

**Approaches for improving service delivery in the non
state sector: what is the evidence on what works,
where and why?**

by

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SUMMARY

Scope of paper

The aim of this paper is to review what is known about how health service delivery might be improved in the non state sector, defined as including all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose activities are intended to treat illness or prevent disease. Services provided include hospitals, nursing and maternity homes, clinics run by various types of professionals (doctors, nurses, midwives, paramedical workers), diagnostic facilities (laboratories, radiology), health prevention and promotion activities, patient support services, and drug sales from pharmacies and unqualified static and itinerant drug sellers including general stores. In many countries, the boundaries between state and non state sectors are blurred, since the same individuals may work in both, and public premises may be used for private gain. While some providers offer services of good quality, many are of poor quality, especially at the more informal end of the market, and deal inadequately with diseases of public health importance such as malaria, TB and STDs.

The current situation results from the interaction on the one hand between 'consumers', who make their decisions of which providers to use on the basis of the price of alternatives, the income they have available to purchase services, their knowledge of the nature of different providers and their preferences for services with different characteristics (particularly relating to quality); and on the other hand providers, who are influenced by what it costs them to provide services, what they can charge, their own knowledge, and the regulatory environment. The paper reviews evidence on interventions on the demand side, interventions on the supply side, approaches which seek to restructure market relationships, and the demands that approaches make on government capacity.

Main conclusions and recommendations

Influencing consumers: A number of approaches exist to supporting consumers in their interactions with the health care marketplace. They tend to have one or more of the following aims: to improve consumer information; to make services or products more affordable through some form of subsidy; to create new institutions that give consumers greater authority to challenge care of poor quality; to create channels of communication through which pressure from civil society (consumer groups, the media) can be brought to bear; and to strengthen the opportunities for patient exit options, so that consumer choice has real resource consequences for providers. Evidence is strongest on social marketing, and shows that it has achieved major increases in coverage for some important interventions. However, there remains much debate about whether social marketing strengthens the private sector by creating new demand that spills over into demand for full-priced commodities or whether, instead, it crowds out the private commercial sector. It is also unclear to what extent such approaches can be extended beyond the delivery of commodities to social marketing of services. Targeted distribution of vouchers that are exchanged for services or products from a private provider can address problems of access as part of a social marketing programme or can be implemented on its own. There are a few examples with some positive experiences, but vouchers have yet to be tested on a large scale, and the logistic requirements are likely to be considerable. Lack of evidence is also the case with other measures to influence consumers, such as

consumer protection legislation, strengthening consumer groups, and allowing greater choice of service provider.

Influencing providers: Systematic reviews of studies to evaluate the effectiveness of interventions to influence provider practice in high income countries demonstrate that enabling and reinforcing strategies, for example combining patient education with interventions to improve provider knowledge, skills and practice, are more effective than those that focus only on providers. While the evidence from poorer settings is not yet strong, governments need to consider combining a range of approaches in working with private providers, rather than relying on single strategies. The selection needs to be based on an analysis of the local context, including: the training, skills-mix and beliefs of the available providers; the constraints they face in trying to provide evidence-based care; and peer influences, provider networks and the degree to which providers are organised within professional bodies. There is a fair amount of evidence of success, for example for projects which have adopted a comprehensive approach, improving providers' knowledge and skills, providing them with the resources to apply what they have learned; and assisting users to recognise good care through widespread marketing of a brand or symbol of quality. In these projects, the quality of clinical care was monitored by external assessment, and significant resources went into promoting the service brand among potential users. These are functions that weak and under-resourced public sectors would find difficult to replicate and finance on a national scale, and governments need to be cautious about conferring official approval on the quality of care of trained private providers unless sound monitoring systems are in place. Using less qualified providers and drug retailers in government-approved programmes requires building stakeholder support to overcome or neutralise the opposition of powerful professional organisations.

Restructuring the market: Governments need to regulate the non state sector both in the sense of legislating and administering formal rules, and also by intervening to alter the incentives available to private sector institutions and thereby their activities and performance outcomes. This can involve restructuring the entire health sector, and introducing approaches to ensuring service provision that apply across the sector, to public and private providers alike. For example, the development of the purchasing function can create a significant new market to which private providers respond, and requires the creation of public provider institutions with increased autonomy which can compete more vigorously with private sector alternatives. The purchasing role can also be applied on a smaller scale, through selective contracting out of services to the private sector. All these functions make significant demands on government capacity, and evidence is limited on successful experiences. Most evidence relates to selective contracting out of clinical and non clinical services, where there is some evidence that contracting mechanisms do not work very well in resource-poor environments, especially where monitoring arrangements are weak. Externally funded contracting arrangements have had some successes, as have contractual arrangements with NGOs, but these are generally yet to be replicated on a large scale. The major issue in regulation is implementation, which has typically been extremely weak. The evidence suggests that under-resourced regulatory systems will achieve little, and that there is need for substantial investment in regulation when the formal private sector is small and relatively weak (and hence lacking political power). Such regulation should focus on setting rules for the emerging formal private sector rather

than trying the impossible task of controlling the informal sector (which is best tackled through means other than regulation).

Demands on government capacity: The more complex the service to be provided, the more severe are likely to be the constraints imposed by government capacity. In particular, capacity constraints are likely to affect approaches such as contracting out, splitting purchasers and providers, and strengthening regulation. In contrast, approaches such as social marketing, where independent agencies can be used to stimulate demand and private retailers can be used as distribution channels, place fewer demands on governments. However, it is important to recognise that these approaches are likely to work best for products rather than services; that only a certain range of health services are susceptible to this approach; and that private sector distribution must be complemented by targeted support for those who cannot afford to purchase, whether through vouchers or public delivery.

Implications for policy formulation

There is a fair amount of experience with ways of working with the non state health sector in low income countries to improve performance, but very little information on the other areas reviewed: influencing consumer behaviour and restructuring the market. Moreover, although some successful efforts to influence private providers are identified, they can be problematic. They may imply sanctioning treatment practices that are contrary to current policy and there may be strong opposition from powerful professional groups. The monitoring function is vital but difficult to sustain in the long term. Successful projects are resource intensive, especially when working with unorganised individual providers, and careful judgements need to be made on the relative return to investment in improving non state sector activities as opposed to investment in a strengthened public sector. Working with the more organised formal private sector – doctors, nurses and pharmacists – is a more feasible starting point for governments, but the poor are likely more frequently to use informal, illegally practising private providers. The challenge remains largely unaddressed of how to bring the informal sector into an overall public policy net. Training and investment in a stronger formal sector, both private and public, and restructuring the market so as to strengthen the purchasing and regulation functions of government, may displace the informal sector, but this is likely to be a very long term process. The approach to the informal sector with the greatest potential appears to be to identify products that can safely be delivered through the retail sector, and develop targeted programmes involving a package of social marketing, provider training, product packaging and subsidies, consumer information, and monitoring.

Approaches for improving service delivery in the non state sector: what is the evidence on what works, where and why?

1. Introduction

In recent years, there has been considerably increased interest in the activities of providers within the non state health sector in low income countries, and in how policy makers might best capitalise on its accessibility and popularity (WHO, 2000; DFID Health Systems Resource Centre, 2000; Smith et al., 2001). However, evidence is limited on what approaches work best. There is much mention of measures such as social marketing, accreditation, franchising, and contracting, but much of the experience is documented only in grey literature, or comes from relatively small scale projects (Swan and Zwi, 1995; Brugha and Zwi, 1998).

The aim of this paper is to review what is known about how service delivery might be improved in the non state sector. After an initial section that sets out current understanding of what the non state sector in low income countries consists of, and why it should be of concern to policy makers, subsequent sections review interventions on the demand side, interventions on the supply side, and approaches which seek to restructure market relationships.

2. Characteristics of the non state health sector in low income countries

The non state health sector may be defined as including all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose activities are intended to treat illness or prevent disease. They include commercial companies both large and small; groups of professionals such as private doctors; conventionally termed 'non-government organisations' such as charities, both international and national; and individual providers and shop keepers. The services they provide include hospitals, nursing and maternity homes, clinics run by various types of professionals (doctors, nurses, midwives, paramedical workers), diagnostic facilities (laboratories, radiology), health prevention and promotion activities, patient

support services, and drug sales from pharmacies and unqualified static and itinerant drug sellers including general stores.

