:

- Get ‘buy-in’ from the leadership of each implementing partner organisation.
- Work with all the implementing partners to ensure they understand how the public–private collaboration’s success contributes to the individual organisation’s mandate and effectiveness.
- Ensure collaboration initiative resources are distributed equitably based on each partner’s needs and level of commitment.
- Make sure that all implementing partners are well informed about the collaborative’s activities.

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Another task in managing partner commitment is working with and helping each partner organisation’s representative to build commitment within his/her respective organisation to the market system strategy’s goals and to institutionalize the partner organisation’s involvement in the collective effort.

**Task 3.2: Hold all partners accountable to their commitment.** Accountability among partner organisations is often discussed but in reality, not well practiced. Although all implementing partners may agree in principle that they should share the work, it is easy to shirk one’s responsibility assuming someone else will pick up the slack.

The leadership team guiding a collaborative effort has a major responsibility to ensure that those who participate are held accountable for their actions related to the common agenda (market strategy) and collective action plan (market interventions). This means monitoring implementing partners’ activities to protect against ‘free riders’. Accountability is two-sided and implies both a willingness to take responsibility for one’s action and an expectation that these actions will be recognized. If some implementing partners do not pull their share, then it is the leadership group’s role to try and work around them or perhaps even exclude them. On the other hand, if an implementing partner is fulfilling its responsibility, it is also the leadership group’s role to acknowledge and reward them.

Tasks to manage accountability include: (i) determining who is responsible for what outcomes; (ii) rewarding and reinforcing compliance with the collaborative efforts agenda and action plan; and (iii) monitoring and addressing network “free riders”.

**Accountability is two-sided: willingness to take responsibility for one’s action and an expectation that these actions will be recognized**

**Task 3.3: Enable each partner to play their role to the best of their ability.** A leadership team guiding collective action (market system strategy) also need to be mindful that implementing partners have varying skills and capacity to fully participate. Moreover, participation can place added administrative burdens, particularly with respect to the level and frequency of reporting required under these new policy tools like regulatory compliance and services contracting.

Therefore, a key task for the leadership team is to build not only the collective effort’s overall capacity but also to help strengthen the individual implementing partner’s capacity to fulfil its roles. Building capacity is a productive investment. Improving an implementing partner’s relationship skills and technical capacity has shown to reduce the transaction cost of collaboration.
ILLUSTRATING STEP 3(A). MANAGING A CHAOTIC START TO IMPLEMENTATION

The Testing Pillar debrief with the COVID-19 National Response Team went well. So well that the National Response Team immediately agreed to all components proposed in the Testing Pillar Strategy. They also agreed to reallocate some of the emergency funds from development partners towards the Testing Pillar’s activities.

Excited, the Deputy Minister and her team return to MoH offices to map out how they will coordinate the implementation process. To keep pace with the pandemic, they agree to the following meeting schedule: Monday morning meetings with all senior managers to discuss progress and resolve problems/conflicts as they arise; bi-weekly meetings with all stakeholders to discuss roll-out of activities; and weekly meetings between Pillar leadership with the COVID-19 National Response team. The government has declared an extension to the existing “lockdown”, so everyone is moving to virtual meetings and other communication channels to conduct business.

Despite the effective planning processes, implementation gets off to a bad start. The MoH achieves a quick win within the first two weeks: they gazetted the streamlined accreditation process in new regulation. But two major bottlenecks emerge.

(Bottleneck 1) The MoH is struggling to negotiate Memoranda of Understanding (MoUs) with the accredited private providers.

During this time, both eligible private hospitals with laboratories and stand-alone laboratories with capacity to meet accreditation standards have begun to repurpose their staff and equipment to accommodate the extra work involved in the COVID-19 testing programme. The MoH has sent them the testing guidelines and protocols and has scheduled training sessions for providers’ staff. The NIPH is moving steadily to accredit the qualifying private labs. The bottlenecks are the MoUs between the MoH and the private facilities. The MoH has been slow to discuss the terms of these. Moreover, the MoH contract officer has not been responsive to the Private Lab Association Director’s calls. The private labs are willing to take a risk and start testing without an MoU. But they are now reconsidering this risk because the MoH contract officer won’t even pick up the phone!

(Bottleneck 2) It is unclear how many COVID-19 test vouchers the CSOs are distributing.

The CSOs have moved to educate the target communities about when and from whom to seek a test, how the voucher system will work, and what they can expect. They have supplemented the work of community health workers (CHWs), currently involved in the maternal health voucher program, and asked to additionally work on the COVID-19 programme. The CHWs are using their community data to quickly identify eligible voucher candidate within each community. The CHWs are in the community every day and handing out COVID-19 test vouchers - but the numbers don’t add up and match their level of activity. The CSO groups suspect that there is under-reporting of the number distributed and where - but a lot of uncertainty remains.
These two problems quickly emerge during the weekly ‘core leadership’ meetings (along with multiple late night calls and WhatsApp messages!). The Testing Pillar’s strategy is at an impasse unless the MoH can get the MoUs in place - and fast! Late one night the core leadership team call each other and agree to convene an extraordinary meeting in two days with all the stakeholders to work on overcoming these bottlenecks.

Implementing partners will have varying degrees of technical incentives and motivations to play their role in a market strategy. During the Design stage, a policy maker and implementing partners used the ‘will-skill’ framework to assess all the implementing partner’s incentive (‘will’) and capacity (‘skill’). By understanding ‘skill/will’, the core leadership team can design specific activities to help each implementing partner organisation overcome its challenges which will ultimately lead to changes behaviour and attitudes enabling them to fulfil their respective role in the market strategy.

**Task 3.4: Continuously engage partners to build trust.** Continuous communication provides an internal platform for public and private implementing partners to address concerns, discuss ideas and build trust between organisations that may have previously been in competition with each other. Consistent and honest communication also helps implementing partners develop a common language with which to co-create a shared vision and common agenda. Continuous communication also encourages sharing knowledge, promoting accountability among partners, and monitoring the process’ results.

Consistent, honest communication helps partners develop a common language with which to co-create a shared vision

There are various channels to communicate internally among the public and private implementing, such as face-to-face meetings, teleconferences, and on-line platforms. Introduction of technology platforms, such as social media and WhatsApp, has help intensify communication and opened access. For communications to be effective, it is important for all implementing partners to have equal representation and involvement in all interactions, and to ensure that decision-making is collaborative and considers all members’ point of view. The channels and frequency of internal communications will change as the collaborative evolves and should be re-evaluated frequently to assess if all implementing partners agree on if internal communications are working.
It is equally important to communicate with external stakeholders to foster external stakeholder buy-in and build support for the public–private collaborative effort. There is a wide range of communication and engagement tactics (see Table 4.4) that require analysis, thoughtful planning, and persistence. A communication strategy is the cornerstone of external communication and engagement to develop a positive image of the collaborative and to consistently communicate the importance of public and private collaboration.

**TABLE 4.4: Activities by intensity of engagement**

<table>
<thead>
<tr>
<th>Communication</th>
<th>Consultation</th>
<th>Participation</th>
<th>Negotiation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Print Materials:</strong></td>
<td><strong>Events:</strong></td>
<td><strong>Events:</strong></td>
<td><strong>Organising/ strengthening public sector capacity to engage and negotiate:</strong></td>
</tr>
<tr>
<td>‣ fact sheets/ brochure</td>
<td>‣ expert panels</td>
<td>‣ expert panels</td>
<td>‣ creating a dialogue platform</td>
</tr>
<tr>
<td>‣ newsletters</td>
<td>‣ briefings</td>
<td>‣ briefings</td>
<td>‣ forming PPP unit</td>
</tr>
<tr>
<td>‣ issue/policy papers</td>
<td>‣ workshops</td>
<td>‣ workshops</td>
<td>‣ assigning private sector advisor</td>
</tr>
<tr>
<td>‣ technical reports</td>
<td>‣ conferences</td>
<td>‣ conferences</td>
<td>‣ mentoring government staff to become private sector experts and champions</td>
</tr>
<tr>
<td>‣ poster / billboards</td>
<td><strong>Govt forums:</strong></td>
<td><strong>Govt forums:</strong></td>
<td><strong>Organising/ strengthening non-state capacity to engage and negotiate:</strong></td>
</tr>
<tr>
<td>‣ press / op-ed</td>
<td>‣ town meetings / open houses</td>
<td>‣ town meetings / open houses</td>
<td>‣ building professional associations</td>
</tr>
<tr>
<td></td>
<td>‣ technical working groups</td>
<td>‣ technical working groups</td>
<td>‣ forming networks and coalitions</td>
</tr>
<tr>
<td><strong>Media:</strong></td>
<td><strong>Interpersonal:</strong></td>
<td><strong>Interpersonal:</strong></td>
<td><strong>Interpersonal:</strong></td>
</tr>
<tr>
<td>‣ print (news, feature stories, op-ed)</td>
<td>‣ one-on-one meetings</td>
<td></td>
<td>‣ building professional associations</td>
</tr>
<tr>
<td>‣ press releases</td>
<td>‣ email and telephone</td>
<td></td>
<td>‣ forming networks and coalitions</td>
</tr>
<tr>
<td>‣ new conferences / media briefings</td>
<td>‣ personal networks</td>
<td></td>
<td>‣ mentoring private sector champions</td>
</tr>
<tr>
<td>‣ advertising</td>
<td>‣ informal gatherings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‣ radio programming</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‣ Website / online forums</td>
<td><strong>Online forums</strong></td>
<td><strong>Online forums</strong></td>
<td></td>
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</tbody>
</table>
ILLUSTRATING STEP 3(B): BUILDING TRUST THROUGH CONTINUOUS ENGAGEMENT

The core leadership team agrees to hold a late evening call to discuss how quickly the implementation process has started to unravel and to search for possible solutions to address the key bottlenecks. The core leadership group is under pressure since they have committed to convening an extra-ordinary meeting in two days with all the major players to work out these bottlenecks.

