Working with the Private Sector to Achieve Public Health Goals at the Country Level[1]

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This note was prepared as a draft core technical framework for the Montreux Challenge meeting on Making Health Systems Work. The purpose of the paper is to begin to develop consensus about key challenges and effective strategies in working with the private sector to achieve public health goals. This is a working document, which will be reviewed and discussed at the Montreux meeting.

1. Critical Challenges for Low Income Countries

The private sector plays a very significant role in the delivery of health services, and the provision of health and health related commodities in developing countries (see Box 1). Even the poor make extensive use of private health providers. Clients often perceive private providers to be more responsive to consumer preferences (in terms of privacy, hotel characteristics and speed of service) and they are often also more geographically accessible than public sector providers. On the part of governments, and others working to achieve global health goals, there is interest in how to take advantage of the opportunities presented by the large number of existing contacts between target populations and the private health sector.

Box 1: Evidence on Role played by private sector in providing services related to global health goals[2]

Review of DHS data from 38 countries showed that for children in the poorest income quintile, 34% to 96% of children seeking treatment for diarrhoea, received that treatment in the private sector, while 37% to 99% of children seeking care for acute respiratory tract infection received that care in the private sector.

In India, the private sector distributes 65-70% of ORS used in the country.

In Sub-Saharan Africa the majority of malaria episodes are initially treated by private providers, mainly through the purchase of drugs from shops and peddlers.

A very broad range of private sector providers make up the private health sector, thus it is difficult to generalize about the private sector or develop "one-size-fits-all" solutions. In particular there appears to be great heterogeneity in the technical quality of care provided by private sector providers, including evidence of very poor quality, which may have significant public health repercussions.

The composition of the private health sector varies across countries, and so it is difficult to identify challenges that are equally relevant in all contexts.

First level challenges

First level challenges are the higher level challenges that directly relate to improved prospects of achieving public health goals.

- How to take advantage of the untapped potential associated with the private sector to expand coverage of products and services which are known to have a public health benefit?
- How to promote a higher quality of care in the private sector, at a minimum to protect the health of patients and broader society, but more broadly to improve quality of care?
- How to engage civil society actors so as to promote greater accountability within the health system (by both public and private providers)

Second level challenges

The second level challenges, identified below, relate less directly to the achievement of health goals but need to be addressed in order to respond to the higher level challenges identified above. The second level challenges reflect the lack of country-specific information about the private sector, and the problems that have been identified with respect to the public sector "doing business" with the private sector, including lack of skills and mistrust between the two sectors.

- How to tailor responses to individual contexts and providers so as to take account of the heterogeneity in the private sector;
- How to overcome mistrust between public and private sectors[3];
- How to improve information availability and reliability about the number and nature of private providers, the range and quality of services which they offer, and treatment outcomes;
- How to develop public sector management capacity to deal with private sector actors, and learn new skills in the private sector way of "doing business";
- In countries where the private sector is diffuse and unorganized - how to promote a more organized, so as to reduce the transaction costs of working with a large number of small, disparate groups;
- In countries where the private sector is more organized - how to strengthen governments ability to manage vested interests in powerful parts of the private sector (including potentially medical associations, private hospital complexes, private health insurance industry) during reform processes.

Quality of care issues in the private sector[4]

- Unnecessary use of antibiotics for treatment of diarrhoeal diseases and non complicated acute respiratory infections (Egypt, Pakistan)
- Insufficient use of oral rehydration salts for treatment of dehydration (Bangladesh, Nigeria, Pakistan, Sri Lanka and Yemen)
- Under-dosing of antimalarials (Vietnam)
- Inconsistent and non-standardized prescribing of antiretrovirals (Zimbabwe, Senegal)
- Non-adherence to treatment guidelines in TB care (India)

2. Scope, definitions and conceptual framework

Unlike some of the other templates prepared for the Montreux meeting, this one on the private sector does not address a discrete health system function. Rather, relationships with the private sector permeate multiple other functions addressed (health financing, human resources, health information).

The private health sector is typically defined to comprise "all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease"[5]. This would include private for-profit (commercial) and private non-profit formal health care providers (private hospitals, health centers, clinics, diagnostic centers etc), as well as traditional and informal practitioners.

