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What can be done about the private health sector in low-income countries?*

Anne Mills,¹ Ruairi Brugha,² Kara Hanson,³ & Barbara McPake²

Abstract A very large private health sector exists in low-income countries. It consists of a great variety of providers and is used by a wide cross-section of the population. There are substantial concerns about the quality of care given, especially at the more informal end of the range of providers. This is particularly true for diseases of public health importance such as tuberculosis, malaria, and sexually transmitted infections. How can the activities of the private sector in these countries be influenced so that they help to meet national health objectives? Although the evidence base is not good, there is a fair amount of information on the types of intervention that are most successful in directly influencing the behaviour of providers and on what might be the necessary conditions for success. There is much less evidence, however, of effective approaches to interventions on the demand side and policies that involve strengthening the purchasing and regulatory roles of governments.

Keywords Health services/supply and distribution; Private sector; Marketing of health services; Quality of health care; Legislation, Health; Consumer advocacy; Developing countries (*source: MeSH, NLM*).

Mots clés Services santé/ressources et distribution; Secteur privé; Marketing services santé; Qualité soins; Législation, Santé; Défense consommateur; Pays en développement (*source: MeSH, INSERM*).

Palabras clave Servicios de salud/provisión y distribución; Sector privado; Comercialización de los servicios de salud; Calidad de la atención de salud; Legislación sanitaria; Defensa del consumidor; Países en desarrollo (*fuentes: DeCS, BIREME*).

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Voir page 329 le résumé en français. En la página 329 figura un resumen en español.

Introduction

In recent years there has been a considerable growth of interest in the activities of providers in the private health sector in low-income countries, and in how policy-makers might best capitalize on the accessibility and popularity of this sector (1–3). However, the evidence is limited as to which approaches work best. There have been many references to social marketing, accreditation, franchising and contracting, but much of the experience is documented only in the unpublished literature or has been gained in relatively small projects (4, 5). The aim of the present paper is to consider how the activities of the private health sector in low-income countries can be influenced so that they help to meet national health objectives.

Characteristics of the private health sector in low-income countries

The private health sector may be defined as comprising all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease. They include large and small commercial companies, groups of professionals such as

doctors, national and international nongovernmental organizations, and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses, midwives and paramedical workers, diagnostic facilities, e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores.

In practice there is a considerable overlap between the public and private sectors (6). Staff employed in the public sector may also practise privately, either on their own account or working for owners of private facilities. This may be legal or may not be strictly legal or controlled. Public 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 private patients and are paid directly by them. If public services become heavily dependent on fee income, as, for example, in China (7), there may be little to distinguish them from private enterprises that operate in the interest of their owners rather than in that of the general public.

The private sector represents a resource that is available and used even in the poorest countries and among lower income groups (8). For example, the majority of malaria

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episodes in sub-Saharan Africa are initially treated by private providers, mainly through the purchase of drugs from shops and peddlers (9, 10). For some diseases of high priority, e.g. malaria, tuberculosis and sexually transmitted infections in the many countries where the public infrastructure is limited, prevention and treatment cannot be substantially scaled up without considering how best to make use of contacts with the private sector.

However, the effectiveness of private services is often very low. Poor treatment practices have been reported for diseases such as tuberculosis (11, 12) and sexually transmitted infections (5, 13), with 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 cheap because they are adjusted to the purchasing power of the client, as when partial doses of drugs are sold. In Sierra Leone, for example, the price of purchased drugs was almost a third of the cost of treatment at a public health centre (14). Another reason for the popularity of private services is that they are often accessible: drugs are sold through general retail outlets with convenient opening hours.

The use of the more expensive private services, or treatment for chronic conditions, can result in households being unable to afford other vital requirements. Over 10% of the income of the poorest quintile of the population is often spent on medical care, as found in a study in Sierra Leone (14). Moreover, rapidly growing private services compete with the public sector for trained human resources. This both weakens the public services and opens possibilities of using private sector resources to promote public health objectives.

How can the operation of the private market be improved? The current situation is the result of interaction between consumers and providers. Consumers make their decisions on which providers to use on the basis of price, available income, their knowledge of different providers, and their preferences for services with different characteristics, particularly relating to quality. Providers 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 should influence demand or supply directly or should seek to restructure the overall environment.

Influencing consumers

Consumers in low-income countries face a number of problems 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 place more weight on aspects of perceived quality, such as the interpersonal skills of providers and the comfort of the environment in which treatment occurs, both of which may be unrelated to technical competence. They may, therefore, be more exposed to inadequately qualified practitioners providing care of very poor quality. Consumers with low incomes may choose to use practitioners in the informal sector, such as

unqualified providers and drug sellers, rather than higher-quality private providers. However, 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 (15).

Relatively few approaches to supporting consumers in their use of the private sector have been tested. 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; and to create new institutions that give consumers greater authority to challenge care of poor quality.