The Deputy Minister realises this will be a ‘heated’ discussion among her core leadership group partners. The private sector is accusing the MoH of dragging its feet on the MoUs because the MoH never really trusted the private sector labs in the first place. And the MoH does not trust the numbers coming from the CSOs and is worried that the vouchers will not get to the communities fast enough to prevent further transmission of the virus. Many of the Deputy Minister’s colleagues are grumbling that she is pushing them too fast to work with the for-profit private sector, about which they have some serious reservations. Her colleagues are suspicious that the only reason the private providers are interested in the process is to take advantage of the government’s naivety – and to gain market share.

To prepare for this call, she gives each leadership partner a call to ‘hear them out’ and understand their perspective on what is working or not working. She takes notes to see if there are solutions to break the logjam in the Testing Pillar’s strategy. The Deputy Minister picks up the phone to talk to the President of APAX to learn what is going on with the voucher numbers. She quickly learns that using paper vouchers is creating all types of problems for the reporting system. Normally, the CHW offer ‘e-vouchers’ for maternal service package which is seamlessly recorded on their tablets and immediately reported to the Voucher Management Agency. However, the MoH has issued paper vouchers instead. As a result, the CHWs have to track and record the COVID-19 vouchers the old-fashioned way – paper and pencil. This gives rise to errors in addition, lost reports, and many other forms of dysfunction.

The Voucher Management Agency is not confident in the numbers they are reporting because the paper reports are incomplete and late. They discuss the feasibility of converting from paper to e-vouchers immediately.

The MoH procurement officer presents a different challenge. He is frank about his team’s lack of capacity to issue MoUs in such a short period of time. He admits it has been slow going – and delays have accumulated in finalising agreements with the first group of accredited private labs and hospitals. But he has been thinking about more efficient ways to issue MoUs to the target number of private facilities. He proposes to the Deputy Minister that since almost all private labs are members of the Private Lab Association, maybe it would be more efficient to enter into an MoU with the Private Lab Association instead of individual facilities. Under this option, the MoH would only have to develop one ‘master MoU’ that would be standard across all the private facilities. This option would also have additional benefits during implementation – as part of the terms, the Association would be responsible for ensuring:

- compliance to clinical guidelines,
- no charge at point of sale for voucher clients,
- rapid turnaround in test results, and
- daily reporting of positive cases to MoH disease surveillance.

The Deputy Minister feels she now has a clear sense of how to overcome the existing bottlenecks.
Introduction

The Diagnosis chapter laid the foundation for an inclusive policy process by understanding the range of public and private actors in the targeted health market system. The Design chapter mobilized many of the critical stakeholders to gain their perspective in developing the market system strategy. The Deliver chapter further strengthened the inclusive process by formalising a structure and process by which a policy maker, in collaboration with a core leadership team comprised of both public and private stakeholders, can orchestrate implementation of the market system strategy. The Detect chapter introduces key concepts in a Monitoring and Results Measurement (MRM) approach that embodies:

- Performance measurement issues and challenges specific to market systems action,
- Performance improvements through flexible and responsive monitoring; and
- Effective evaluation issues and challenges.

This chapter also highlights the importance of MRM in guiding collective action by multiple implementing partners involved in a market system strategy and holding each one accountable for their respective roles and responsibilities. Holding the implementing partners accountable helps to nurture trust – another key governance behaviour.
To nurture trust, policymakers must facilitate consensus on shared metrics (see Task 2.2), agree on processes and mechanisms by which to collect and report on shared metrics, and openly and regularly share data on agreed set of metrics.

The objective of a market strategy is to improve a health market system’s performance so it can deliver on the core principles of UHC. To stay on track to achieve UHC and ultimately improve health outcomes, a policymaker needs to know if his/her market strategy is effecting positive change in the intervening markets. The SLM is a helpful tool for a policymaker to stay the course. Figure 5.2 shows the linkages between the SLM and the Monitoring and Results Measurement approach (MRM).

Monitoring promotes continuous learning and adjustment to “improve” the effectiveness of a market system strategy (see Figure 5.3). Monitoring ‘tracks up’ through the SLM, focusing on the links between activities and outputs (health market system changes). Monitoring enhances performance by informing practice. Evaluation, on the other hand, provides evidence to ‘prove’ market facilitation outcomes (e.g. impact and their attribution to market strategy). Evaluation ‘traces down’ through the SLM focusing on the links between outcomes and impact (health outcomes). Evaluation fosters accountability by informing policy.

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There are many technical resources available as well as accepted good practices in MRM. This chapter does not aim to replicate but rather complement them by focussing on those aspects specific to market systems development and implementation. Moreover, this chapter focuses more on monitoring than evaluation given the operational focus of the MM4H course.

**Monitoring – Strengthening Performance and Improving Practice**

A government’s central role in an inclusive policy process is facilitative – that is encouraging new and improved performance among the different implementing partners. A policymaker’s facilitation role – supporting behaviour change in others outside one’s direct control – has profound implications for approaches monitoring. Market systems are complex and intervening to make them more efficient and inclusive is not a matter of implementing a fixed plan that follow a straight, linear path. Monitoring must be both rigorous and pragmatic to deal with this complexity.

- First, there is imperfect and incomplete information on the health market system a policymaker is trying to influence. Market strategies need timely, accurate feedback to assess effectiveness and adjust actions accordingly. MRM must be integral to the intervention process and the role of all implementing partners.

- Second, complex health market systems are unpredictable. Change processes are driven by implementing partners operating in a dynamic environment. There is rarely a clear path or ‘right answer’ for intervening and outcomes are not fully within a market strategy’s control. Flexibility and responsiveness are crucial.

There are considerations and guidance to design a responsive and rigorous framework for good practice monitoring. Key elements of this are presented below:

**Involve implementing partners**

In the Deliver chapter, implementing partners will have reached consensus on what “success” looks like and the indicators to measure success to develop a common vision. Every implementing partner will have a role in monitoring the strategy’s progress and impact. A policymaker should encourage each implementing partner to monitor information important to it’s own (future) performance in the market strategy. This requires assigning in an in-house staff person to collect, analyse and report the data to the collective group. If the implementing partner does not have this capacity, a policymaker may consider hiring an outside consultant to assist them in this task.
Create a data culture

Good monitoring needs to be a joint endeavour - monitoring ‘with’ and not monitoring ‘of’. Although a policymaker can legislate and regulate data reporting, buy-in is critical for to create a culture of data driven decision-making among the implementing partners. Shared metrics (see the Deliver chapter, section 3.3 Task 2) is a first step towards buy-in. Joint monitoring as to whether a market strategy is creating the “correct” incentives and desired behaviors is another step towards building buy-in. A data culture offers many benefits: (i) greater access to reliable and timely data, (ii) cost savings by working with and/through implementing partners, and (iii) most importantly, building trust and accountability.

Communicate effectively

A policymaker, with his/her leadership team, needs to think carefully about what needs to be communicated and to whom. There is a tendency to share all information with everybody. A policymaker needs to balance information sharing. At best, sharing all information with everyone is not helpful and can even be damaging. It can also lead to information overload. At its worst, it can put inappropriate information into the hands of people who are not able to interpret it correctly, and lead to misperceptions and erroneous expectations. The implementing partners, while discussing shared metrics should also develop a simple, audience-specific communications strategy. The market strategy’s SLM can guide the implementing partners to decide who needs to know what, when and in what form.

Experiment and adapt

Complex health market systems are unpredictable. Although the strategy articulates a vision of change, a policymaker, in collaboration with implementing partners, may not know exactly how best to get there. Some interventions will work as planned, some will work partially, and some will not work at all. An inclusive policy process needs to be open-minded, open-ended, pragmatic and experimental – a ‘learning as one implements’ approach. Often referred to as “active learning”, this flexible and experimental approach to implementation allows all partners to learn which interventions work and which ones fail (see Figure 5.4). There are several advantages to active learning: i) it does not restrict the implementing partners to prescribed policy solutions; ii) it allows the implementing partners to explore broader options and to think creatively in their application; and, iii) it enables implementing partners to take advantage of changes as they occur in the health market they are attempting to shape.

FIGURE 5.4: Adaptive Learning Cycle
Encourage a culture of openness and curiosity

Experimentation and adaptation require a management culture of openness and inquisition.

- **Continually reinforce strategic mission and objectives:** “...if you don’t know where you are going, any road will take you there!”. Being flexible and adaptive can only work if clearly bounded by strategic mission and objectives.

- **Encourage respectful dissent and creative tension:** Adaptive learning and experimentation require a spirit of open, critical enquiry across all implementing partners that allows them to continually ask what does and does not work, and why. A policymaker must work hard to develop and maintain a culture of openness, honesty, and receptiveness to constructive criticism.

A policymaker must work hard to develop and maintain a culture of openness, honesty, and receptiveness to constructive criticism

If implementing partners are unable to critique themselves and one another, then the full potential of improving practices through MRM will not be realised.

- **Embrace failure:** It is inevitable that some interventions will not work and implementing partners should not regard this as failure. Implementing partners must therefore be prepared to make tough but informed choices and discontinue a market intervention in response to market signals. This requires a change in mindset – albeit a difficult one – that accepts trial and error and learns to support rather than blame when an intervention fails.

**Intended vs. unintended consequences**

Implementing partners often focus on monitoring the intended consequences of a market system strategy and its multiple interventions. However, implementing partners may not be on the look-out for unintended consequences. Shifts in the market system may be positive, where the strategy is achieving its intended and/or better outcomes than expected. Equally, the consequences may be negative. In this case, the implementing partners will want to change the market intervention(s) to isolate and mitigate any negative effects.
Develop an MRM Plan

The following steps offer guidance on how to develop Monitoring Plan using Results Chains as the unit of analysis.