While it is conventional to talk as if the non state sector were distinct from the public sector, in practice there is considerable blurring between them (Mills, Bennett and McPake 1997). Publicly employed staff (usually doctors, but also other professionals such as nurses and midwives) may practise privately, either on their own account or working for a private facility owner. This may be legal, or not strictly legal but not controlled. Public facilities such as hospitals may operate their own private wards and manage the income from them; or may allow work for private gain on their premises as when doctors admit their own private patients and are paid directly by them. When public services become heavily dependent on fee income, as in the case with health services in China for example (Liu and Mills, in press), then there may be little to distinguish them from a private enterprise which operates in the interest of its owners rather than that of the general public.

Why has so much interest developed in the non state sector? Firstly, it represents a resource that is available and used, even in the poorest countries and amongst lower income groups (Berman 2000). For example, the majority of malaria episodes in Sub-Saharan Africa are initially treated by private providers, mainly through purchase of drugs from shops and peddlers (Hanson et al. 2000; McCombie 1996). For some high priority diseases such as malaria, TB, and sexually transmitted infections (STIs), in the many countries where public infrastructure is limited, prevention and treatment cannot be substantially scaled up without considering how best to make use of private sector contacts.

Secondly, despite this widespread use, the effectiveness of the services provided is often very low. Studies have documented poor treatment practices for diseases such as TB (Uplekar et al. 1998; Lonnroth 2000) and STIs (Benjarattanaporn et al. 1997; Brugha and Zwi 1998) which have implications not only for the individuals treated but also for disease transmission and the development of drug resistance. Why then are private services so popular? One reason is that they are often both cheap and accessible. Cheap because their services are adjusted to the purchasing power of the client, for example through sale of partial doses. In a study in Sierra Leone, for

example, the price of purchased drugs was almost one third of the cost of treatment at a public health centre (Fabricant, Kamara and Mills 1999). Accessible since drugs are sold through general retail outlets, and opening hours are convenient.

Thirdly, use of the more expensive private services, or treatment for chronic conditions, can drive households into poverty or at least put them at risk and mean they go without vital other requirements. Studies often find that over 10% of the income of the poorest quintile is spent on medical care (Fabricant, Kamara and Mills 1999). And finally, rapidly growing private sectors compete for trained human resources with the public sector. On the one hand this weakens public services; on the other hand it opens possibilities of using private sector resources to promote public health objectives.

The fundamental question is therefore how can the operation of the non state sector be improved. The current situation is the result of the interaction on the one hand between 'consumers', who make their decisions of which providers to use on the basis of the price of alternatives, the income they have available to purchase services, their knowledge of the nature of different providers and their preferences for services with different characteristics (particularly relating to quality); and on the other hand providers, who are influenced by what it costs them to provide services, what they can charge, their own knowledge, and the regulatory environment. Efforts to improve the current situation must influence demand or supply directly, or seek to restructure the overall environment. It must also take into account the institutional weaknesses in low income countries, which render problematic those strategies that rely heavily on a well functioning bureaucracy.

3. Influencing consumers

Consumers in low-income countries face a number of difficulties in relation to the private sector. They often lack knowledge about appropriate means of treating and preventing illness. This translates into low levels of demand for effective disease control measures. They are dependent on providers for information, for example on the interpretation of their symptoms, and this can make them vulnerable to self-interested behaviour by providers. Consumers are usually unable to assess the

technical quality of services, with the result that they judge technical quality on the basis of other information observable to them – such as the interpersonal skills of the provider and the comfort of the environment in which treatment occurs – both of which may be unrelated to the provider’s technical competence. The lower their level of education, the more they are likely to be exposed to inadequately qualified practitioners providing care of very poor technical quality. In particular, the poor may choose to use practitioners in the informal sector, such as unqualified providers and drug sellers, rather than higher-quality private providers, though very little is known about the patterns of health-seeking behaviour in different socio-economic groups, or about the extent to which the poor rely more than the better-off on low-quality private providers (Bloom and Standing 2001).

A number of approaches exist to supporting consumers in their interactions with the health care marketplace. They tend to have one or more of the following aims: to improve consumer information; to make services or products more affordable through some form of subsidy; to create new institutions that give consumers greater authority to challenge care of poor quality; to create channels of communication through which pressure from civil society (consumer groups, the media) can be brought to bear; and to strengthen the opportunities for patient exit options, so that consumer choice can have real resource consequences for providers.

Social marketing

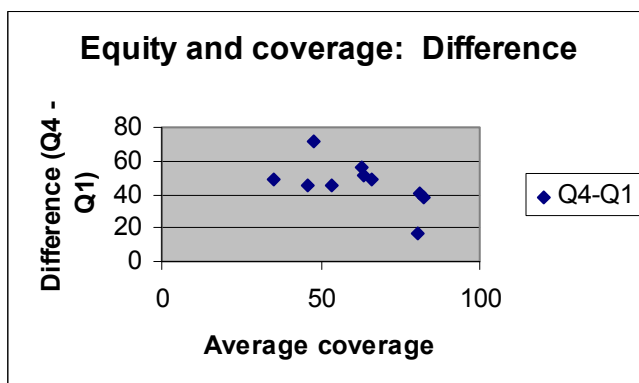
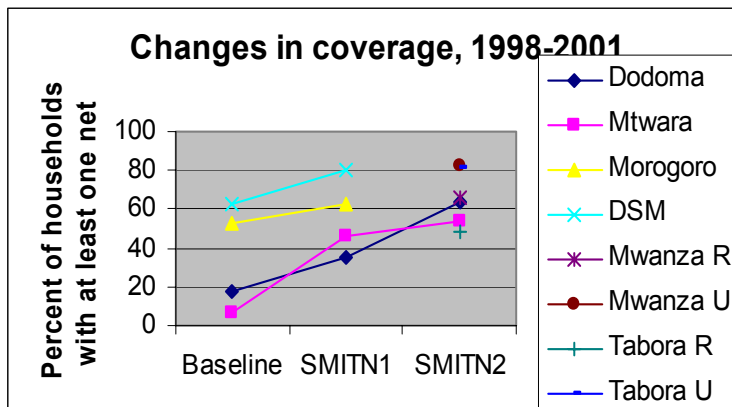
Social marketing is increasingly being used to tackle lack of consumer information. It uses commercial marketing techniques to stimulate demand for effective public health interventions that are then sold, often through the private sector. Social marketing organisations are often non-profit firms or associations, but the products tend to be distributed through various for-profit outlets and non-governmental organisations. Social marketing has been applied to such diverse interventions as family planning, the treatment of sexually transmitted infections, the use of insecticide-treated mosquito nets, hand washing and water purification. Although important increases in coverage have been achieved for a wide range of socially marketed interventions (eg see Box 1), there remains much debate about whether social marketing strengthens the private sector by creating new demand that spills over into demand for full-priced commodities or whether, instead, it crowds out the private commercial sector

(Hanson, Kumaranayake and Thomas 2001). The lack of evidence about the impact on the market is exacerbated by the fact that social marketing projects tend to measure their success in terms of sales of their own branded products rather than by the development of the market as a whole.

Box 1: Social marketing and equity in Tanzania (Source: PSI Tanzania 2002; Hanson and Worrall 2002)

The Social Marketing of Insecticide-Treated Nets (SMITN) project began to market mosquito nets in 1998 in four regions of Tanzania. In 2000 it was expanded to cover all regions of the country. The project promoted and distributed untreated mosquito nets and a dip-it-yourself insecticide treatment kit through the retail distribution network, NGOs and public sector health facilities. Nets were sold initially at a small subsidy, though over time the market price of domestically produced nets fell and by the end of Phase II social marketing prices slightly exceeded the commercial sector price. The price of the insecticide treatment kit was substantially subsidised.