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 organizations are often non-profit firms or associations, but the products tend to be distributed through various for-profit outlets and nongovernmental organizations. 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, 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 (16). The lack of evidence 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.

By providing subsidized commodities, social marketing also 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 public, usually donor, funds. This form of subsidy is usually untargeted, raising the possibility that a substantial share leaks to people who would otherwise have purchased the product at the full price. Furthermore, other measures are needed to ensure access for very poor people who cannot afford even the subsidized product.

There is limited experience with the branding of services and the use of social marketing to promote them, e.g. in reproductive health (3). However, the consequences of the social marketing of services may be quite different from those of commodities because of the less flexible nature of the supply of services. Increasing demand for commodities is likely to be met with an increase in supply, but qualified staff are in shorter supply 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 utilization 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.

Use of 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. 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 the preferences of patients. A voucher system nevertheless needs a mechanism for determining who qualifies for subsidy, and vouchers can be traded among individuals, making it more difficult to ensure that subsidies reach the target group. Voucher systems have been used for targeting insecticide-treated mosquito nets in the United Republic of Tanzania (17) and sexual health services for sex workers in Nicaragua (2), but their potential remains underexploited.

Consumer protection

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. A number of improvements followed, but other complementary measures are needed in order to confront the poor quality of care in the private sector (18).

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 they choose providers; and social marketing approaches could prove useful in publicizing such information. Although regulation and accreditation are, strictly speaking, provider-side interventions, they 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.

Influencing private providers

Governments should use a range of approaches when working with private providers rather than relying on single strategies.

Training

The improvement of knowledge and skills is a necessary starting point. Most private providers receive no guidance from the public sector on diagnosis and treatment (19). Consequently, their practices are determined more by biased information from pharmaceutical companies (20, 21). Although imaginative ways of disseminating evidence-based information to private providers are insufficient on their own to change behaviour, they offer a potentially affordable strategy that has been little explored (5). Training is central to most approaches. For example, it has improved the diagnosis and counselling practices of informal providers in India (22), the provision of antimalarials by shopkeepers in Kenya (23), and

the management of diarrhoea and acute respiratory infections by private medical practitioners in Mexico (24). However, improvements attributable to one-off training may be short-lived (25), and follow-up and supervision in the private sector is difficult for an underresourced public sector unable to supervise its own health workers.

Regulatory and participative approaches

The private ambulatory sector can be highly competitive, so that success in meeting users' perceived needs and retaining clientele is vital to the economic survival of providers (8, 26). Private providers may use treatments they know to be ineffective because of actual or perceived user demand (25, 27). The involvement of service users in the training of providers has successfully reinforced improvements in practice (28). However, private providers may engage in what they know to be unethical practices in order to maximize income (26, 29). Regulatory approaches, including consumer protection legislation (18), have helped to highlight these practices but have done little to control them (26). In Pakistan the deregistration of paediatric antimotility drugs for diarrhoea led to their substitution by more dangerous adult formulations (30). An approach that could have greater impact in the longer term is for the public sector to work with providers' representative organizations in order to promote professional ethics, building on non-financial incentives such as the desire of providers for social recognition and prestige (31, 32). Such organizations could also be used to support measures promoting rational drug prescribing, which have mainly been applied in the public sector (33).

Resourcing providers

Private providers may lack access to essential diagnostic services and treatments. One approach has been to provide them with prepackaged 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 prepackaged antimalarials subsequently marketed them to street vendors who then sold individual tablets at higher unit cost to the poorest customers (34, 35). 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 patients do not have tuberculosis and are asked to report back to the referring doctors with their results (36). The doctors welcome participation since the scheme supports their client base. It already helps to improve diagnostic skills and may have the potential to evolve into a more formal certification or accreditation scheme.

Comprehensive approaches

Some successful projects have adopted a comprehensive approach, improving providers' knowledge and skills, assisting users to recognize and demand good care, and helping providers to apply what they have learnt. In the Clear 7 Project in Uganda, which provided prepackaged drugs for the treatment of sexually transmitted infections through private clinics and shops, improved cure rates and prevention practices were reported (37). The Green Star Project in Pakistan improved access and increased the coverage of a wide range of

family planning services among previously unreached women (38). In these projects the quality of clinical care was monitored by external assessment, and the project brands were promoted among potential service users: functions that weak public sectors would find difficult to replicate on a national scale. However, 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, the approval of less qualified providers is often vehemently opposed by professional organizations (39). The approach also runs the risk of further segmenting the market along income/quality lines.

Restructuring the market

Recognizing the importance of the private 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 (1, 40), 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.