**STEP 1: Build a Results Chain**

A results chain is a visual tool showing the chain of causality of a specific market intervention – *what the intervention is doing and why*. This clarifies the ‘logic’ of the programme, by showing how activities will lead to outputs, outcomes, and eventually health impact. Since a result chain is tailored to a specific intervention, they are more detailed than the SLM.

A results chain is related to but different from the more commonly used *logical framework*. A logical framework summarises a programme that combines outputs, outcomes, and impact for its key interventions in a single table. It presents an overall programme in a single diagram. While useful for a ‘bird’s eye view’, it does not explain different activities/interventions and the changes that they will trigger in the health market system. Results chains, on the other hand, through a simple diagram, map the pathway to impact and activities in detail, illustrating why they are doing what they are doing and how each partner implementing partners work can help achieve impact. The results chain provides the basis for assessing if and to what extent changes are taking place. For day-to-day management, therefore results chains are more useful to track progress.

Figure 5.5 shows a basic skeleton for a results chain. Activities are listed at the bottom, and the goal/impact at the top. The results chain shows how the activities at the bottom would lead to different changes (light grey boxes), ultimately leading to “reduced incidence of COVID-19 cases” (teal box at top). When developing a results chain, remember:

- Develop and document a results chain for each intervention,
- Show all key changes arranged in logical order for each results chain, demonstrating as far as possible how the selected intervention leads to achievement of development goals; and

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2 Guidance adapted from “Guidelines to the DCED Standard for Results Measurement: Articulating the Results Chain” Adam Kessler with Nabanita Sen, April 2015
Include sufficient detail in each results chain so that one can assess – either quantitatively and/or qualitatively – changes at all levels.

**STEP 2: Define indicators**

Although the results chain is the management and measurement ‘backbone’ of intervention, it is only meaningful if the indicators of change are well formulated, e.g. SMART (specific, measurable, achievable, relevant and time-bound—see Figure 5.6) and if they are tested and amended accordingly.

Assigning at least one indicator to each box in the results chain helps track progress accurately and to examine assumptions about how change is predicted to take place. For some market interventions, this can create a large number of indicators to track. A policymaker, along with the implementing partners, need to assess if this level of detail is useful and informs decisions or used for reporting. Selecting indicators is dependent on achieving a balanced performance assessment:

- **At different levels:** Choosing indicators at different levels of change and tracking up through different levels of results chains.
- **Using different methods:** Ensuring a balance of quantitative and qualitative assessments to help ‘triangulate’ findings.
- **Across different dimensions of performance:** Need to ensure indicators capture different dimensions of change and objectives concerned with issues of, for example, sustainability, scale, effectiveness, and efficiency.
- **According to SMART rules:** Ensure indicators comply with SMART rules.

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### Key issues when defining indicators

- What are the key constraints/ opportunities in the COVID-19 testing market system?
- Why are un/underserved groups unable to access the tests they need?
- Who are the market players in the lab sector?
- Why are the different market players not already solving the identified problems?
- What constraints – in terms the capacity and incentives of market players – account for this?
- How can the market system strategy assist the market players address these constraints?
- What incentives are needed to change market players’ behaviors?
- How feasible is the market strategy and the set of specific interventions?
- What would be the results of the strategy and interventions being considered?

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ILLUSTRATING STEP 1: DEVELOPING RESULTS CHAINS

As part of the exercise to develop ‘shared metrics’ for defining success, the Testing Pillar team agrees to develop Results Chains (RCs) for each intervention to ensure that their activities reinforce the SLM. They brainstorm different ideas by ‘doodling’ on a blank page to draw a few results chains in free form (i.e. without levels). The Pillar team quickly realises that its preliminary ideas for the Testing Strategy and interventions are not clear - and as a result, it cannot draw logical RCs. It turns back to the original analysis undertaken during the diagnose stage to help fill in the gaps (see box on page 83). Since it takes the whole of the meeting time to further clarify the activities using data from the diagnose stage, they decide to adjourn for the evening and set a time for the next brainstorming session.

Two days later, the same group, along with MoH staff with monitoring and evaluation expertise, meet on ZOOM. They begin the first step of the detect stage, by writing down the main market strategy activities. Since they propose more than one activity, they try to show the relationships between them by asking and answering three sets of questions: (i) Does one activity lead to another? Or will they be undertaken at the same time? (ii) Do they all target the same population groups? Or do they target different ones? And (iii) Do they all aim to produce one specific change? Or are they aimed at different changes?

In the second step, they describe the main change(s) in systems, markets, intermediaries, and the enabling environment that is expected to result from activities, by adding a different box for each major type of projected change. The M&E experts advise the participants to add enough detail so they can actually measure whether the projected change is being realised in practice. In the third step, the group describes the expected medium-term changes (system and access impacts) and the long-term outcomes in terms of population health and the impact of the outbreak on other essential health...
services. In the final and fourth step, the group documents the assumptions implicit in the results chain to highlight the external factors that may affect whether the logic (or links) in the results chain will hold. They also double-checked the draft results chain with the SLM to ensure they were aligned.

They develop the following RCs (see figure below). It was a long ZOOM call. The group decides to call it quits and asks the M&E staff to work on the draft to further develop the RCs.

<table>
<thead>
<tr>
<th>OUTCOMES</th>
<th>ACCESS</th>
<th>MARKET SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Family income sustained and economic resilience strengthened</td>
<td>18. Isolation of infected patients quicker and more effective</td>
<td>8. Private labs understanding and awareness of new regulatory rules and guidelines increased</td>
</tr>
<tr>
<td>21. Community transmission reduced</td>
<td>19. Referral of infected patients quicker and treatment started sooner</td>
<td>13. Number of accredited private labs increased</td>
</tr>
<tr>
<td>22. COVID-19 related mortality and morbidity reduced</td>
<td>17. Use of high-quality COVID-19 lab tests increased</td>
<td>9. Accreditation rules simplified and operational</td>
</tr>
<tr>
<td>23. Impact on essential health services minimised</td>
<td>15. Financial barriers to increase target population's access to COVID-19 lab tests removed</td>
<td></td>
</tr>
</tbody>
</table>

NB: Private labs redeem vouchers which provides a steady revenue, eases working capital concerns, increases bank’s confidence in offering credit, and ultimately means private labs have the financial resources necessary to reinvest in essential testing inputs and service delivery

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>INTERVENTION AREAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. MOH shares and trains private labs in clinical standards and guidelines</td>
<td>1. Increase number of accredited private labs</td>
</tr>
<tr>
<td>5. MOH reviews and implements simplified accreditation rules</td>
<td>2. Increase-target populations understanding of COVID-19 test and benefits</td>
</tr>
<tr>
<td>6. CSOs support private labs to develop marketing strategies</td>
<td>3. Increase-target population ability to access COVID-19 tests</td>
</tr>
<tr>
<td>7. MOH covers test costs through issuance of vouchers</td>
<td></td>
</tr>
</tbody>
</table>
STEP 3: Establish baselines

During the Diagnosis stage, a policymaker and key stakeholders will have collected a significant amount of data to inform their definition of key health system challenges and to prioritise the market systems in which to intervene. Important information emerges from the diagnostic process that can never be captured upfront by a single, large scale baseline survey. A policymaker may have to augment this data with a number of smaller, targeted studies to complete their baseline information. It is important that the baseline quantifies the status of all key indicators measuring the results chains. Without baseline data, a policymaker can only ‘count’ outputs delivered, and they will not be able to assess the level of change caused through their market interventions.

In considering establishing baselines, a policymaker needs to ask him/herself the following three key questions:

- Have we made the most of the information gathered during the diagnostic process? Building the baseline from one's diagnosis saves effort and keeps strategy and measurement coherent. A policymaker and implementing partners should 'diagnose down and measure up'.

- Are we putting too much faith in a single programme-wide baseline study? Often it is better to conduct several smaller baseline surveys specific to each system or intervention given how specific data needs are and how locations and target groups are likely to vary across interventions.

- When should we conduct a baseline? Timing is critical. Given the time needed to realize change in a market system, surveys conducted too early may preempt any signals of change in the market intervention during the diagnostic and piloting processes. But significant delays in capturing baseline information may make the results less accurate.

STEP 4: Set best estimates (projections)

Projections of how much each indicator will change by is NOT a target – it is a “best estimate”, or projection, of the results by a given date in the future, based on current information. The information gathered during the diagnostic process can help make realistic projections. Projections might focus on an estimate of size of current market (e.g. number of COVID tests in the marketplace) or activities (e.g. number of consumers tested). The projections also more useful when timebound – how much change will occur and by when it is forecasted to occur.

Estimates may not be exact, but they are important. They help a policymaker and implementing partners make decisions. Estimating projections always involves responding to a range of stakeholder interests and needs while tempering ambition with realism. As such, estimating projections is an inherently ‘political’ process. Managing this process well demands:
- **Making accurate predictions** informed by detailed analytical assessments that assess ‘performance gaps’ and ‘trend analysis’.

- **Aligning best estimates with decision-making priorities** by linking indicators and projected estimates with key decisions.

- **Measuring and interpreting progress** recognising that project estimates are not targets and that not hitting them isn’t necessarily a sign of failure; particularly if you know that early and can investigate and adapt your approach.

- **Managing stakeholder needs and expectations** of the reform process requires a policymaker manage the different implementing partners interests to ensure the integrity of market strategy processes. Key to a policymaker’s success in managing expectations involves determining what needs to be measured when, how frequently and by which implementing partner.

- **Establishing projections as milestones** that are progressive and iterative – not absolute – measures of performance. This is particularly important in earlier days as a policy maker and where implementing partners are still learning and adapting.