Household surveys conducted at baseline and the end of each phase of the project showed that coverage increased substantially in all project areas (top graph). As overall coverage increased, socio-economic differentials in net ownership diminished. The bottom graph shows the relationship between “average” coverage and equity of coverage, measured as the absolute difference between the highest and the lowest socio-economic quartiles, and suggests that equity improved as coverage increased. Affordability remained the most frequently cited reason for not owning a net, especially among the poorest group. Other barriers to access, such as knowledge and availability, were much less important: over 80% of those without a net knew where they could get one, and 63% reported that they knew the price.



By providing subsidised commodities, social marketing helps to increase affordability. The level of subsidy differs enormously between projects and types of intervention; however, the price of a product often covers its cost, leaving the promotion and distribution costs to be covered by other, usually donor, funds. This form of subsidy is usually untargeted, raising the possibility that a substantial share leaks to people who would otherwise have purchase the product at the full price. Furthermore, other measures are needed to ensure access for very poor people who cannot afford even the subsidised price.

In contrast to products, there is limited experience with the branding of services and the use of social marketing to promote them, e.g. in reproductive health (Smith et al. 2001; Montagu 2002). However, the consequences of social marketing of services may be quite different from those of commodities because the supply may be less responsive (elastic). Increasing demand for commodities can quite quickly be met with increased supply, but qualified staff are a more scarce resource and long periods inevitably elapse while new personnel are trained. This means that an increase in demand is likely to result in higher prices and/or staff being drawn from the public sector. In both cases, the overall effect on utilisation is diminished. To the extent that the social marketing of services succeeds in reorienting demand towards the suppliers of services of higher technical quality, the incentives to provide high quality can be expected to strengthen in the long run. In the meantime, however, there is a risk that the tendency for markets to be segmented along income/quality lines will be reinforced, with the usual consequences for equity.

Vouchers

Targeted distribution of vouchers that are exchanged for services or products from a private provider is an alternative to an untargeted subsidy at the point of purchase or a means-tested exemption for services supplied through the public sector. Vouchers interfere less with the supply side, since providers continue to sell at the market price. They also allow consumers to exercise choice over where they receive services: the money follows the patients, and providers therefore have to compete for business, making them more sensitive to patients' preferences. A voucher system nevertheless needs a mechanism for determining who qualifies for the subsidy; and vouchers can be more readily traded among individuals than services, making it more difficult to

ensure that subsidies reach the target group. As important, a mechanism is also required which allows providers to exchange the redeemed vouchers for either cash or new stock, together with means to detect and minimise fraud (such as exchanging vouchers for other, non-targeted products). Voucher systems have been used for sexual health services for sex workers in Nicaragua (Box 2) and for targeting subsidies on insecticide-treated mosquito nets to those most vulnerable to malaria in the United Republic of Tanzania (see Box 3). A number of other countries are currently discussing how they can use vouchers to expand access to ITNs while promoting the commercial distribution sector.

Box 2 Vouchers for sexual health services in Nicaragua (Source: Gorter et al. 1999)

Since 1995 a voucher programme has been operating in Managua, Nicaragua, with the aim of increasing the uptake of reproductive health services by female sex workers. Every 3-5 months approximately 1200 vouchers (corresponding to the estimated number of sex workers operating at any given time in the city) are distributed by fieldworkers and NGOs at prostitution sites. The vouchers entitle the sex workers to free services at one of 8-10 private, NGO and public clinics, which are contracted to the voucher agency by competitive tender. Approved providers must follow a set treatment protocol, and receive training. Contracts are reviewed after each round of voucher distribution, and renewed subject to an assessment of quality of care. The clinics return the vouchers to the voucher agency, which reimburses the provider an agreed fee per voucher. The sex workers were involved in the design of the programme, and have a number of opportunities to express their preferences and complaints. In each round, 10% of recipients are interviewed about their experience. Initially, sex workers reported that the gatekeepers to care (nurses and receptionists) lacked sensitivity: training and sensitisation of this group helped to improve their attitudes towards these clients. Technical quality of care (as assessed by an examination at the project outset) was lower than expected, and training and treatment protocols were introduced.

While the prevalence of STIs is only slightly lower than at the beginning of the project (possibly due to a high turnover of female sex workers), incidence among women who have used vouchers more than once dropped by 65% in the first three years of the programme. Following a recommendation by the sex workers, they now receive vouchers to give to their regular partners and/or clients as well. Sex workers appreciated the fact that they could choose which clinic to attend, and made their choice on the basis of distance and friendliness. The clinics reported that their main benefit was improvement in the technical quality of their services, and that the lessons learned were applied to all of their clients. They felt that their reputation was enhanced by being contracted by a prestigious public health agency (the Central American Health Institute, ICAS).

Box 3 Vouchers for mosquito nets in Tanzania (Source: Armstrong et al. 2002)

The KINET project, implemented by the Ifakara Health Research and Development Centre, used vouchers to subsidise insecticide-treated nets for pregnant women and children under 5. The vouchers, which provided a 17% discount on the price of a net, were distributed at maternal and child health (MCH) clinics and could be used as part-payment for a net purchased from any retailer. The shopkeeper returned the redeemed vouchers to the wholesaler in exchange for the full value of the voucher plus a small margin; and the wholesaler returned vouchers to the project, also earning a small profit margin. As well as providing a subsidy, the vouchers were designed to reinforce the IEC messages, and to provide a link between the public sector (distributing vouchers) and the private sector (supplying nets). The operation of the voucher scheme was evaluated through a series of focus group discussions with community leaders and parents of children under 5; in-depth interviews with MCH staff and retailers; and questions administered in a household survey.

The redemption rate was extremely high: 97% of all vouchers issued were used to purchase nets. However, awareness of the scheme was low, with only 43% of mothers aware of the scheme; and only 12% of mothers said they had used a voucher to purchase a net. Among the target group, vouchers were more likely to be used in the least poor than in the poorest households. Overall, the evaluation concluded vouchers had a useful role within a social marketing approach, and that they provided a way to strengthen the role of public health services. They also served as an important IEC tool to promote nets among those most at risk. However, more time and more intensive effort was needed to promote the vouchers.

Consumer protection legislation

Consumers often lack the institutional structure to seek redress when they have been victims of medical malpractice or negligence. One example of the creation of such a structure was the incorporation of private medical practice into the Indian Consumer Protection Act of 1986 (Box 4). While such measures can have a positive impact, they are unlikely to be effective on their own, and other complementary measures are needed in order to confront the poor quality of care in the private sector.

Box 4: Consumer Protection Act in India (Source: Bhat 1996)

Cases can be brought against private medical providers under the Consumer Protection Act (COPRA) of 1986. The Act creates quasi-judicial consumer councils at district, state and national levels, which are supposed to provide quicker and less expensive access than civil litigation. However, the system faces a number of constraints: in particular, the responsibility to demonstrate medical negligence lies with the consumer, and there is an unwillingness of doctors to testify against their colleagues. The lack of standards for “appropriate care” also makes it difficult to prove negligence. The chances of success are low (71% of cases were ruled in favour of the doctors). Access is costly, and use of this redressal mechanism is likely to be limited to higher-income and better-educated groups. There is also a lack of capacity in the legal system: 200,000 cases are pending at the consumer courts. The legislation has improved information flows but may also have led to more defensive medicine and higher fees. Suggestions for improvement include streamlining the legal process, penalties for false claims, screening committees to reduce the burden on consumer councils, and an orientation programme for new doctors entering private practice.

Civil society pressure

The role of civil society, including NGOs, consumer advocacy groups, and the media, in influencing local and international policy issues is increasingly being recognised. An example of how such pressure has been brought to bear on health policy issues appears in Box 5. Opportunities to strengthen such pressure exist by supporting consumer groups in various ways and providing specialised training in health issues to journalists.