Another (complementary) way in which to consider and define the private health sector is to focus on activities which private sector actors in the health sector may engage in. This leads to a rather broader definition (see Table 1), encompassing, in addition to the providers identified above, retailers, civil society organizations, private financing agents etc.

The complexity of engaging private sector actors depends substantially on the nature of the task in which they are to be involved. For example, selling condoms or ITNs is not that dissimilar to the sale of other non-health commodities, and therefore private retailers (without medical training) may be well placed to do this. Contracting for services which are relatively straightforward to specify in advance and to gather information about how well the job is done, is likely to be easier than contracting for more complex and difficult to measure tasks[6]. So it is likely to be easier to contract vector control services than clinical services.

Table 1 – Health sector tasks which may engage private sector actors

Task	Private sector actors likely to be engaged
1. Provision of clinical services (including diagnostic, pharmaceutical services)	Private for-profit and private non-profit health care providers (including private hospitals, health centres and clinics). Traditional healers and midwives. Unqualified doctors (quacks). Diagnostic centers. Pharmacies. VCT centers.
2. Distribution of health and health related commodities (e.g., ITNs, ORS, condoms, drugs)	General retail outlets (shops and stores), drug sellers.
3. Advocacy and watchdog functions – tracking progress towards achieving country and global commitments	Civil society organizations, advocacy groups etc.
4. Provision of preventive and psycho-social support services	Community groups involved in providing support to HIV+ patients. Behavior change communication through employers and youth groups.
5. Provision of auxiliary (non-clinical) support services (such as laundry, transport, management, cleaning services in health facilities.	Private for-profit firms
6. Financing	Employers (through employer based medical benefit schemes). Private health insurers. Community based health insurance schemes.

The note focuses primarily upon the first three rows of the table above – the provision of clinical services, the distribution of health and health related commodities, and the private sector advocacy and watchdog function. It excludes from consideration global level public/private partnerships and also does not address strategies that involve efforts to introduce private sector management techniques into the government sector (such as the establishment of autonomous hospitals).

In recent years there has been a blurring of boundaries between public and private sectors – or at least a greater recognition of this phenomenon. So drugs and other commodities purchased by the public sector may leak into informal drug markets, government health workers may moonlight in the private sector[7], or alternatively may impose private charges when they see patients in public health facilities[8], or even refer their government patients to their private practices[9].

3. Tackling the tractable problems in countries: what is effective and feasible?

3.1 Improving Coverage and Quality

Table 2 presents a range of interventions which have been used to promote greater **coverage** of services through the private sector. The table documents the mechanism underpinning the intervention, as well as summarizing evidence on effectiveness.

Many of the interventions (such as social marketing, vouchers and franchising) have been used predominantly by disease or service specific programmes. In some instances (as is commonly the case with franchising) the range of interventions provided are broadened out from this disease or service-specific base. Typically experience with the intervention remains fairly small scale (though with some notable exceptions).

Table 2 – Summary evidence on interventions to expand coverage

Intervention	Mechanism underpinning intervention	Evidence on Effectiveness
Social Marketing	Increased coverage by private sector actors via information provision to consumers, subsidy of products and expanded distribution chain.	Tends to increase uptake of marketed commodity; impact on other brands of the same commodity retailed through other outlets less clear, and hence concerns about crowding out existing private sector
Vouchers	Promotes consumer choice and ability to afford to seek care from private sector actors, through subsidy of goods or services.	Appear to be positive impacts on uptake of a service or commodity, but relatively limited experience with this mechanism, and administratively complex to target vouchers.
Contracting out	Expands private sector coverage of particular services via government finance, and may (through contract specification) improve quality of care. Sometimes said to improve efficiency and quality through competition.	Larger evidence base on this intervention but mixed findings. Contracting out, under certain circumstances may lower costs, expand coverage, but effectiveness requires appropriately structured and administered contracts. One rigorous study shows greater improvement in immunization coverage among poorest groups[10]. Also evidence of contracts not achieving, or only partially achieving goals.
Public/private partnerships (build own transfer/build own operate)	Joint public/private investment in new facilities reduces costs and extends coverage through leveraging private sector resources.	Only anecdotal evidence regarding the effectiveness of this intervention in low income country contexts
Franchising	Increases supply of quality health care services via encouraging franchisees to follow protocols and guidelines.	May increase uptake of services, but requires consumer willingness to pay for services.