**STEP 5: Prepare a measurement plan**

A measurement plan turns results chains, and all its details, into an operational plan to generate the data and analysis needed to monitor performance. The measurement plan also serves as a reference document that a policymaker can consult and communicate widely across the implementing partners and stakeholders.

While there isn’t a ‘standard’ in what a measurement plan should contain, there are some key elements. At a minimum, a measurement plan clearly defines the roles and responsibilities of all implementing partners on who will undertake each measurement task, when, where, and using which methods (see Table 5.1).

<table>
<thead>
<tr>
<th>RC level / Reference#</th>
<th>Indicator/Definition</th>
<th>Baseline</th>
<th>Target</th>
<th>Source</th>
<th>Tool(s)/MOV</th>
<th>Who/When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Source: “Making Markets Work: Training Programme”; Bangkok 2016; The Springfield Centre

A policymaker and implementing partners need to make decisions on each of the following:
- **RC level and number**: List each anticipated result from the results chain against its respective ‘level’ (e.g. system change, growth/access, health outcome) and assign a number.

- **Indicators**: Clearly define each indicator including any assumptions that need to be validated in time.

- **Baseline and targets**: Using the data gathered during the diagnostic process, identify what baseline information is available for each indicator. List the projected estimates for each indicator.

- **Data Source**: Determine the source for each indicator; does secondary data exist or will the implementation partners need to produce primary data?

- **Method / means of verification (MOV)**: Determine appropriate methods to report on each indicator.

- **When, Who**: Decide who will collect the data, if the work can be conducted ‘in-house’ by the different implementing partners or ‘outsourced’ to others. Also, determine how frequently the data should be collected and reported.

Factors to consider when drafting a measurement that help balance ambition with realism include budgets, resources, and capacity.

ILLUSTRATING STEPS 2-5: **PREPARING A MEASUREMENT PLAN**

Now that the technical team, along with their respective monitoring and evaluation staff, have finalised the RCs, a section of the team that is focused on supply-side interventions convenes another ZOOM meeting to discuss the measurement plan. It is aware that time is slipping away and wants to be sure to quickly set up baseline data, as well as collect necessary data to measure progress.

Using the MRM template:

- The supply-side team assigns a number for and classification of each indicator.

- There is some discussion on how to define the indicators, but they agree on keeping them SMART.

- To its surprise, the team already has a lot of the baseline data needed thanks in large part to their hard work in collecting data to inform the diagnosis of the lab market system. Also, since private providers have not previously been authorised to test for COVID-19, the supply-side team realise it is starting at zero for many of the interventions focusing on increasing supply.

- Although the supply-side team wants 100% of relevant private providers to conduct COVID-19 tests, the private sector representatives consulted have pointed out that approximately 20% of providers lack the capacity to meet even the ‘relaxed’ accreditation standards. As a result, the supply-side team focuses its projections only on the 80% of accredited providers.
The supply-side team decides to keep the data collection process simple. It agrees to rely on existing data sources, such as the MoH Quality Department reports as well as MoH surveillance data. The challenge will be confirming if the MoH has accomplished its end of the bargain with the private providers. The team agree to survey the participating private providers using a simple online survey instrument to ensure the providers have the supplies they need and that their staff are adequately trained. However, MoH surveillance department staff are quite vocal about the private sector under-reporting disease data. The private sector groups push back, complaining about the cumbersome and time-consuming nature of the required reports. At the request of the supply-side team leader, the MoH surveillance team and the private lab association agree to hold a side-bar conversation to develop a streamlined reporting system, as well as identify other strategies to enhance private sector reporting.

The supply-side team will present their MRM to the demand-side team on tomorrow’s ZOOM call.

<table>
<thead>
<tr>
<th>RC level / #</th>
<th>Indicator/ Definition</th>
<th>Baseline</th>
<th>Target</th>
<th>Source</th>
<th>Tool(s)/MOV</th>
<th>Who/ When</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Guidelines distributed to accredited private labs # of MoH trainings performed</td>
<td>0</td>
<td>100% of contracted</td>
<td>Private labs</td>
<td>Survey Monkey</td>
<td>MoH Quality Dept/ Bi-weekly during months 1 &amp; 2</td>
</tr>
<tr>
<td>9</td>
<td>Streamlined accreditation rules approved</td>
<td>0</td>
<td>1</td>
<td>FDA/Lab Council licensing data base</td>
<td>Lab Council reports</td>
<td>End of Month 1</td>
</tr>
<tr>
<td>11</td>
<td>No. of vouchers issued (100% of target population have a voucher)</td>
<td>0</td>
<td>Month 1: 35% Month 2: 75% Month 3: 80%</td>
<td>Target population</td>
<td>CSO voucher tracking reports</td>
<td>CSOs/Bi-weekly during months 1-3</td>
</tr>
<tr>
<td>12</td>
<td>No. of newly accredited private labs (80% of total# of private labs)</td>
<td>0</td>
<td>Month 1: 35% Month 2: 75% Month 3: 80%</td>
<td>Private labs</td>
<td>FDA/Lab Council Licensing data base</td>
<td>Lab Council reports/ Monthly during Months 1-3</td>
</tr>
<tr>
<td>13</td>
<td>No. of accredited private labs contracted to perform COVID-19 tests</td>
<td>0</td>
<td>Month 1: 35% Month 2: 75% Month 3: 80%</td>
<td>Private labs</td>
<td>Private Lab Association contract tracking report</td>
<td>Private Lab Assoc./ months 1-3</td>
</tr>
<tr>
<td>14</td>
<td>Increased knowledge of COVID-19 tests</td>
<td>0</td>
<td>75% of interviewees answer questions correctly</td>
<td>Recipient survey</td>
<td>Mobile app surveys Focus Groups Outreach Meetings</td>
<td>CSO’s/Conduct all MOV’s in Months 2 &amp; 3</td>
</tr>
<tr>
<td>17</td>
<td>No. of tests performed by accredited &amp; contracted labs (% of total population)</td>
<td>0</td>
<td>Month 1: 35% Month 2: 75% Month 3: 80%</td>
<td>Private labs</td>
<td>MoH Disease surveillance reports</td>
<td>MoH / Daily surveillance reports</td>
</tr>
</tbody>
</table>
STEP 6: Keep all key market players partners engaged

The purpose of MRM is to inform management of an inclusive implementation process on progress and performance. If the implementing partners do not use the data to inform decision-making, then it does not matter how good the monitoring system/approach is and it has failed its primary duty. How the MRM data is presented – language, complexity, detail – plays a critical role in informing and responding to the management decision-making structures and processes. Technical rigour underpins the data validity, but it is important to remember that many of the implementing partners using the data will likely have different skill sets and technical abilities. Understanding these, and the processes through which decisions are taken will inform the nature, format, and format of key data outputs.

Performance monitoring is also an important tool for fostering experimentation, encouraging learning and sustaining momentum – all part of modulating the inclusive implementation process. A market system strategy is comprised of several interventions. Not all market interventions will work as planned and only a few will generate the type of system change or health impact hoped for. Partners must therefore be prepared to make tough but informed choices and discontinue a market intervention in response to market signals. This requires a change in mindset – albeit a difficult one – that accepts trial and error and learns to support rather than blame when an intervention fails. Although partners may learn to experiment, often they take too long to decide to stop a failed market intervention (see Figure 5.7).

FIGURE 5.7: Portfolio management of a market strategy

It is important that the partner organizations perceive visible change otherwise they may lose interest in participating in the market strategy. Constant monitoring, assessment and adaptation of the collective group’s efforts is one of the best ways to ensure momentum. Because changes in health market systems take time and results are often gradual, it is important to celebrate both the ‘small’ and ‘large’ victories along the way. Celebrations keep implementing partners energised and motivated. Announcing these successes also builds support in the implementing partners’ collective action, thereby creating legitimacy for the market strategy and its goals.
ILLUSTRATING STEP 5: WHERE DID WE GO WRONG?

The Testing Pillar team convenes the extraordinary meeting with all the implementing partners to discuss key bottlenecks and to propose solutions to address them. Three months since the Testing Pillar Strategy was officially launched, the Deputy Minister convenes the first ever monitoring meeting to assess progress. In this meeting, she learns of some challenges in data collection.

- The MoH does not have an up-to-date list of all the licensed private labs - particularly those located outside of the capital city. But the Private Lab Association Executive Director does have these data - and these are used to develop a comprehensive inventory of all licensed providers.

- The Private Lab Association has already conducted a ‘quick and dirty’ inventory of each private lab’s infrastructure, equipment, and staff as a proxy to assess quality. He shares this inventory with the Directors of both the MoH Quality Department and the NIPH’s accreditation staff.

- Private providers were not responding to the bi-weekly survey, so the Private Lab Association Executive Director has stepped in. He has assigned one member of his staff to call each one of the accredited providers every other week to collect the required data. The staff member puts the data in an excel sheet and sends it to MoH Quality Department.

- After a few weeks of back and forth between the MoH disease surveillance and the Private Lab Association teams, they finally agreed on a ‘work around’, allowing the private providers to use a web-based interface to directly input their data without having to give them security access to the MoH disease surveillance data system.

- The CSOs are struggling to keep track of their outreach activities and the numbers of vouchers distributed. The Deputy Director makes a mental note to talk with her HMIS team to see if they can help the CSOs collect the data in time for the monitoring meeting and then work out a more long-term solution.

- Such feedback is highly encouraging. While there are some areas requiring improvement, all agree that a lot is going well and exceeding expectations. However, in spite of this good progress, the team is stopped in its tracks when they hear a most disturbing finding: newly accredited private providers have tested only 30% of voucher-holders - not the 80% anticipated by this time.

