**Title: Comparative costing analysis of Primary Health Care: PPP-PHC model vs traditional PHC model**

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**Background:** The goal of Universal Health Coverage (UHC) is to ensure access to affordable, equitable and quality health services for all by 2030 and is at the top of global health policy agenda. Whilst no clear blueprint to UHC exists, there is renewed emphasis on primary health care (PHC) as a viable approach to achieve UHC. Because of the cost implications, progress to UHC would requires involvement of the private sector through partnerships such as public-private partnerships (PPP). Partnerships have been shown to improve efficiency, reduce costs and increase value in health care. Philips through collaboration with the county government of Kiambu in Kenya set up first of its kind PPP-PHC intervention in 2014, Community Life Centre (CLC), to address access to care, quality outcomes and efficiency of care in low-resource settings. As part of the collaboration, the Kiambu County has been carrying out routine monitoring and evaluation of health indicators, revenue, expenditure and staffing with support from Philips. However, there has not been a costing analysis of the PPP-PHC model compared to a conventional county run model. Therefore, this study seeks to understand the value-add of a PPP-PHC model through comparative costing analysis of the two models.

**Methods**: The study employed activity-based costing. Direct and indirect cost were allocated to respective cost centres including direct materials (drugs and consumables), direct and indirect labour, overheads, and property and equipment.

**Results**: Initial results shows, in the initial phase of the partnership, the cost per capita for maternal service is higher in the PPP-PHC model than in traditional PHC due to the high capital investment. At the start of the partnership, the reimbursement to PPP facility was more than the expenditure until late 2016 where expenditure exceeded revenues. However, health expenditure by the non-PPP facility is consistently higher than the revenues throughout the study period.

**Conclusion**: The PPP was formulated on the premise on creating a value addition in healthcare with a view to achieving UHC. While the results show that revenues and expenditures of a PPP are significantly lower than the non-PPP models, full results from the costing study will be used to contribute to the current discourse on role of PPPs in achieving UHC. While the PPP could create demand for service, there is further need to understand their role in achieving efficient health systems in such low-income settings.

Word count: 390

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