Table 3 below presents potential interventions that focus primarily upon improving **quality**, although note there is a degree of overlap between Tables 2 and 3. Again, with the exception of regulation, and perhaps training, most interventions have only been implemented on a relatively small scale in the developing world.

Table 3 – Summary evidence on interventions to improve quality

Intervention	Mechanism underpinning intervention	Evidence on Effectiveness
Information dissemination to consumers	Creates greater consumer knowledge that enables consumers to use private providers wisely and detect poor quality care.	Limited evidence on how this affects user choice of provider and decision to seek care in the private sector.
Providing resources to private providers	Improves quality of care through better or more appropriate resources e.g., subsidized provision of key equipment, or provision of drugs pre-packaged in complete dosage.	Only anecdotal evidence regarding the effectiveness of this intervention.
Franchising	Increases supply of quality health care services via encouraging franchisees to follow protocols and guidelines.	May increase uptake of services, but requires consumer willingness to pay for services.
Accreditation	Creates incentives for providers to improve quality of care by signaling higher quality providers to health care purchasers.	Limited empirical evidence regarding effectiveness, but a priori likely to be more effective when implemented in connection with powerful purchaser (eg. social health insurance scheme) (which is not common in low countries.
Regulation	Promotes quality of care (and potentially efficiency, equity etc) via legislation and/or the enforcement of stipulated standards.	Substantial evidence of health sector regulations remaining unimplemented or only weakly implemented due to lack of regulatory capacity, or being perverted by powerful vested interests. Regulatory strategy should probably focus on discrete high priority issues, and be backed up by strengthening of (appropriate) regulatory capacity.
Training, continuous education for private providers	Increases private provider skills and therefore quality of care. Could take form of continuous medical education for formal private providers or training for shopkeepers in appropriate prescribing.	Larger evidence base, but again somewhat mixed findings. In particular findings vary as to the extent to which training alone will solve quality problems, versus the need for a package of interventions which also create better incentives for private providers to offer good quality care.

While a very wide range of interventions have been promoted to address quality of care and coverage by the private sector the empirical evidence regarding their effectiveness is limited and somewhat mixed. A number of recent reviews of private sector interventions have been conducted. Two systematic review of evidence on methods to work with the private sector concluded that:

> "The evidence concerning their [interventions with respect to the private sector] effectiveness remains weak….Much of the applicable literature is descriptive rather than evaluative, detailing experiences that may have great potential without rigorously testing their effectiveness[11]."

> "Despite the enthusiasm for introducing private sector interventions in health services in developing countries the lack of robust evidence concerning their effectiveness is of concern[12]."

Even if a particular intervention appears to be effective with respect to narrowly defined goals, it is possible that it may have broader unanticipated effects that counteract the apparent success from a narrowly defined perspective. For example, social marketing initiatives may lead to greater sales of the marketed commodity, but it is less clear what happens to other competing commodities that were not marketed. Moreover many of the studies in the literature have been conducted around specific interventions supported by external actors, and as concluded by Mills et al:

> "Successful projects are hugely resource intensive especially when they involve working with unorganized individual providers[13]."

A key question with respect to these interventions is whether and how they can be scaled up.

While the evidence concerning the effectiveness of interventions identified in Tables 2 and 3 is mixed, it seems, given the huge potential of more effective work with the private health sector, imperative to continue experimenting and evaluating such arrangements, thus the first priority for work in this area may be to:

- ***Priority 1 - Strengthen the empirical information base on effective interventions to promote access through the private sector, or raise quality in the private sector***. New initiatives promoting interventions such as those listed in tables 2 and 3 should be strongly encouraged to include a robust evaluative element (preferably with evidence on changes over time and with control groups). Evaluations are particularly important with respect to interventions that have been scaled up, and which therefore may have different costs and benefits. Factor supporting scale up also need to be identified.