- The Testing Pillar team responsible for mobilizing demand is also puzzled. They decide to ‘track back’ through their RCs to see where any breakdown(s) might be. They obtain the following results:

- 100% of the vouchers have now successfully been distributed, and ‘spot tests’ confirm that they’ve (very largely) gone to the intended recipients.
Phone surveys with recipients confirm an appropriate level of awareness and understanding of voucher use, where to get tests, and the value in getting a test. They are all very positive.

The Private Lab Association has facilitated good awareness and understanding of the new accreditation rules and arrangements; and understanding of the voucher programme (who, where, and how many).

Initial bumps in the road in motivating the NIPH accreditation staff to get out there and assess / accredit eligible labs have been overcome and the number of accredited labs now approximates the targeted number.

All newly accredited providers have been successfully issued with MoUs to participate in the voucher scheme.

Armed with these results the team is even more puzzled. The interventions have been delivered to plan – so why are tests only at 30% not 80% by the end of the third month of the programme? An urgent stakeholder focus group discussion is arranged for the morning. During the discussion, it becomes immediately apparent what the problem is – that many of those with vouchers have been unable to attend the facilities to receive the tests. Many reasons are given for this – the top three being illness/infirmity, costs and limitations of travel (in many cases public transport availability has been curtailed), and lockdown restrictions meaning people can’t reliably travel to or from the home within curfew hours. Quickly, they move on to brainstorm possible solutions:

**Option #1:** Adding the cost of transportation to the voucher value.

**Option #2:** Setting up satellite sites in public facilities located in or near the target communities.

**Option #3:** Establishing mobile testing sites using existing private sector laboratory infrastructure and staffing.

The Deputy Minister creates a small task force to explore the potential of each of these options. It will report back to the larger group early next week. But it is clear to all the implementing partners that they will have to adapt their strategy soon to reach their target numbers in testing.

The small task force returns the following week with their proposal. They have consulted across all relevant implementing stakeholders to discuss the Five Factors for the analysis of each of the options (recall that these are: (i) the nature of the market, (ii) its history and momentum, (iii) the insights provided by innovations in comparable contexts, and the (iv) incentives, and (v) capacities of the players implicated in the vision of the future). After much internal discussion, the group selects Option #3: establishing mobile test sites. They return to the RCs to ‘install’ a new RC for this new workstream, and to ensure that it fits to the overall logic of the strategy. They are confident that this additional intervention will see tests rapidly increase in alignment with targets.
OUTCOMES

24. Family income sustained and economic resilience strengthened
25. Community transmission reduced
26. COVID-19 related mortality and morbidity reduced
27. Impact on essential health services minimized

ACCESS

20. Turnaround time on negative test results improved
21. Use of high-quality COVID-19 lab tests increased
22. Isolation of infected patients quicker and more effective
23. Referral of infected patients quicker and treatment started sooner

MARKET SYSTEM

15. Number of mobile lab testing facilities increased
16. Number of accredited private labs increased
17. Supply of high-quality COVID-19 lab tests increased
10. Contract btwn private labs and CSOs established and operational
11. Private labs understanding and awareness of new regulatory rules and guidelines increased
12. Accreditation rules simplified and operational
13. CSOs market private lab COVID-19 testing services effectively
14. Vouchers to target population groups distributed
5. MOH brokers a contract between private labs and CSOs
6. MOH shares and trains private labs in clinical standards and guidelines
7. MOH reviews and implements simplified accreditation rules
8. CSOs support private labs to develop marketing strategies
9. MOH covers test costs through issuance of vouchers

ACTIVITIES

1. Increase number of mobile lab sites
2. Increase number of accredited private labs
3. Increase-target population understanding of and willingness to use COVID-19 lab testing services
4. Increase-target population ability to access COVID-19 tests

INTERVENTION AREAS

18. Target population understanding of and willingness to use COVID-19 lab testing services increased
19. Financial barriers to increase target population’s access to COVID-19 lab tests removed
20. Turnaround time on negative test results improved
21. Use of high-quality COVID-19 lab tests increased
22. Isolation of infected patients quicker and more effective
23. Referral of infected patients quicker and treatment started sooner
24. Family income sustained and economic resilience strengthened
25. Community transmission reduced
26. COVID-19 related mortality and morbidity reduced
27. Impact on essential health services minimized

NB: Private labs redeem vouchers which provides a steady revenue, eases working capital concerns, increases bank’s confidence in offering credit, and ultimately means private labs have the financial resources necessary to reinvest in essential testing inputs and service delivery.
Evaluation – Fostering Accountability and Improving Policy

Evaluation is primarily concerned with issues of accountability and informing policy. Evaluation entails ‘tracing down’ through the SLM focusing on the links between outcomes and impacts (health outcomes).

- Did health outcomes improve?
- If yes, did they improve because the un/underserved population groups have increased access to the target health markets?
- If yes, did the market system change because of government – and other actors’ interventions?

The answers to these questions deal with complex issues of causality and attribution. Figure 5.8 presents a stylised example of this process. For example, in our case study example of the COVID-19 testing market system in Country X, having implemented an ambitious program to contract private labs and mobilise target population, the government expected big success. Indeed, the health ministry made some dramatic policy reforms such as greatly simplifying accreditation, contracting for health services for the first time ever, and setting up a voucher program, all in record time. But target community members were not redeeming voucher in the private labs and as a result, the number of tests and referral to contact tracing staff are not occurring. The government could not expect a decline in COVID-19 cases; and if there was it couldn’t be as a result of increased testing.

**FIGURE 5.8: A stylised example of a results chain for COVID-19 case**

- Health Impact
  - Reduced incidence of COVID19 cases
  - Isolate and treat COVID19 cases
  - Redeem vouchers

- Access Impact
  - Increased awareness
  - Eligible labs perform # tests

- System Impact
  - Distribute vouchers
  - Contract eligible labs

- Intervention
  - Mobilize target groups
  - Reform accreditation

Then there is no attribution to the market strategy, even if number of COVID19 cases has decreased

...but if use has not increased...?

Intervention may appear ‘successful’
Evaluation is the process of tracing, exploring, explaining, and attributing. In this case, the focus of evaluation is not if a new drug or treatment, for example, is better than another. Instead, the focus of evaluation is if (and how) a new set of institutional arrangements are leading to increased access to improved health market systems and if this is driving improvements in health outcomes.

A market system strategy must be able to (a) measure causality from interventions to health outcomes via system-level changes and (b) isolate the impact of the market interventions from wider influences. Yet measuring ‘causality and influence’ is a challenge. When measuring indicators, the further they are from the point of intervention, the weaker is the degree of causality and/or attribution due to increased likelihood of interference from external influences. These factors can be addressed but there are implications such as:

- **Methods**: More complex experimental methods are often required to demonstrate causality.
- **Cost**: Increased complexity, combined with a wider scope of investigation, adds to cost and resource requirements.
- **Time**: when you do it, and how often you do it practically in terms of time lags between outputs, outcomes, and impacts; and procedurally in terms of method / cost considerations.

Figure 5.9 illustrates how to balance credibility with practicality in achieving ‘plausible attribution’. A policymaker should invest in rigorously demonstrating impact at the systems level while estimating contribution, with transparency, at the outcome level.

**FIGURE 5.9: Balancing credibility with practicability**

- **Prove**
  - MRM system and reporting that supports the measurement and attribution of outputs, outcomes and impacts
  - Validate causality reasonably
  - Demonstrate results rigorously

- **Estimate contribution transparently**

- **Intervention**
  - Improve MRM system and practice that supports ‘real time’ intervention monitoring, learning and adjustment
  - Increased access to improved healthcare at affordable costs
  - Improved performance of mixed health markets
  - Improved Health Outcomes
Different approaches and different methods

As a policymaker and his/her team move along the ‘improve-to-prove’ spectrum, there are also different types of evaluation approaches (see Figure 5.10). Proving requires a ‘higher burden of proof’. Two of the most common evaluation approaches include:

- **Process evaluation** is typically conducted at key strategic timing points during the market intervention. They are typically independent and led by external parties. A process evaluations primary purpose is learning and adapting and applies the findings to influence how and where future market interventions investments are made.

- **Impact evaluation** is concerned with ‘before’ and ‘after’ market intervention’s effect. An impact evaluation can inform future policy and future market design and investments. But given that an impact evaluation’s findings are made post-market strategy, they cannot influence strategy during implementation.

![FIGURE 5.10: Typology of evaluation approaches](image)

A policymaker needs to be clear on the purpose of any evaluation. Do you want to influence ‘real time’ market intervention implementation? Or are you more concerned with ex-post evaluations that can aid reflection and debate in a more ‘neutral space’ and hence can better inform future policy and new market strategy design. Figure 5.11 illustrates different evaluation approaches based on objectives: causality versus generalisability. Please note two points in particular:

- Causality is focused on linking change to intervention; and
- Generalisability is focused on extrapolating findings across a whole population.
FIGURE 5.11: Different data collection methods

- **Case Studies**: Detailed analysis of particular cases to assess specific causes of change.
- **Experiment**: Comparisons made between two groups - one consuming and another not consuming services; sample surveys; analysis open to statistical analysis.
- **Quasi-experiment**: A collection of techniques such as FGDs, semi-structured interviews, asking “what if” questions, and information with secondary sources.
- **Participant Judgement**: Asking participants themselves to estimate change on a ‘before and after’ basis without taking wider effects into account systematically.


As one moves from generalisability to causality, research methods move from qualitative to quantitative - from ‘voice and expression’ to ‘numbers and aggregation’. Both are valid approaches, but they do different things and do things differently. Purpose and balance are the watchwords in choosing an evaluation method.

**Consumers are the final evaluators – so listen!**

It is important to remember that the primary purpose of managing markets is to put the un/under-served population groups at the centre of all government reform efforts. It is therefore appropriate to end the course with thinking about **patients**. Delivering on the promise of UHC entails increasing access to quality healthcare with financial protection to un/under-served population groups. All monitoring and evaluation efforts consider: Have things changed? How have they changed? What difference has change made? As policymakers approach policy formulation, intervention design, complex implementation, it is easy to forget about those whose lives one hopes to improve.

