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Trust me if you can! Realist insights on how mistrust undermines effective Public Private Engagement and strategies to address it in West-Africa

Barriers to effective Public-Private Engagement for health in West-Africa include ideological rifts, conflicting interests and limited governance capabilities. Little is known on how these elements jointly cause engagement failures. We used the implementation of the fee exemption for caesarean section policy introduced in Benin in 2009 to investigate how the engagement of private providers is organised and regulated. We adopted a Realist Evaluation approach (Pawson & Tilley, 1997) and used an embedded case study design, using qualitative and quantitative data.

The fee exemption policy only considers public and not-for-profit private actors, on the grounds that the non-profit private sector shares the value of public oriented services and can be trusted to implement the policy. However, we found that, analysing the fees at 44 health facilities, 14 private not-for-profit facilities kept charging the patients substantial additional fees on top of the €153 per caesarean section reimbursed by the government. Our analysis shows how implementation of this policy by private not-for-profit facilities depends on how top-down and bottom-up trust is facilitated.

In a context where the public administration is seen as too bureaucratic, slow and unreliable in its financial procedures, hospital managers perceive the fee exemption policy as a threat, especially if out-of pocket payment is their main funding source. In such cases, hospital managers who have the decision space to do so are more likely to charge extra fees and prevent users to receive the full benefit from the fee exemption policy.

We found that trust between state and private-not-profit providers is more likely to be facilitated by (1) removing the risk for private actors of losing resources, for instance by setting up simple, reliable and transparent administrative procedures; (2) taking into account the actual cost for facilities of implementing the policy; (3) compensating short-term financial loss in case of delayed reimbursements; (4) using evidence to make explicit the challenges of each sub-sector (public or public not for profit) in implementing the policy to facilitate a richer and more inclusive policy debate; (5) making each sub-sector accountable for its commitments toward the successful implementation of the policy.

In conclusion, we found a dynamic interplay between financial interests, decision space, power and trust at the interface between the public and private-not-profit health sector in Benin. Since UHC requires a mobilisation of all actors, promoting trust between public and private actors will be essential to achieve universal health coverage in West-Africa.