Box 5: Influencing policy at the local level: Sale of kidneys in Thailand (Source: Teerawattananon, in press)

The Thailand Medical Council has established a clear legal framework regarding organ transplantation. Three independent physicians must concur on a diagnosis of brain death before organs may be removed for

transplant; living donors must be immediate family members, or have been married to the patient for at least three years; and living donors cannot be paid. In 1999, the Thai media exposed a case in which a private hospital had violated all of these legal requirements, and where purchasing of kidneys was suspected. There had been violation of the brain death certification, with the only physician signing the certification involved in the transplant surgery; there was evidence of payment to relatives of as much as \$400; there was no evidence of kinship for 25% of living donors; three-quarters of consent forms failed to declare non-payment; and there was evidence of kick-back payments to ambulance services transferring accident victims, as well as to neighbouring hospitals for transferring potential “brain death” patients. Following investigation, one doctor’s license was permanently revoked, four had their licenses temporarily suspended, and lawsuits were filed in criminal courts. Stories appeared in the media every day, forcing immediate and serious action by all the agencies concerned. Newspaper editorials and special articles played a catalytic role, forcing the Health Minister to act. Policy analysts played a role in briefing and coaching journalists.

This case illustrates the synergistic roles played by the media, social pressures, the Law Society, the Medical Registration Division, and the Medical Council, and how the relative freedom of the press helped to compensate for the lack of strict enforcement through official channels.

Strengthening the impact of “exit” options: the role of patient choice

One of the most powerful mechanisms available to consumers to express their degree of satisfaction with a service is their ability to “vote with their feet” and stop using a provider that fails to meet their expectations. Where provider revenue is linked to the level of utilisation, as in the case of most non state providers, this provides an important motivation for providers to respond to patient preferences. Such an approach, however, requires patients to have alternative providers available to them, in order to be able to exercise effective choice. This is usually the case with primary care in urban areas, and there is some limited, qualitative evidence from experiences with contracts in South Africa that suggests that greater decentralisation of decision making to the consumer is related to better quality services where there is competition in a given market (Box 6). Given limitations on consumer ability to judge quality, it is also important that there be some mechanism to ensure provider quality: for example specifying which type of providers can be accessed by consumers, or using accreditation to signal quality.

Box 6: Contracting primary care providers in South Africa (Source: Palmer 2001)

A study of three alternative contractual mechanisms for the delivery of primary care in Southern Africa compared one contract within the private sector, where an insurer made capitated payments for primary care of those insured, to two models where the public sector block purchased services on behalf of state patients. For the public sector contracts, the study found problems around the specification and monitoring of contracts for clinical service delivery to be a key hindrance. Comparison with the private sector contract highlighted how two key features more likely within a private sector setting lessened these problems, suggesting how contracts within the public sector might operate more successfully. The study’s findings show how in markets where it is possible to 1) have multiple purchasers and providers, and 2) to define the population to be covered by the contract, it is possible to create a system of incentives for the provider which are more self-enforcing, thereby avoiding the problems of detailed specification and monitoring of

contracts by a third party. Multiple purchasers and providers create the possibility of exit from any contractual arrangement and this supports a degree of accountability from provider to purchaser. The possibility of defining the population to be covered by the contract allows for payment by capitation, which encourages attention to preventive care without requiring this to be closely monitored. Together, these features suggest that whether environments can support the exercise of choice is likely to be an important element of the success of any public policy to outsource the provision of health care.

In the case of hospitals, markets are often more competitive than they appear, especially when private and non-profit alternatives are considered (Box 7). And in some circumstances, lower level facilities may provide effective competition for hospitals as was found in urban Lusaka (Nakamba, Hanson and McPake, 2002). However, in rural areas, choice may be very restricted, limiting the potential of this option.

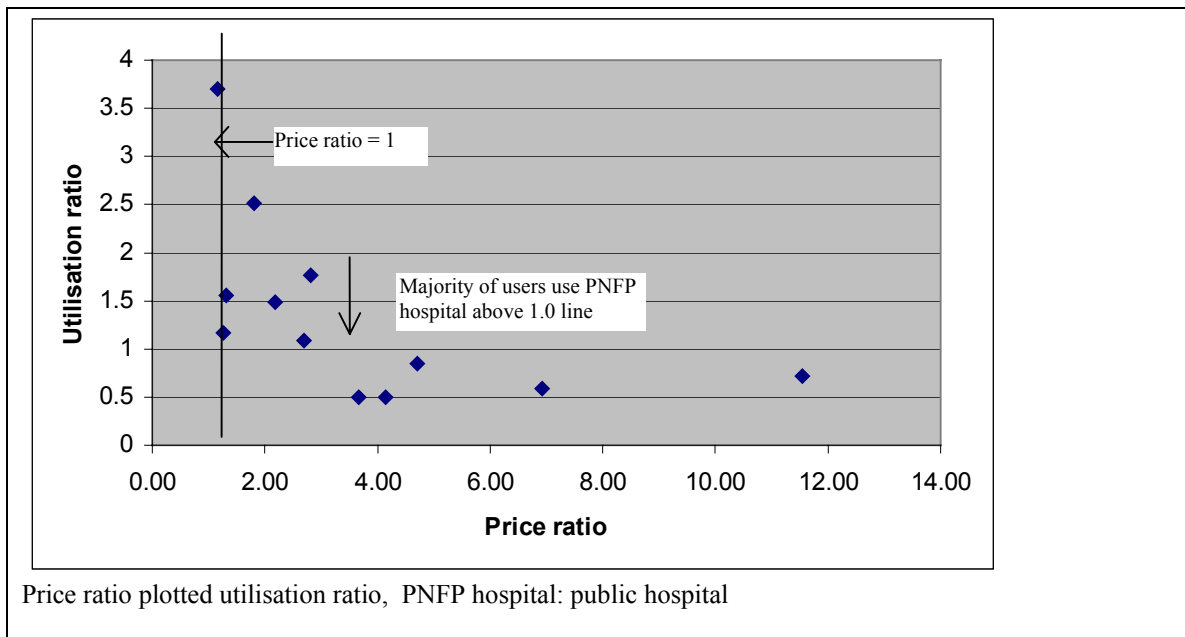
Where the public sector funds non state as well as public providers, there is potential for using the payment mechanism to link revenue to utilisation, thereby increasing the responsiveness of both provider types to patient choice. This could take the form of block grants that are calculated to reflect utilisation levels, or vouchers that can be used to pay for services, strengthening the link between utilisation and revenue. Such measures can ensure that access to higher quality services is not restricted to those who are able to afford the higher level of user fees in non state facilities.

Box 7: Consumer choice of hospitals in Uganda (Source: Ssenkooba et al., forthcoming)

Evidence from Uganda shows that in districts where patients have a choice between a public and a private, not-for-profit hospital, there is a preference for services provided by private not-for-profit hospitals, even when prices are similar to or exceed public sector price levels. Data on utilisation and prices were collected from public and NGO hospitals in three districts that had both types of provider. Ratios of NGO to public utilisation (aggregating inpatient and outpatient services) and prices are plotted in the figure below.

NGO utilisation exceeds public hospital utilisation, even when NGO prices are considerably higher. At a price ratio of 1, utilisation ratios range from just over one to over 3.5. Public sector utilisation only exceeds that of NGOs at price ratios of over 3.5. This analysis suggests that their higher perceived quality allows NGO hospitals considerable leeway to set higher prices.

Government provides financial support to the NGO sector in the form of block grants. Currently there is little relationship between the government grant and utilisation levels for either public or NGO providers. However, modifications to the way the government grant is paid could improve affordability of NGO services and increase the responsiveness of public providers to patient preferences.



Other measures

There are other potential approaches to strengthening the position of consumers in private medical markets, about which even less information is available: for example, direct consumer education could help to inform patients about what constitutes care of good quality for a range of common medical procedures; information about prices could help patients when choosing providers; and social marketing approaches could prove useful in publicising such information. Furthermore, regulation, accreditation and franchising, although strictly speaking provider-side interventions, play an important role in sending clear and transparent signals to consumers about which providers are registered and meet minimum requirements in terms of structure, equipment and staff.