Remember: consumers are the final evaluators... so it is important to listen to them!
EPILOGUE

A year has passed since the Deputy Ministry created the MoH technical team to diagnose key problems in the laboratory and diagnostic market system, and to design a strategy and a portfolio of interventions to address these.

The Testing Pillar has been successful. This success has been instrumental in helping the government to monitor the pandemic’s evolution, to separate those infected from those susceptible to infection, to contact trace and decrease transmission to low levels. The country is now reporting few cases, and zero deaths during the last month. The government of Country X has been able to contain COVID-19 using this strategy. Recently, technological developments have led to the availability of cheap tests, costing just over $1. With financial barriers now very low, the voucher programme is on the brink of being discontinued.

During a meeting of the MoH’s senior managers, the Minister proposes that the Deputy Ministry should now focus on revitalising the country’s UHC strategy. The centerpiece of this will be an expansion of the NHIF, underpinned by substantial government funding. This will cover more benefits for more people and ensure that essential health products and services are accessible, effective, and affordable wherever patients seek them. Given the constraints in the public sector delivery system, the Deputy Minister knows that a market systems approach will be required to achieve this.

Fortunately, due to the experience of the Testing Pillar, an effective PPD process has become institutionalised. The MoH and its partners took a problem-driven approach to responding to the acute phase of the COVID-19 outbreak. This was underpinned by a systematic analysis of key challenges, and a logical approach to addressing them. They also established a new set of relationships within the country – spanning organizational and sectoral divides – to implement the approach, and to measure performance against targets.

The MoH and its partners took ownership of the problem, found feasible and effective solutions, and built the relationships necessary to realise them. The Deputy Minister leaves the meeting with her boss excited about the chance to return to the task of building a sustainable UHC strategy. And, in addition, the next time a public health crisis hits, she knows that she and her colleagues will be ready!
In this course, we have provided detailed guidance on the Diagnosis of key health market system problems, the Design and Delivery of problem-driven strategies to address them, and the Detection of outcomes – from the perspective of access, quality and financial protection. We have NOT provided an exhaustive account of how to execute specific types of interventions. Instead, we have provided a set of principles on which to develop your own ideas as you diagnose problems, design, and implement market interventions, measure, learn, and accelerate progress towards your goals.

In closing, we wish to highlight the following as the key messages from the preceding chapters.

MESSAGE 1: Engage multiple stakeholder groups to drive forward change in the health market system

Countries recognise that engaging the private health sector can add resources, expertise, and value to market system strategies. Hence, the correct unit of analysis when considering how to address health policy challenges is not the public healthcare network, nor is it the private healthcare network; it is the market system in which the full range of players relevant to a problem interact.

MESSAGE 2: Good interventions are about tackling root causes, not symptoms

The Pathway to Impact focuses on identifying and pursuing root causes rather than symptoms of market system limitations. Through an inclusive diagnostic process,
policymakers can: (i) identify the market systems most relevant to UHC challenges and assess opportunities for improvement, (ii) understand which supporting functions and rules are needed for identified market systems to perform well, (iii) evaluate underlying reasons for the absence of underperformance of the existing complement of supporting functions and rules, and (iv) prioritize among the different health market systems before action is taken.

**MESSAGE 3: Any effective market system strategy’s must be based on a realistic vision of a well-performing health market system**

In the design stage, decision-makers must create a transparent vision of a desirable future – a well-performing health market system – by defining who will do, and who will pay. This future vision identifies the new institutional arrangements that will drive improved performance in the market. Through assessment of the ‘Five Factors’, market players’ incentives and capacities are identified, and a realistic and feasible vision of the future is derived. Key elements of this are the government’s facilitative role in the market, an understanding of its capacity and limitations, and the use of tools of government to stimulate changes within the system.

**MESSAGE 4: A market system approach requires meaningful and sustained cross-sector collaboration**

A formal, inclusive process can have a significant positive effect, increasing and improving interactions between the public and private sectors, thereby enhancing mutual understanding and trust. For many countries, inclusive processes have been initiated in some form, but there is usually scope to build upon and refine these following the good practices outlined in the Deliver chapter – which presents the real ‘software’ of the Pathway to Impact. In this new governance style, relationships matter, and governments must invest in the new roles and skills required for policymakers play the role of leader and facilitator.

**MESSAGE 5: Make learning a central objective of market system interventions**

In a market systems approach, the emphasis is on both the outcomes from and the learning enabled by implementation of the intervention. The experimental approach to implementation and measurement encourages policymakers to constantly scan the environment, identify changes in the market system as they emerge, test and
modify assumptions, measure progress and proactively look to identify unintended consequences (good or bad!) as the intervention rolls out and evolves. This learning approach implies that good diagnostic work is needed throughout the life cycle of the market system strategy.

**MESSAGE 6: The experimentation approach to implementation requires a change in mindset – albeit a difficult one**

It is inevitable that some interventions will succeed while others will fail. Implementing partners should not regard this as failure. Instead, implementing partners must be prepared to make tough but informed choices to discontinue an intervention in response to the data. This change in mindset accepts trial and error – and learns to support, rather than blame, when an intervention fails.

**MESSAGE 7: Policymakers must play an instrumental role as stewards of health sector and facilitators of health market systems**

The Pathway to Impact clearly demonstrates the six governance behaviours (build understanding, deliver strategy, enable stakeholders, foster relations, align structures, and nurture trust) needed to effectively manage health market systems of the larger mixed health sector. Embracing these governance behaviours, as well as a health market facilitation approach, inspires – and indeed requires – a new way of governing the health sector.

**MESSAGE 8: The Pathway to Impact lays a solid foundation for achieving UHC**

Although our case study has focused on COVID-19 testing, the principles of MM4H that are realised through applying the Pathway to Impact can be used to address any problem in the health systems domain. We wish you good luck in all your future market system endeavours!
APPENDIX: DATA COLLECTION METHODS & GUIDANCE

Introduction

Chapter Two has outlined the diagnostic process— with key frameworks that help make sense of the ‘messiness’ of real market systems in health and the problems that relate to them. However, methods are needed to generate information to populate the frameworks and ensure these are practically useful for actual decision making in the local context. These methods are our focus in this appendix.

Data on health markets—and the private health sector in particular—is typically limited in most countries, for several reasons:

- Government commonly has the attitude that the private sector is ‘someone else’s problem’, and this means that data on health markets is not regarded as a priority,
- Development partners often do not recognize the private sector’s role in the health system, and therefore do not routinely collect data on its activities,
- Government agencies may not have the systems or staff to undertake the necessary data collection,
- Government often lacks the capacity to analyze data on the private sector and its activities,
- On the private sector side, providers often do not report to the Ministry of Health—for various reasons, including fear of increased taxation and/or government scrutiny of their operations and activities, and
- Lack of reciprocity (i.e. government often does not share information with the private sector—on policy reforms, regulatory changes and standards—and this might create an unwillingness within the private sector to do so).

This appendix organizes common methodologies used to generate important data on health markets, with a focus on those data that can support the diagnostic process. They are organized by supply and demand:

- **Supply-side assessments:** These include general landscape tools which seek to generate descriptive data—who, where, how many, with what type of capacity—and tools that are more evaluative in focus, and concentrate on issues of service availability and performance; and

- **Demand-side assessments:** There is a wide range of consumer and market research tools that are intended to reveal a consumer’s pathway to a specific health product/set of services, and to probe more deeply into issues such as consumer preference and ability and willingness to pay (i.e. demand).
Supply-Side Assessments

General Landscaping Tools

Using tools such as Private Sector Assessments, or Market Scoping Exercises, we can understand the general landscape of the market. These tools generate general ‘census-type’ data on the size and scope of private sector provision – the rationale being that if we wish to influence private sector operations towards public health goals, we need to have some basic information and data on the sector. This descriptive data provides a critical first step to understanding the role, size and scope of private sector provision within a market system. Therefore, the type of data gathered through such tools usually includes findings related to, for example:

- The public-private mix in terms of health facilities, pharmacies, and medical labs;
- The public-private mix of supply chain functions (manufacture, wholesale, distribution etc.);
- The public-private mix of human resources in health, by cadre and geographic location;
- The public-private mix of health training institutes;
- Health financing trends, including private out-of-pocket expenditures (overall and by market system); and
- The public-private mix of facilities, staffing, etc. in key disease areas or health themes.

General landscape assessments rely on different sources of data, including:

- Published literature, government documents and existing data sets,
- Health ministry data from different departments on facilities, human resources, health training institutes, etc.,
- Key informant interviews, including interviews with private sector representative bodies and stakeholders,
- Field visits to private facilities across all relevant geographies, and
- Secondary analysis of demographic health surveys, national health surveys and living measurement surveys.

For a comprehensive list of the data sources for a private sector assessment, please consult Table A1 below. In addition, governments may wish to conduct two different types of facility census: Service Provision Assessment (SPA) and Master List Facility Census.

Service Provision Assessment (SPA)

This tool provides an assessment of a country’s health service delivery system. Using a representative sample of both public and private health facilities, the SPA team collects information on the overall availability of different facility-based health services in a country and their readiness to provide those services. The inventory questionnaire collects information for the calculation of service readiness indicators. A first step for governments seeking to do market systems analysis is to check if the SPA has been completed in the last five years and if it includes non-state facilities; if not, then a Master Health Facility List and/or Facility Census (see 3) can supplement the data in the SPA.
SPA surveys answer four broad groups of questions (see Box A1 for health service foci):

- What is the availability of different health services in a country? Specifically, what proportions of the different facility types offer specific health services?
- To what extent are facilities prepared to provide health services? Do facilities have the necessary infrastructure, resources, and support systems available?
- To what extent does the service delivery process follow generally accepted standards of care? Does the process service delivery process meet acceptable quality standards and content?
- Are clients and service providers satisfied with the service delivery environment?