In addition, although rather more contentiously, a further priority may be to strengthen basic regulatory functions. Regulation is distinct from many of the other interventions listed in the tables above, as it is a core function of the health system. While the evidence on the effectiveness of regulation is generally poor (or even counter productive), it is ultimately difficult to envisage many of the other interventions being effective without at least some basic regulation of the private sector. This topic requires further discussion.

- ***Priority 2 - Strengthen basic regulatory functions*** through (i) focussing on developing very basic regulatory functions in developing countries and (ii) building a clearer understanding and greater consensus about what are core minimum regulatory functions (eg. consumer protection, licensing of private providers, drug prescribing regulations) – acknowledging that they may well differ between countries. Note that basic regulation (such as licensing) may also contribute to the information base (see priority 3 below).

3.2 Second level challenges

In terms of scope for action, the second level challenges identified above offer greater scope for action. Specifically the following areas appear to offer promise;-

- ***Priority 3 - Generating basic information on private health sector characteristics at the country level*** – while there is currently no commonly accepted and codified manner in which to describe and analyse the role that private sector actors play in a particular country context – parts of such an analytical framework do exist[14], and could be elaborated to develop a basic, and commonly agreed tool for conducting private sector assessments. In order to tailor possible interventions to different

contexts it is important to have some understanding of what the local private sector context looks like. In addition, efforts in this area could be linked to the Health Metrics Network, and attempt to bring private providers into health information systems in a more routine fashion.

- ***Priority 4 - Building institutional capacity in the currently unorganized and disparate private health sector*** – the transaction costs of working with the private sector may be reduced if the private sector were to be more organized, through the establishment of private physicians associations etc. Such a development may also promote a stronger sense of professional ethics (although note that a possible downside might be that it creates stronger vested interests who may oppose specific sorts of reforms);

- ***Priority 5 - Building skills and attitudes amongst public sector managers conducive to dealing with private providers*** – public sector managers need training in and exposure to new skills such as how to negotiate and agree contracts with private health providers[15]. This could build upon existing training modules but also more innovative strategies such as exchanges with private sector executives could be considered. Exchange strategies, as well as other interventions (e.g., joint training) may also help build trust between public and private sectors.

3.3 Building the private sector role as advocate and watchdog for health

During the past decade active global civil society organizations have been effective in changing the nature of the development debate (witness changes in strategy amongst multilaterals and governments on debt relief issues, and more recently the scale up of antiretroviral therapy), and some have become increasingly engaged in health debates. Coalitions such as the "People's Health Movement" are gaining voice at the local, national and international policy levels to advocate for equitable access to effective health services. Such groups hold the promise of making health policy makers at global and country levels, as well as service providers in both public and private sectors, more accountable.

The Global Fund, has tried to build upon this notion by establishing Country Coordinating Mechanisms (CCMs) that are required to include civil society actors, notably representatives from affected communities. Evaluations of this mechanism suggest that despite the requirements CCMs are often government dominated and civil society organizations have weak voice[16].

While there are a large number of civil society organizations which already play an advocacy role of sorts, they may benefit from enhanced capacity and improved information upon which to base their advocacy efforts. The meeting participants may choose to discuss whether this is an avenue worth pursuing further.

4. Addressing the gaps at the international level: what else should be done and by whom?

Many global health initiatives explicitly recognize the importance of the private health sector, have extensive experience of working with the private sector, and in recent years have been at the cutting edge of work related to the private sector. Some global health initiatives (such as the Global Fund) have underlying principles which emphasize the role of the private sector. There is currently no consolidated attempt to address the private sector challenges laid out here. Action to-date is scattered and there is not always exchange and learning between initiatives specific to different services or diseases.

With respect to the priorities identified above, the World Bank, through its flagship course on health sector reform has provided some limited training to government officials on working with the public

sector and has plans to expand this into a new course on public/private collaboration which will focus on how to create an enabling environment for both sectors to help contribute towards improved health outcomes (this course has already been piloted in Asia).

The Public/Private mix network undertook a significant amount of research in this area (now published as a book) but is no longer functional.

References

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