4. Influencing providers

Systematic reviews of studies to evaluate the effectiveness of interventions to influence provider practice in high income countries have demonstrated two lessons that are relevant to low income countries (Brugha and Zwi 1998): first, practice enabling and reinforcing strategies, which, for example, combine patient education with interventions to improve provider knowledge, skills and practice, are more effective than those that focus only on providers. While the evidence from poorer settings is not yet strong, governments need to consider combining a range of

approaches in working with private providers, rather than relying on single strategies. Second, the selection should be based on an analysis of the local context, including: the training, skills-mix and beliefs of the available providers, the constraints they face in trying to provide evidence-based care; and peer influences, provider networks and the degree to which providers are organised within professional bodies.

Training

Improving knowledge and skills is a necessary starting point. Most private providers receive no guidance from the public sector on diagnosis and treatment (Dartnall 1997), so that their practices are determined more by biased information from pharmaceutical companies, who reap the rewards (Avorn, Chen and Hartley 1982; Kamat and Nichter 1997). While insufficient on its own to change behaviour, imaginative ways of disseminating evidence-based information to private providers is a potentially affordable strategy that has been little explored (Brugha and Zwi 1998). Training is central to most approaches. For example, it has improved the diagnosis and counselling practices of informal providers in India (Chakraborty, d'Souza and Northrup 2000); the provision of antimalarials by shopkeepers in Kenya (Marsh et al. 1999); and the management of diarrhoea and acute respiratory infections by private medical practitioners in Mexico (Bojalil et al. 1999). INFECTOM is one such approach, developed by BASICS to improve the integrated management of childhood illness (IMCI) skills of private providers (Chakraborty, d'Souza and Northrup 2000; Luby et al. 2002 – see Box 8).

Box 8: Improving sick-child case management in Pakistan (Source: Luby et al. 2002)

In 1997-8, three cycles of the INFECTOM training strategy (assessing provider practices through interviews of mothers, feedback to the providers, 'contracting' with providers to commit to specific improvements in practice, ongoing monitoring of their practices through repeated interviews of mothers) were implemented among private providers in two urban communities in Pakistan. Non-qualified (non-MBBS) providers were more co-operative than medical practitioners (MBBS). However, the latter showed greater improvements in diagnostic and therapeutic practices. Some dangerous practices, such as excessive use of injections, showed only modest reductions. Publicising performance rankings after the third round appeared to have little impact. An advantage over traditional monitoring and supervisory approaches is that providers are aware that any health care interaction may be assessed. As with other strategies that seek to reinforce positive practice changes, the INFECTOM approach requires substantial resource inputs.

The advantage of training is that it can be given to those providers, often informal ones, whom the poor most frequently utilise (Berman 2000); and may be the only

feasible strategy where alternative sources of care are not available. However, one problem for governments is that it may involve recognising what are illegal – even though widespread – dispensing practices, threatening the interests of strong formal professional lobby groups when efforts are made to scale-up successful projects to national level (see Box 9). Moreover, improvements due to once-off training may be short-lived (Ofori-Adjei and Arhinful 1996), and follow-up and supervision in the private sector is difficult for an under-resourced public sector unable to supervise its own health workers.

Box 9: Training providers

Training shop keepers to advise on antimalarial use in Kenya (Source: Marsh et al. 1999)

In 1996, shopkeepers serving a population of 3,500 in Kenya were trained in how to provide information to customers on effective management of childhood fevers, using over the counter preparations (antimalarials and antipyretics). Following training, there was a large and significant increase in the proportion of cases where chloroquine was dispensed, and in the provision of correct doses in the home-treatment of childhood fevers. There was strong support for the programme from shop keepers and communities.

Training pharmacists to manage sexually transmitted diseases in The Cameroon (Source: Crabbe et al. 1998)

A project which successfully trained pharmacists in syndromic diagnosis and the dispensing of pre-packaged drugs to customers for sexually transmitted infection in Cameroon was not scaled up to programme level and was later abandoned. This was partly due to the influence of the powerful medical lobby on policy makers, opposing efforts to legitimise and improve the quality of what were widespread but illegal dispensing practices.

Provider responsiveness

The private ambulatory sector can be highly competitive, so success in meeting users' perceived needs and retention of clientele is vital to providers' economic survival (Berman 2000; Bhat 1999). Minimising patients' waiting times is one provider response, even if this reduces the time spent with patients, compromising quality of care. Private providers use treatments they know to be ineffective due to actual or perceived user demand (Ofori-Adjei and Arhinful 1996; Paredes et al. 1996). They may manage patients who present with the same condition differently, depending on the payment mechanisms and what they believe patients are able and willing to pay. [see Box 10 - Chabikuli et al., in press]

Box 10: Different care for insured and cash-paying patients in South Africa (Chabikuli et al., in press)

In 1999, 65 private general practitioners (GPs) in two urban districts in Gauteng Province, South Africa, were interviewed by telephone. Each was presented with a set of sexually transmitted disease syndromes and asked to describe how s/he would manage the patient, firstly if the patient was insured,

then secondly if the patient was paying cash (uninsured). The effectiveness of reported prescriptions were similar. However, for most syndromes, uninsured poorer patients were offered significantly cheaper and less convenient antibiotic regimens. The results suggest that GPs' perceptions of patients' willingness or ability to pay for drugs have a bearing on quality of care. The paper concludes that poor quality of care and the choice of inconvenient antibiotics impacts disproportionately on the poor, when they use the same private sector services.

Private providers' perceptions of what patients want may not correspond with actual demand. Therefore, the involvement of service users in the training of providers can help to re-educate providers, reinforcing positive changes in practice, for example in reducing unnecessary injections (see Box 11 – Prawitasari Hadiyono et al. 1996). However, the constraint, as stated earlier, is in the limited potential for educating consumers to recognise quality in clinical diagnosis and treatment services.

Box 11: Bringing service users and providers together in Indonesia (Source: Prawitasari Hadiyono et al. 1996)

In Indonesia, service users and providers were brought together for a single 90–120 minute group discussion to exchange experiences about what takes place in the clinical encounter. With the assistance of a behavioural scientist, participants focused on the discrepancies between user and provider perceptions of who was promoting inappropriate injection use. The interaction assisted providers to see the differences between their reported beliefs and their actual practices. This intervention was shown, in a controlled trial, to have reduced inappropriate use of injections over the subsequent 3 months. Providers expressed the need for peer norms to reinforce and support improvements in practice.

Resourcing providers

Private providers may lack access to essential diagnostic services and treatments. One approach has been to provide them with pre-packaged drugs for common conditions such as malaria and sexually transmitted infections. However, perverse outcomes can occur; for example, it has been reported that pharmacists supplied with pre-packaged antimalarials have marketed them to street vendors who sold individual tablets at higher unit cost to the poorest customers (Deming et al. 1989; Foster 1991). Such strategies therefore require a high level of monitoring. They may, moreover, be difficult to justify where the supply of drugs to the public sector is poor.

In Hyderabad, India, private providers refer patients with chronic cough to the local hospital for laboratory investigations; most do not have tuberculosis and are asked to report back to the referring doctors with their results (WHO 2001). The doctors welcome participation since the scheme supports their client base. It has already

helped to improve diagnostic skills and may have the potential to evolve into a more formal certification or accreditation scheme.

Regulatory or participative approaches

Private providers may engage in what they know to be unethical practices to maximise income (Bhat 1999; Yesudian 1994). Regulatory approaches, including consumer protection legislation (Bhat 1996), have helped highlight these practices but have done little to control them (Bhat 1999). In Pakistan, the deregistration of paediatric antimotility drugs for diarrhoea led to their substitution by more dangerous adult formulations (Bhutta and Balchin 1996). Weak government capacity for implementing regulations has promoted interest in strategies that reward providers for good practice, which is the principle underlying provider accreditation schemes. These are, understandably, more attractive to the private sector, as an alternative to strengthening government controls (see Box 12). However, accreditation, even more than regulation, requires high capacity for monitoring provider practices and is resource intensive. Apart from schemes that focus on a narrow range of services, such as family planning (see below), they are feasible only in more mature health systems, working with well organised larger health facilities; and not with the solo, often informal, private providers that the poor frequent (Smith, Brugha and Zwi 2001).