### Master Health Facility List and/or Facility Census

Increasingly district health managers and health professional councils are hiring local research firms to conduct a facility census to enable them to count and track the number and type of health facilities in a specific geographic area. The rationale for conducting a private sector facility census is to better understand the size, scope, characteristics, and geographic distribution of private health facilities to inform policy and program design. Census findings can also facilitate greater private sector dialogue on gaps in areas such as infrastructure, capacity, and training of private facilities, and to develop joint solutions to overcome these challenges. Finally, census data can foster collaboration not only between the public and private sectors, but among the private providers themselves.

The census may take a broad approach and gather data from the entire private sector, or it may take a more targeted approach and focus on a geographic area or health area. While public health facilities can be included in the census, it is usually unnecessary because a health ministry has up-to-date and reliable information on that part of the system. However, many health ministries are combining information on both sectors to create a comprehensive data set and facility map to better understand levels of access to services in the targeted areas. In addition to providing a complete picture of the number and type of health facilities, a private facility census can provide information on the private health sector’s overall composition, distributions, strengths, and most pressing gaps and need.

The type of facility census depends on the level of effort required to identify and gather local information within the geographic area. In addition, the breadth and depth of the questionnaire also drives cost. A comprehensive, nation-wide private facility census may be as costly as a SPA and take as much time. Still, a comprehensive census is often worth the time and expense – and most are feasible, costing only one-to-three times as much as a sample survey, yet providing much more data.

Moreover, if converted into dynamic web-based platform, a health ministry can continuously update the census information and use this as one of several governance tools to regulate the private sector. See Box A2 for an example.

## Box A1: SPA survey focus areas

- Infrastructure, Resources and Systems
- Child Health
- Maternal and Newborn Health
- Family Planning
- HIV/AIDS
- Sexually Transmitted Infections
- Malaria
- Basic surgery
- Non-communicable diseases
BOX A2: Using census data to target treatment in Malawi

Diarrhoea is a major risk to children’s health in Malawi. According to the 2010 DHS, 17.5 percent of all children under five had experienced an episode of diarrhoea in the two weeks preceding the survey. In 2012, the Malawi Ministry of Health adopted the WHO guidelines recommending the use of zinc along with ORS for uncomplicated diarrhoea. However, most private sector providers did not have access to the new guidelines, nor was there any information on private providers who had received training.

With assistance from USAID, the Malawi MoH conducted a facility census that included questions on diarrhoea management (as well as many other areas). The map on the right shows all the private facilities along with the portion of health providers in each facility who received training in ORS and zinc at the time of the survey.

Analysis of the data revealed that a large percentage of private providers in Malawi’s most densely populated areas had received no training on the use of ORS and/or zinc. The analysis allowed the MoH to target its training where the need was greatest – and to reach out to these facilities to provide training alongside supplying them with donated ORS and zinc.

Source: Johnson, D et al., 2015.

Demand Side Assessments

Health care consumers take an active role in their healthcare. They make daily decisions on the urgency or perceived threat of illness and where they can receive cost-effective care (in terms of money, time, and effort). In addition, health care consumers consider gender and family structure of the sick person in his/her decision making. A policymaker can no longer assume that ‘if I build the clinic, the patients will come’. They need to understand the dynamics of consumer choice, loyalty, and decision-making processes in the market for specific or general health products and services. Yet, in many countries, Ministries of Health often overlook consumer research as part of the diagnostic process.
There are different types of demand side assessments, with different methods of data collection. Some of these track aggregate data on patient pathways through a spectrum of ‘need-to-use’; while others seek to probe more deeply in an effort to understand and explain differential experiences in patient pathways – in particular by assessing service quality in detail. These two levels both concern consumer market research – but at different levels of detail. The aggregate, ‘what is going on’; and the disaggregated ‘why’ responses.

In general, consumer research explores a consumer’s needs and expectations for the health product or service and learns about his/her journey across stages of awareness, decision-making, access and use. The research identifies the barriers preventing the consumer from using the product or service in question, and the key motivators that encourage them to do so. These insights help a policymaker identify the most pressing challenges and opportunities faced by the consumer.

While there are many ways to perform such research, most organisations use one or more of the basic research methods described below. The type of data you need and how much you’re willing to spend will determine which techniques you choose to meet your requirements. It is important to note that the demographic data and DHS analysis in the first layers of demand-side analysis can provide some preliminary notions on where consumers seek health services and products in the public and private sectors. Yet they cannot reveal a consumer’s pathway to a specific health product or service, nor the decisions that he or she makes along the way. For these insights, policymakers need to invest in proper consumer research.

Some options for this include:

1. **Surveys**: Surveys use concise and straightforward questionnaires to analyse a sample group that represents the targeted market. The larger the sample, the more reliable the results. There are many ways to survey large groups of health consumers: in-person surveys, telephone surveys, mail surveys, and online surveys. Given the challenges in developing countries, the most common approach is in-person surveys. These one-on-one interviews are typically conducted in high-traffic locations such as high-volume clinics, maternity wards and hospitals. In person surveys can generate response rates of more than 90 percent, but they are costly.

2. **Focus groups**: In focus groups, a moderator uses a scripted series of questions or topics to lead a discussion among a group of people. These sessions take place at neutral locations, usually at facilities with videotaping equipment and an observation room with one-way mirrors. A focus group usually lasts one to two hours, and it takes at least three groups to get balanced results.

3. **Personal interviews**: Like focus groups, personal interviews include unstructured, open-ended questions. They usually last for about an hour and are typically recorded. Focus groups and personal interviews provide more subjective data than surveys. The results are not statistically reliable, which means that they usually don’t represent a large enough segment of the population. Nevertheless, focus groups and interviews yield valuable insights into customer attitudes and are excellent ways to uncover issues related to new products or service development. (See box A3).
BOX A3: Importance of understanding consumer demand: Jacaranda Maternity Services, Kenya

In Kenya, the most recent DHS showed evidence of improved access to institutional delivery. However, the data also showed that poor women living in peri-urban communities had difficulty accessing such services, as evidenced by the high maternity rates and high percentage of women still delivering at home. To address this challenge, health officials, with the assistance of a DfID-funded project, conducted consumer research and a market study. The market study dispelled many commonly held myths such as, all Kibera residents were poor and that access was not an issue because of the numerous public and private health facilities in Nairobi. The research found that the residents living in Kibera were heterogeneous with multiple income levels; they had different health-seeking behaviors influenced by cultural practices and aspirations influenced by their villages of origin; male partners played a major role in family health-seeking and health spending behaviors and were regarded as the primary decision-maker in many aspects of maternal health; and finally, many families used both public and private health facilities – depending on the illness and who in the family was sick.

The market study revealed that Jacaranda offered high quality maternity services; nevertheless, they struggled to bring in a sufficient number of clients to break-even. The DfID project helped Jacaranda address some of the obstacles, including marketing campaigns to raise awareness on its services, break-even analysis to estimate service mix and patient volume load, and costing study to explore cost savings to reduce prices. Ultimately these market interventions did not work because the most important obstacle was never addressed – linkages to a public hospital to manage emergency obstetrics. Without this guaranteed referral, many women did not want to take the risk.


4. Observation: Individual responses to surveys and focus groups are sometimes at odds with people’s actual behaviours. When you observe consumers in action by videotaping them in stores, at work, or at home, you can observe how they buy or use a product. This can give you a more accurate picture of customers’ usage habits and shopping patterns.

5. Field trials: Placing a new product in a selected health centre or pharmacy to test customer response under real-life selling conditions can help make product modifications, adjust prices, or improve packaging. Similarly, testing consumer response to a new health service and/or restructuring of a health facility can also provide useful insight.

6. Use-to-need Gap Analysis: A particular focus for Population Services International (PSI) is the application of Use-to-need Gap Analysis to understand consumer dynamics in more detail. Its purpose is to identify where use is inadequate, and to try to identify the causes of this. The utility of this tool is highlighted through the example on hypertension in Myanmar shown in Box A4.
BOX A4: **Use-to-Need Gap Analysis: An application to hypertension in Myanmar**

In this case, an analysis of use and need across the patient pathway was undertaken to shed light on where to target their interventions. The starting point was to recognise that, with hypertension, public health impact would require patients to achieve control of their blood pressure. To achieve control, patients need to be diagnosed as hypertensive, go onto treatment, and adhere to their treatment regimens. In addition, providers needed to prescribe effective drug regimens. Using data from a survey the team calculated use and need as:

- **Need:** 6.2 million people living with hypertension in Myanmar
- **Use:** 606,000 people living with hypertension who have their blood pressure under control
- **Gap between use and need:** 5.6 million people living with hypertension who do not have their blood pressure under control

By identifying the gap between **Use** and **Need** across treatment areas, the team was able to understand where further investigation was needed. Rather than focusing on screening new patients as originally planned, the team shifted its focus to target ways to increase the number of people on treatment and to identify the reasons why people on treatment were failing to achieve control.

In cases such as this, detailed consumer research is needed to understand users’/ non-users’ perceptions and expectations of the products and services in question. In this case, a range of such include:

7. **Usage, Attitude, Image (UAI) market studies:** UAI studies help generate information on a variety of different issues. Firstly, the UAI survey provides information on the percentage of consumers who know about the service (awareness), the percentage of consumers who are aware of the service and have tried it (reach), and the percentage of consumers who have tried the service and continue to use it regularly (retention). Secondly, it can show the rate of consumer adoption of a service — that is, how fast the service is accepted by consumers (and hence if/what potential demand stimulation measures might be required). Thirdly, personal and business information about survey respondents can help a practitioner identify who is using; and who is not using the service. This helps decide whether the challenge lies in better marketing of existing services; or modifying the service to better meet (un)met needs.