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 public system, which is often both inadequately regulated and inadequately steered towards serving a public health interest (2). By focusing on the purchasing rather than the providing side of the health services market, government may seek to achieve similar ends in the public sector to those pursued through contracting out policy in the private sector. Formal regulation may influence the number of providers through licensing, but the development of purchasing may 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. These can be expected to compete more vigorously with private sector alternatives.

Contracting out services

Over the past decade, many countries have moved towards greater contracting out to private providers, largely for non-clinical services but also for clinical services (41, 42), much of the latter having been reported in the unpublished literature (43–47). Formal contracts are 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 commoner for services that are less easy to specify, e.g. most clinical services (48). Long-term relationships have traditionally dominated in primary care (49). 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. Indeed, very little is yet known of the nature of the relationship between purchaser and provider and how this affects the care provided.

Regulating the market

Regulation that primarily aims to intervene strategically in the health service market appears to be relatively rare (50). In any case, the major issue in regulation is implementation, which has typically been extremely weak, especially in sub-Saharan Africa (51). 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 (18). Experience gained in 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 (52). Regulation seems to be a function of the market as well as, potentially, an influence on it.

Comprehensive restructuring

Comprehensive attempts to fully restructure the health service market are relatively rare, especially in the very poorest countries. In Zambia the Central Board of Health has been created to perform the purchasing role at national level. It contracts with district health authorities and referral hospitals, both public and nongovernmental. The volume of contractual business with hospitals run by nongovernmental organizations represents a significant departure from a standard integrated public sector approach and alters the demand side of the market considerably. It also offers the opportunity for public coordination 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. Other effects of reform are constrained by the underexploitation of the new structures. For example, contract mechanisms permit 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 (53). The restructuring approach has yet to be fully tested in a low-income context.

Conclusions

A fair amount of experience has been gained on how to work with private providers in low-income countries in order to improve their performance. However, very little information is available on influencing consumer behaviour and restructuring the market. Although we have identified some successful efforts to influence private providers, they can be problematic. These efforts 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 they involve working with unorganized individual providers. Consequently, careful judgements have to be made concerning the relative return on investment in improving private sector activities as opposed to investment in a strengthened public sector. Working with the more organized formal private sector, i.e. doctors, nurses and pharmacists, is a more feasible starting point for governments. In this connection, however, there is a dilemma in that the poor more frequently use informal, illegally practising private

providers. How to bring the informal sector into an overall public policy net remains an unsolved problem. 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 dominance of private provision in the health systems of low-income countries makes it vital to conduct more research into understanding and influencing their behaviour and to experiment more with alternative strategies. In particular, research is necessary on the success of demand-side strategies, which could both complement and increase the effectiveness of interventions targeted at providers. ■

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Résumé

Secteur sanitaire privé dans les pays à faible revenu : que peut-on faire ?

Il existe dans les pays à faible revenu un secteur sanitaire privé très important regroupant un large éventail de prestataires et utilisé par toutes les couches de la population. On peut toutefois s'inquiéter de la qualité des soins donnés, surtout dans la partie la plus informelle de ce système. Cela est particulièrement vrai en ce qui concerne les maladies d'importance majeure en santé publique comme la tuberculose, le paludisme et les infections sexuellement transmissibles. Comment peut-on influencer les activités du secteur privé dans ces pays de façon qu'elles contribuent à la

réalisation des objectifs sanitaires nationaux ? Bien qu'on ne dispose guère de données satisfaisantes, il existe des informations sur les types d'intervention les plus à même d'influencer directement le comportement des prestataires et sur les conditions requises pour parvenir à des résultats. On connaît moins bien, en revanche, les approches efficaces en ce qui concerne les interventions au niveau de la demande de soins et les politiques consistant à renforcer le rôle des pouvoirs publics en matière d'achat et de réglementation.

Resumen

¿Qué hacer con el sector sanitario privado en los países de bajos ingresos?

En los países de bajos ingresos existe un sector sanitario privado de grandes dimensiones. Se trata de una gran variedad de proveedores a los que recurren amplios segmentos de la población. El tema de la calidad de la atención prestada, sobre todo en el extremo más informal de la gama de proveedores, suscita una considerable preocupación. Así ocurre sobre todo con las enfermedades más importantes en el campo de la salud pública, como la tuberculosis, el paludismo y las infecciones de transmisión sexual. ¿Cómo se puede influir en las actividades del sector privado en esos países para que contribuyan al logro de los

objetivos de salud nacionales? Aunque la evidencia disponible no es satisfactoria, se dispone de bastante información sobre los tipos de intervención más eficaces para influir directamente en la actitud de los proveedores, así como sobre las que podrían ser las condiciones necesarias para asegurar el éxito de esas iniciativas. La evidencia es mucho menor, sin embargo, en cuanto a la manera de enfocar eficazmente las intervenciones orientadas al lado de la demanda y las políticas que entrañan el fortalecimiento de las funciones adquisitiva y reguladora de los gobiernos.

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