Box 12: Support for hospital accreditation in India (Source: Nandraj et al.; 2001)

A survey was conducted in Mumbai, India, in 1997-8 to elicit the views of the principal stakeholders, including private hospital managers and policy makers, on the introduction of accreditation and what form it should take. There was a high level of support for the classical features: voluntary participation, a standards based approach to assessing hospital performance, periodic external assessment by health professionals, and the introduction of quality assurance measures to assist hospitals in meeting these standards. Hospital owners, professional bodies and government officials all saw potential – though different – advantages in accreditation: for owners and professionals it could give them a competitive edge in a crowded market; while government officials reckoned it could increase their influence over an unregulated private market. Areas of disagreement emerged; for example, hospital owners were opposed to government or third party payment bodies having a dominant role in running an accreditation system.

An approach that could have greater impact in the longer term is for the public sector to work with provider representative organisations to promote professional ethics, building on non-financial incentives such as providers' desire for social recognition and prestige (Bennett and Franco 1999; Segall 2000). Such organisations could also

be used to support measures to promote rational drug prescribing, which have mainly been applied in the public sector (Laing and Hogerzeil Ross-Degnan 2001). In urban India, high proportions of private medical practitioners regularly attend continuing medical education sessions, organised by their specialist associations (unpublished). These could be used as entry points for government to promote evidence-based care approaches, without having to put new systems in place.

Comprehensive approaches

Some successful projects have adopted a comprehensive approach, improving providers' knowledge and skills, providing them with the resources to apply what they have learned; and assisting users to recognise good care, through widespread marketing of a brand or symbol of quality. In the Clear 7 Project in Uganda, which provided pre-packaged drugs for the treatment of sexually transmitted infections through private clinics and shops, improved cure rates and prevention practices were reported (Jacobs et al. 1999). The Green Star Project in Pakistan improved access and increased the coverage of a wide range of family planning services among previously unreached women (Agha, Squire and Ahmed 1997).

In these projects, the quality of clinical care was monitored by external assessment, and significant resources went into promoting the service brand among potential users. These are functions that weak and under-resourced public sectors would find difficult to replicate and finance on a national scale. Governments should be cautious about conferring official approval on the quality of care of trained private providers unless sound monitoring systems are in place. Moreover, using less qualified providers and drug retailers in government-approved programmes requires building stakeholder support to overcome or neutralise the opposition of powerful professional organisations (Smith, Brugha and Zwi 2001), which was achieved in the Ugandan project (Jacobs et al. 1999), but not in The Cameroon (Crabbe et al. 1998).

5. Restructuring the market

Recognising the importance of the non state sector in health system outcomes does not imply that the public sector has a diminished role to play. Rather, attention is drawn to the often neglected governmental role of stewardship (WHO 2000; Saltman

and Ferroussier-Davis 2000), without which the private sector operates unchecked and unguided. Governments should regulate the private sector not just in the sense of legislating and administering formal rules but also by intervening to alter the incentives available to private sector institutions and thereby their activities and performance outcomes. This can involve restructuring the entire health sector, and introducing approaches to ensuring service provision that apply across the sector, to public and private providers alike.

Government stewardship

The concept of stewardship relates not only to the role of government vis-à-vis the private sector but also to a realignment of governmental functions in the system, which is often both inadequately regulated and inadequately steered towards serving a public health interest (DFID Health Systems Resource Centre 2000). The development of the purchasing function can create a significant new market to which private providers respond. The separation of purchasers and providers involves the creation of public provider institutions with increased autonomy (see Box 13). These can be expected to compete more vigorously with private sector alternatives. By focusing on the purchasing rather than the providing side of the health services market, government can seek to achieve similar ends in the public sector to those pursued through contracting out policy in the private sector.

Box 13: Hospital autonomy in Colombia (Source: McPake et al. 2002)

In Colombia, the reform programme includes among its measures the attempt to universalise a segmented health system, the creation of a purchaser-provider split and the transformation of public hospitals into 'autonomous state entities'. These are intended to contract with multiple competing insurers and the local health secretariat for the provision of services.

A study aimed to track hospital performance in terms of efficiency and quality of care in the post-reform period in Bogotá. Trends in hospital inputs, production and productivity, technical quality, patient satisfaction and finances, and qualitative data based on interviews with hospital workers were collected. There was some evidence of increased activity and productivity and sustained quality despite declining staffing levels. For example, figure 1 shows trends in total admissions, and figure 2 shows trends in bed occupancy rates. Qualitative data suggest that hospital workers have noticed considerable changes which include greater responsiveness to patients but also a heavier administrative burden.

Figure 1: Trends in total admissions

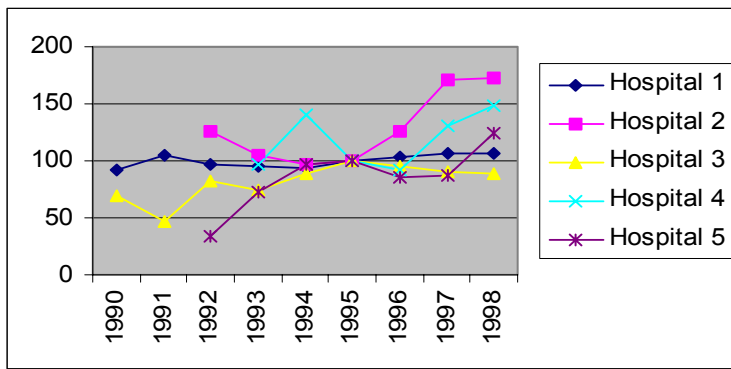
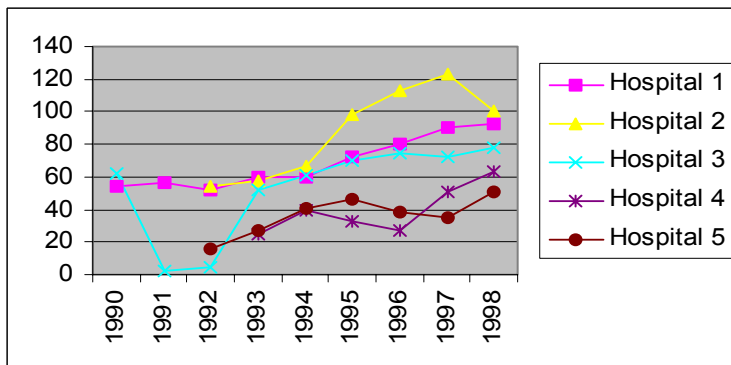


Figure 2: Trends in Bed occupancy rates



It is difficult to attribute specific causality to all of the changes measured and this reflects the inherent difficulty of judging the effects of large scale reform programmes as well as weaknesses and gaps in the data available.

Contracting out services

Over the past decade, many countries have moved towards greater contracting out to private providers, largely for nonclinical services but also for clinical services (Broomberg, Masobe and Mills 1997; Gilson et al. 1997), much of the latter having been reported in the unpublished literature (Slack and Savedoff 2000; Loevinsohn 2000; Bushan, Keller and Schwartz 2002; Connor 2000; Abrahamson 1999). Formal contracts appear more common for services that are relatively easy to specify and monitor, e.g. hospital catering and the provision of commodities, whereas less formal, more trust-based relationships are more common for services that are less easy to specify, e.g. most clinical services. There is some evidence that contracting mechanisms do not work very well in resource-poor environments even for non clinical services, especially where monitoring arrangements are weak (Mills, Bennett

and Russell 2001; Bhatia and Mills 1997 – see Box 14). Externally funded contracting arrangements have had some claimed successes, as have contractual arrangements with NGOs for preventive services (Mills, Bennett, Russell 2001, Marek et al 1999), but these are generally yet to be replicated on a large scale. There is also some evidence that long-term relationships have traditionally dominated in primary care (for example, Palmer 2000 and Box 15). This suggests that the development of competition may not be a common outcome of increasing reliance on contractual relationships for clinical services, whether or not the market would otherwise be contestable, or potentially competitive. Competition may therefore be unlikely to be the source of any efficiency gains that might be associated with increased use of contracting.