8. **Product concept and price sensitivity tests:** The aim of a product concept test is to learn what consumers think of the service idea and get feedback so that improvements can be made, and market penetration deepened. A product concept test helps a practitioner learn whether users / potential users understand and want the benefits offered by the service and its features. Offering a price sensitivity test together with a product concept test provides information on how much consumers will pay for the service as they understand it.
### TABLE A1: Data Sources for Private Sector Assessments and Market Scoping Exercises

#### Population, Health, and Nutrition Data

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic Health Surveys</strong></td>
<td><strong>DHS</strong> is a population-based surveys supported by USAID that provide data on health-seeking behaviour for priority health areas, including family planning, HIV and AIDS, and maternal and child health. Available on the <a href="https://dhsprogram.com">Demographic and Health Survey Program</a> (formerly MEASURE DHS) website.</td>
</tr>
<tr>
<td><strong>AIDS Indicator Surveys</strong></td>
<td><strong>AIDS</strong> provide demographic and HIV-related information for high-prevalence countries, with support from USAID. The data are structured similarly to DHS data. Available at <a href="https://aidsindicator.org">AIDS Indicator Surveys</a>.</td>
</tr>
<tr>
<td><strong>Service Provision Assessments</strong></td>
<td><strong>SPA surveys</strong> also funded by USAID to capture information about levels and types of health facilities and limited measures on quality of care. The extent to which private health facilities are included in an SPA is often based on the existence (and robustness) of a registry of such facilities. Available on the <a href="https://dhsprogram.com">Demographic and Health Survey Program</a> website.</td>
</tr>
<tr>
<td><strong>World Bank Data</strong></td>
<td>The World Bank <a href="https://datacatalog.worldbank.org/">Data Catalog</a> provides download access to over 8,000 indicators from World Bank data sets.</td>
</tr>
<tr>
<td><strong>World Bank HealthStats</strong></td>
<td>Comprehensive database of health, nutrition, and population statistics—over 250 indicators, as well as background information on poverty, labor force, economy, and education. Users can access data by country, topic, or indicator, and view the resulting data (and wealth quintiles) in tables, charts, or maps. Available at <a href="https://data.worldbank.org/health">World Bank HealthStats</a>.</td>
</tr>
<tr>
<td><strong>WHO Data and Statistics</strong></td>
<td>The World Health Organization’s portal offers data, statistics, and analyses organized according to a number of issues and themes, including health systems.</td>
</tr>
<tr>
<td><strong>PubMed/MEDLINE</strong></td>
<td>From the United States National Institutes of Health, database of more than 22 million citations for biomedical literature from MEDLINE, life science journals, and online books. Citations may include links to full-text content from PubMed Central and publisher websites. It includes articles on demand- and supply-side characteristics, often country-specific. Click on <a href="https://pubmed.ncbi.nlm.nih.gov">PubMed/MEDLINE</a>.</td>
</tr>
<tr>
<td><strong>POPLINE</strong></td>
<td>Comprehensive collection of population, family planning, and related reproductive health and development literature. It is designed to help program managers, policymakers, and service providers access scientific articles, reports, books, and unpublished documents (gray literature). It includes evaluations and situation analyses. Click on <a href="https://www.poppubs.org/">POPLINE</a>.</td>
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</table>

#### Business Environment Data

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Doing Business Project</strong></td>
<td>This data base measures business regulations for local firms in 185 economies and selected cities at the subnational level. A project of the World Bank and the International Finance Corporation. Click on <a href="https://www.doingbusiness.org/">Doing Business Project</a></td>
</tr>
</tbody>
</table>

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| **World Economic Forum, Global Competitiveness Report** | An annual assessment of the competitiveness landscape of 144 economies, providing insight into the drivers of productivity and prosperity. Users can download the latest report or access the Global Competitiveness Index Data Platform to view and download data. |
| **International Institute for Management Development Competitiveness Yearbook** | Ranks and analyzes how a nation’s environment creates and sustains the competitiveness of enterprises. Click on International Institute for Management Development Competitiveness Yearbook |
| **National Health Accounts** | Country health expenditure information is available from the WHO website. Also check out country Ministry of Health’s website for most recent National Health Accounts reports. |
| **Living Standards Measurement Surveys** | The World Bank’s Living Standards Measurement Survey Finder provides data on household health expenditures. |
| **Public Expenditures Reviews** | Public health expenditure review demonstrate how government health resources are allocated and spent. Public Expenditure Reviews are diagnostic studies prepared to help countries establish effective and transparent mechanisms to allocate and use available public resources in a way that promotes economic growth and helps in reducing poverty. |

**Government Policies, Regulations, Reports**

| **Ministry of Health** | Most MoHs have their own website to access policy and planning documents. Key documents include: Ministry of Health Five Year and/or Strategic Plan; Health specific Strategies. Also many Professional Boards and Councils have their own websites to locate related policies, standards and regulations. |
| **Ministry of Policy and Planning** | Look for Gov’t development policies describing the role of health in a country’s overall growth and development. Also see if there is a private sector and/or PPP policy governing private sector engagement throughout government agencies. |

Source: Adapted from SHOPPlus Assessment to Action and O’Hanlon, B. How to Guide
## Appendix II - MM4H Worksheets

### WORKSHEETS: Diagnose

**DIAGNOSE/WORKSHEET 1: Key questions to select the market system to be prioritised for intervention**

<table>
<thead>
<tr>
<th>Question</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance of the market system to the priorities defined in NHSPPs</td>
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<tr>
<td>% of population lacking access to affordable, high-quality care within this market</td>
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<tr>
<td>Impacts of the lack of access on morbidity and mortality</td>
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<tr>
<td>Importance regarding time-sensitive goals, such as outbreak response</td>
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<tr>
<td>Potential for providing better access to goods and services available in the market</td>
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<tr>
<td>Prospects for ensuring higher-quality care in facilities where patients seek care</td>
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<tr>
<td>Opportunities to enhance financial protection against the costs of care</td>
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<tr>
<td>These prospects/opportunities compare favourably with other market systems</td>
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<tr>
<td>Government’s ability to define what it wants, and verify if this is being delivered</td>
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<tr>
<td>The state of government’s understanding of market players and structure</td>
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<tr>
<td>Willingness and ability of market actors to adopt change in line with UHC</td>
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<tr>
<td>Availability of counterpart(ies) with whom to consult, include, and negotiate</td>
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</tbody>
</table>
## DIAGNOSE/WORKSHEET 2: Evaluation of supporting functions and rules in the selected market system

<table>
<thead>
<tr>
<th>Illustrative Attributes</th>
<th>Present</th>
<th>Adequate</th>
<th>Matched</th>
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<tbody>
<tr>
<td>Supporting Functions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Information (demand-side)</td>
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</tr>
<tr>
<td>Information (supply-side)</td>
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<tr>
<td>Supplies, skills, and technology</td>
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<tr>
<td>Capital financing</td>
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<tr>
<td>Rules and Norms</td>
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<tr>
<td>Standards/guidelines</td>
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<tr>
<td>Regulations</td>
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<tr>
<td>Taxes/tariffs</td>
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<tr>
<td>Formal/informal norms</td>
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</tbody>
</table>

NOTES
DIAGNOSE/WORKSHEET 3: The Five Whys

CAUSE 1

CAUSE 2

CAUSE 3

CAUSE 4

CAUSE 5

NOTES
WORKSHEETS: Design

DESIGN/WORKSHEET 1: CURRENT PICTURE: Analysis of institutional arrangements in the selected market system

<table>
<thead>
<tr>
<th></th>
<th>Who currently does?</th>
<th>Who currently pays?</th>
<th>Absent, adequate, mismatch?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Market</td>
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<td></td>
</tr>
<tr>
<td>Supporting Functions</td>
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<td></td>
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<tr>
<td>Rules</td>
<td></td>
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</tbody>
</table>
DESIGN/WORKSHEET 2: FUTURE PICTURE: What do we need? Who will do it? Who will pay for it?

<table>
<thead>
<tr>
<th>Core Market</th>
<th>Who will do?</th>
<th>Who will pay?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DESIGN/WORKSHEET 3: “Will Skill” Analysis

- Low will, high skill
- High will, high skill
- Low will, high skill
- High will, low skill

NOTES
DESIGN/WORKSHEET 4: **Strategic Logic Model Template**

- **Health impact**
- **Health System Outcomes Aligned to UHC**
- **Health Market System Change(s)**
- **Health Market Intervention(s)**

**NOTES**
DESIGN/WORKSHEET 5: **Five Factors**

<table>
<thead>
<tr>
<th>Nature of market</th>
</tr>
</thead>
<tbody>
<tr>
<td>History &amp; momentum</td>
</tr>
<tr>
<td>Innovation from elsewhere</td>
</tr>
<tr>
<td>Incentives</td>
</tr>
<tr>
<td>Capacity</td>
</tr>
</tbody>
</table>

WORKSHEETS: **Deliver**

**DETERMINE/WORKSHEET 1: Define market system ‘success’ aligned to UHC**

<table>
<thead>
<tr>
<th>UHC Goal</th>
<th>Specific performance objectives</th>
<th>✓</th>
<th>Market Actor/Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WORKSHEETS: Detect

DETECT/WORKSHEET 1: Results Chain template

How to get from activities at the bottom to goal on top?
## DETECT/WORKSHEET 2: Results Chain Measurement Plan

<table>
<thead>
<tr>
<th>RC level / Reference#</th>
<th>Indicator/Definition</th>
<th>Baseline</th>
<th>Target</th>
<th>Source</th>
<th>Tool(s)/MOV</th>
<th>Who/When</th>
</tr>
</thead>
</table>

**NOTES**

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