Nevertheless, some argue that the contracting framework restructures relationships and responsibilities in ways conducive to efficiency improvement requiring for example precise work statements and quality standards and the establishment of information and control systems (Enthoven, 1985). Further, where contracting is associated with payment mechanisms responsive to activity levels, they introduce incentive to activity, irrespective of the competitive environment. This is likely to be desirable where the effects of the lack of any kind of incentive to activity have become plain, but also carry risks that perverse incentives to inappropriate activity will impose costs. However, there has been little research judging the extent of development and effectiveness of either managerial frameworks or increased incentives to activity. Indeed, very little is yet known of the nature of the relationship between purchaser and provider and how this affects the care provided. What might be concluded for policy is that competition may be a red herring in the contracting

debate – how internal management of provider institutions is reshaped by contracts is likely to be the key point.

Box 14: Contracting out of ancillary services in Sri Lanka (Source: Russell and Attanayake 1997)

In Sri Lanka, there are formal and complex rules for the contracting out of hospital ancillary services. There is a hierarchy of tender boards related to the value of the tendered contract and rules on eligible suppliers or bidders. A review of experience of contracting for food supply to hospitals suggested that cost-minimisation was claimed to be the dominant criterion in selecting from among tenders but that despite the extensive rules, collusion among suppliers, or between suppliers and tender board members, was commonly alleged. The contracts usually succeeded in achieving low prices for hospitals and quantities were variable daily according to bed occupancy rate. Quality specification and monitoring was quite approximate. There were vague clauses in the contract on the quality of supplies, such as ‘in good condition’ or ‘at acceptable quality’ and quite frequently, hospitals would refuse to accept the food supplied. This was the only sanction for non-performance applied. Arrangements for monitoring any collusion between the diet clerk who issued payment vouchers and suppliers were in place, but left some scope for such practice. Suppliers were usually the principal risk bearers because most contracts fixed food prices but price variability of rice and vegetables was high, and because low bed occupancy could make the business unprofitable.

Overall, the study concluded that it was unlikely efficiency gains were being leveraged owing to the lack of transparency in tender board procedures and the nature of competition for contracts which appeared to drive down quality rather than increase efficiency. This emphasises that a contracting approach requires investment in new capacities, especially in quality monitoring among purchasers – but also that weaknesses of governance typical of low-income countries are not eliminated by restructuring relationships. What is less clear is whether or not the implications of weak governance are greater or smaller under different structural arrangements.

Box 15: Contracting for the services of private GPs in South Africa (Source: Palmer and Mills 2002)

In South Africa, Provincial Departments of Health contract with private GPs to provide clinical and medico-legal services to patients within a defined geographic area. Most of this work is the provision of curative primary care services, usually in a separate part of the GP’s private surgery. A study examined contractual relationships in eleven private GP practices in two provinces (Western Cape and Eastern Cape) through interviewing participants in those relationships. The contracts were based on a fee-for-service payment mechanism governed by a standard charge for a list of services. This was recognised by both Provinces and GPs to result in high volumes of patients seen quickly in order to maximise hourly income. There was no specification of quality, or of treatment protocols. The contracts were monitored by monthly reports submitted by each GP detailing number of patients seen, diagnosis and drugs dispensed. The principal sanction specified in the contract was termination by the purchaser in case of ‘breach of a material condition’, ‘serious negligence or default in performing a duty’ or ‘misconduct calculated to discredit the medical profession’ but these were not further described or ever resorted to. On the providers’ side there was also a lack of effective sanction despite occurrences of late or insufficient payment. Few GPs could produce a copy of the contract. Monitoring by the Provinces was patchy. Where it occurred, it focused on volumes of services and did not address issues of quality. GPs argued that local reputation was the more effective check on the quality of their practice. A lack of doctors in rural towns in South Africa meant that most GPs faced little effective competition for their contract. However, the GPs were also reliant on the contract to augment rather meagre incomes from private practice, resulting in a market situation of mutual dependency.

The researchers concluded that the contracts were ‘relational’ in nature – relying less on formal written contract provisions and more on a continuing working relationship between GPs and provinces. However relational contracts are generally understood to be underpinned by mutual trust. In this case, trust was argued to be lacking to a significant degree both because the history of the relationship extended to the apartheid era and because some GPs had been found guilty of fraud in both provinces. There were therefore significant contractual difficulties, and dissatisfaction with the contract on both

sides, but no clear alternatives to ensure primary care provision to this population. The study argues that given mutual dependence and the limited power of the purchaser to control the behaviour of the provider, the most feasible ways forward are more careful selection of those the state wishes to work with, and better strategies for communication and regular interaction.

Regulating the market

Regulation that primarily aims to intervene strategically in the health service market appears to be relatively rare (Kumaranayake 1998). In any case, the major issue in regulation is implementation, which has typically been extremely weak, especially in sub-Saharan Africa (Kumaranayake et al. 2000) (Box 16). This implies that regulation is unlikely to have had a major impact on private providers or on market structure and explains the widespread development of the informal private sector. Growth of the private sector is largely determined externally, even when enabling measures intended to support the sector are in place (Bhat 1996). Experience gained in Thailand, a middle income country, suggests that important opportunities to regulate, before the private sector becomes both politically and economically strong enough to resist, should not be missed by low-income countries (Pitayangsarit, Wibulpolprasert and Tangcharoensathien 2000). Regulation seems to be a function of the market as well as, potentially, an influence on it. The evidence suggests that under-resourced regulatory systems will achieve little, and that there is a need for substantial investment in regulation at a point at which the formal private sector is small and relatively weak. However, such regulation should focus on setting rules for the emerging formal private sector rather than trying to control the informal sector, which middle income experience suggests will assume decreasing importance as the formal sector grows.

Box 16: Regulating the private sector in Zimbabwe (Source: Hongoro and Kumaranayake 2000)

A study reviewed the operation of five pieces of legislation thought to be most relevant to private for profit providers in Zimbabwe:

- The Medical, Dental and Allied Professions Act which covers control of entry and quality of services by individuals and institutions.
- The Public Health Act which covers activities and services that relate to communicable disease.
- The Drugs and Allied Substances Control Act which controls the pharmaceutical market.
- The Traditional Medical Practitioners Act which provides for registration and discipline of traditional healers.
- The Dangerous Drugs Act which provides further controls on the market for dangerous drugs.

It was found that knowledge of regulations was reasonable, although variable. However, there was consensus among health sector stakeholders that regulations were ineffective and unenforced. Practices running counter to regulations such as employment of unlicensed workers, unnecessary procedures and

self-referrals to own laboratories and surgeries were identified. The problems were widely attributed to the failure of inspection systems. Resources for inspection systems were scarce relative to the scale of the inspection task. For example, the Health Professions Council which is responsible for enforcing the Medical, Dental and Allied Professions Act is staffed by one Registrar and six or eight supporting staff in Harare. The integrity of inspection systems was also questioned, the supervision of the inspectors' task being deemed inadequate. There is a dominance of the medical profession among the regulators, potentially an instance of 'regulatory capture' by which the regulated exert undue influence on the regulatory process. Other problems were identified in regulatory design such as outdated legislation – for example the Public Health Act had not been adequately updated in the light of the HIV/AIDS epidemic and there was little consideration of the private for-profit sector at all; inadequate price and quality regulatory mechanisms; and unclear procedures for processing consumer complaints.

The Zimbabwean experience demonstrates the difficulties of regulation in low-income contexts and suggests that regulatory approaches are likely to have little impact on quality or appropriateness of care provided through the private sector. Better outcomes from these kind of approaches would require substantially increased investment as well as a political will to supervise inspection systems starting at the top. Some have placed emphasis on the alternative approach of using consumer organisations to police providers. This is intuitively appealing, placing responsibility with those more likely to be motivated to respond, but there is very little experience of this kind of approach, making its feasibility difficult to judge.

Comprehensive restructuring

Comprehensive attempts to fully restructure the health service market are relatively rare, especially in the very poorest countries. Comprehensive restructuring might be considered the logical destination of a route that begins with selective contracting-out and is underpinned by a logic of establishing clearer frameworks to manage services and increase incentives to activity. In order to apply the same management framework to both public and private providers, a few countries such as Colombia (see Box 13) and the UK have divided the whole health sector into purchaser and provider groups. These attempts raise important questions of whether the market will generate the expected competition, and whether any competition that arises will exert downward pressure on cost or will be conducted on the basis of technically relevant dimensions of quality. For example, instances of 'quality competition' which inflates the technological content of health services have been documented in Thailand (Bennett 1997) and Bangladesh (Amin 2001). Other important questions concern whether purchasers are able to monitor and enforce contracts, or respond to performance appropriately with rewards and penalties. These questions are raised about contracting-out processes in many settings, but raise new issues in a context in which the whole health sector is intended to operate on the basis of contracts, and purchasers are therefore spread thinly over contracts. However, a comprehensive approach better justifies investment in relevant specialist skills among purchasers and in information systems to support purchasing.

The Zambian case provides one example of a comprehensive restructuring approach in a very poor country (Box 17.). Given that the structures put in place in Zambia have not been fully used, it might be argued that the restructuring approach has yet to be fully tested in a low-income context. However, the limited signs that the approach has met with some success in Colombia (see Box 13), suggest that the current tendency to dismiss its relevance to low-income countries could be premature. But policy makers in low-income countries would be wise to wait for increased understanding of the capacity and consequent investment requirements, especially on the purchasing side, and clearer cut evidence of positive impact in middle and high-income countries, before feeling confident that this approach is worthy of the required investment. In the interim, where contracting has been developed on a piecemeal basis, seeking evidence of the extent and effectiveness of managerial framework improvement and the effects (positive and negative) of any increased incentives to activity would provide a basis for decisions on whether to progressively increase the use of contracting by public purchasers, perhaps eventually moving towards a comprehensively restructured sector.

Box 17: Restructuring the health sector in Zambia (Source: Kamwanga et al. 1999)

In Zambia the Central Board of Health (CBoH) has been created to perform the purchasing role at national level. It contracts with district health boards for primary care and services at levels up to and including the district hospital, and with hospital management boards, of both public and nongovernmental hospitals for referral level services. This is an example of a comprehensive restructuring of the health sector which does not imply regulated or managed competition since no competition is expected on either side of the market.

The Zambian reform was not effectively structured so as to capitalise on opportunities of moving towards a managerial framework in which good performance is directly rewarded or poor performance penalised. Budgets are not directly related to the provision of services but still work on the basis of entitlement – a bed base formula in the case of hospitals and a capitation one in the case of districts. Difficulties in effectively monitoring activity levels are seen to preclude more sophisticated contract forms, but without these, CBoH financing can be assumed to be independent of performance by districts and hospitals and there is little leverage exercised by the purchasers. More modest objectives of setting out mutual expectations of services delivered and financial transfers and separating the interests of demand and supply might be inferred from the reform design. However, the budgetary mechanism permits the relationships between purchasers and providers to mimic those of integrated systems, and health ministry officials continue to intervene directly in the affairs of provider institutions instead of focusing on regulatory and other functions of stewardship. The volume of contractual business with hospitals run by nongovernmental organisations represents a significant departure from a standard integrated public sector approach and alters both sides of the market. It also offers the opportunity for public co-ordination of non-profit providers, whereby, for example, the geographical equity of service provision can be increased and the planning of coverage of preventive interventions can be improved. However, these opportunities have also not been exploited. Nongovernmental providers are little affected by the contract mode of operation and continue to enjoy a large degree of autonomy.

It might be concluded that the Zambian experience represents a missed opportunity. Substantial investment in new structures was made but the logic of those structures was dependent on further policy measures which were never introduced. Under these circumstances, little effect of the reforms could be expected, or is suggested to have occurred by existing evidence. Whether or not such restructuring could deliver improvements in equity and efficiency in a low income setting remains an unanswered question.

6. Demands on government capacity

Making greater use of the non state sector rests, at least in part, on the premise that it is difficult to improve delivery of publicly owned services, and hence ways of making better use of the resources in the non state sector are required. However, many of the approaches reviewed above are strongly dependent on state capacity to design, implement and manage the new relationships.

For policy change to stand any chance of being successfully implemented, a number of preliminary steps are required: a clear policy framework needs to be developed, commitment to the policy both from internal actors such as health staff and external actors such as politicians needs to be generated, and an implementation strategy needs to be thought through. Failure to perform effectively one or more of these tasks has frequently suspended the implementation of policies.

In many countries, a substantial amount of decision-making rests in the hands of a very small policy elite: namely senior national technocrats and external policy advisors. This leads to a number of adverse consequences. First, implementation of policy change may suffer due to lack of ownership of reform programmes on the part of key stakeholders such as politicians, health workers and health service users. Second, while reform proposals may be technically sound they are not always politically feasible. Third, the almost complete exclusion of implementers from policy circles has implications not only for the ownership of reforms but also for reform designs. This has been particularly evident in some Sub-Saharan African countries, where a common understanding amongst the policy elite about the direction of the reform programme can result in relatively sophisticated programmes and plans which mask real difficulties in implementation (Russell, Bennett and Mills 1999).

Certain types of policies require the establishment of very new functions within Ministries of Health or may even require the development of new organisations such as accreditation bodies. The types of functions which are commonly only weakly established in traditional Ministries of Health (or are not established at all) include regulation and monitoring; information provision; and management of contractual relationships including methods of paying providers. With respect to the non state sector, lack of information is a key problem – regulation, contracting, training, incentives, all require that the MOH know the numbers, location and characteristics of private providers.

Some of the problems in implementing new policies stem from constraints in the broader environment. The scope for improving the performance of contractors in the health sector may be constrained by regulations on government contracting procedures; for example, government regulations may impose a fixed price which discourages bids and results in a service of very poor quality (Mills, Bennett and McPake 1997). There are often substantial vested interests in the private sector – for example, senior officials and politicians not uncommonly have investments in the private medical sector - which can make it difficult to strengthen regulations. Finally, corruption poses a number of constraints upon effective implementation, and may damage the credibility of reforms to such an extent that they are no longer viable. While corruption is an issue in any system, policy change which decentralises financial control risks aggravating it.

The more complex the service to be provided, the more severe are likely to be the constraints imposed by government capacity. In particular, capacity constraints are likely to affect approaches such as contracting out, splitting purchasers and providers, and strengthening regulation. In contrast, approaches such as social marketing, where independent agencies can be used to stimulate demand and private retailers can be used as distribution channels, place fewer demands on governments. However, it is important to recognise that these approaches are likely to work best for products rather than services, and that only a certain range of health services are susceptible to this approach.

7. Conclusions

This review has indicated that there is a fair amount of experience with ways of working with the non state sector in low income countries to improve performance, but very little information on the other areas reviewed: influencing consumer behaviour and restructuring the market. Moreover, although some successful efforts to influence private providers were identified, they can be problematic. They may imply sanctioning treatment practices that are contrary to current policy and there may be strong opposition from powerful professional groups. The monitoring function is vital but difficult to sustain in the long term. Successful projects are hugely resource intensive, especially when working with unorganised individual providers, and thus careful judgements need to be made on the relative return to investment in improving non state sector activities as opposed to investment in a strengthened public sector. Working with the more organised formal private sector – doctors, nurses and pharmacists – is a more feasible starting point for governments, but their dilemma is not just that the private ambulatory sector is often the preferred source of care, but that the poor are likely to more frequently use informal, illegally practising private providers. The challenge remains unaddressed of how to bring the informal sector into an overall public policy net. Training and investment in a stronger formal sector, both private and public, and restructuring the market so as to strengthen the purchasing and regulation functions of government, may displace the informal sector, but this is likely to be a very long term process.

Given the dominance of non state provision in the health systems of low income countries, it is vital that there be more research effort devoted to understanding its behaviour and how to influence it, and more experimentation with alternative strategies. In particular, research is badly needed on the success of demand side strategies, which could both complement and increase the effectiveness of interventions targeted at providers.

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