Working with Private Sector Providers for Better Health Care

AN INTRODUCTORY GUIDE

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In many developing countries, when people first seek diagnosis and treatment for an illness they visit a private pharmacist, nurse, midwife, doctor, a drug seller or traditional practitioner. People use these private sector providers (PSPs) because they are often nearer, open for longer hours, and are seen as more considerate and sometimes less expensive than their public sector counterparts. PSPs are often a significant part of the health system in developing countries. Consequently they are an important focus for governments which aim to improve the performance of their health system.

Poor people in particular visit PSPs for diagnosis and treatment of illness, including those illnesses which contribute most to the population disease burden, such as malaria, sexually transmitted infections, diarrhoea and tuberculosis. They often pay out of their own pockets for health services and products from PSPs as they are not generally members of pre-paid health schemes. Poor people are thus both vulnerable to the drain on their resources resulting from ineffective treatment and to the sometimes catastrophic costs of serious illness. Both may lead to further impoverishment.

This Guide aims to provide a practical but critical approach to developing strategies for working with PSPs for better health care. Its focus is the encounter of individual people, especially poor people, with individual private health providers and the factors that determine the health and financial outcome of that interaction. The Guide highlights how to work with the private sector to achieve key health objectives – **increasing coverage** of information, products and services provided by PSPs, especially for health care priorities, **improving the quality of care** which PSPs provide and thirdly, **controlling excessive health care costs**.

Private sector involvement in health is sometimes promoted from an ideological viewpoint. This Guide takes another position, that, as a matter of pragmatism, decision-makers should build on the comparative advantage of the private sector in their own context.

The Guide approaches its task in the belief that PSP behaviour is influenced by the interplay of **policy-makers** who set policy, enact legislation, enforce regulations and purchase care for their populations, **people** who do or do not buy products and services from PSPs, and the **providers** themselves who bring their experience, skills and motivations to their encounters with clients.

We examine critically, and in some detail, thirteen strategies grouped under coverage, quality and cost objectives with a policy-maker, provider, or people focus. Many strategies involve two or more of the stakeholders and may have an impact on more than one objective. However, focusing on **coverage, quality, cost**, plus **policy-makers, providers and people**, serves as a helpful aide-memoire to make sure that all these dimensions are routinely considered. The strategies are summarised in the following table:

	Working through **POLICY-MAKERS**	Working with **PROVIDERS**	Enabling **PEOPLE** – users, communities and their representatives
Increase **COVERAGE** of products and services with a public health benefit which are affordable for target groups	**Strategy 1** Lower policy, regulatory and fiscal barriers to wider availability	**Strategy 2** Subsidise marketing of products with a public health benefit through retail networks **Strategy 3** Recruit PSPs into an accredited network for specific health services with a public health benefit **Strategy 4** Contract with PSPs for packages of essential health care	**Strategy 5** Expand demand among priority target groups **Strategy 6** Introduce exemption schemes for priority target groups
Limit harmful practices and improve technical **QUALITY** of care	**Strategy 7** Enact and enforce legal restrictions and regulatory controls	**Strategy 8** Provide training supports and incentives to PSPs to conform to good practice norms	**Strategy 9** Enact consumer protection law and raise awareness of consumer rights **Strategy 10** Increase service user knowledge through community education campaigns
Control treatment **COSTS** to users of PSPs	**Strategy 11** Set PSP price levels	**Strategy 12** Finance PSPs through prospective payment mechanisms	**Strategy 13** Publish information to users on maximum permitted prices

Table 1 : Strategies for Working with Private Sector Providers for Better Health Care

The Guide is structured as follows:

SECTION 1 : Introduction (page 4) provides an overview of the Guide's approach.

SECTION 2 : Why take notice of Private Sector Providers (page 8) outlines why PSPs are important in health service delivery in developing countries, especially for the poor; and the justification for working with them. Some readers may prefer to skip this section and go to Section 3, or straight to Section 4 which describes and evaluates different strategies for working with PSPs

SECTION 3 : Objectives in working with Private Sector Providers (page 12) outlines the dimensions of the objectives of increasing **coverage**, improving **quality**, and controlling **costs** to users. It explores the barriers to increasing coverage, summarises the factors that influence quality of care and excessive health costs and identifies the main strategies for achieving these objectives.

SECTION 4 : Strategies for working with Private Sector Providers (page 16) considers and presents the evidence of effectiveness for the thirteen strategies. The Guide presents a **description** of each strategy. **Case studies** are used to illustrate the application of the strategy in a particular context or to illustrate a particular point. **Cautions, pitfalls and evidence gaps** follow. Contextual **features which facilitate** a particular strategy are identified. We then invite readers to engage in determining how suitable a particular strategy might be in their own contexts, and draw **conclusions** as to the likely success or failure of the strategy for achieving the objectives.

SECTION 5 : Taking things forward (page 58) provides advice on **next steps**. We describe two patterns of private sector provision in developing countries. We examine how these will influence the choice of strategies for working with PSPs, given likely resource constraints and government capabilities. We hope that this will assist in the selection of strategies with the greatest chance of success.

The **glossary** of common terms (page 66) explains some of the technical language marked with an '*' used in the Guide. A list of acronyms used in the Guide follows.

The **references** section (page 68) is a starting point for some of the literature on PSPs; we also provide details of key web-sites which are useful starting points in the search for more detailed information.

The authors of this Guide are keen to receive feedback and to examine how the Guide's value can be enhanced in the future; your contribution of comments, information, and experience will be of great value and much appreciated. The authors' contact details are given on the inside back page of the Guide.

Introduction

Can private sector providers (PSPs) of health care contribute to achieving public health goals in developing countries? Should the state control them, ignore them, or work with them? What mix of these things is most appropriate, and in what contexts? If engagement and collaboration is a way forward, what form should this take? What are the prerequisites for working effectively with PSPs? How do we take greatest advantage of what PSPs have to offer, while limiting any potential ill-effects on equity and quality?

The aim of this Guide is to provide a practical but critical approach to developing strategies for working with PSPs for better health care. A particular concern is improving access to good quality care for the poor.

This Guide is intended for policy-makers and programme managers working in developing countries' ministries of health. We refer to them as **decision-makers** throughout the Guide. It is also aimed at **donor advisers** working to support the health sector in those countries; such advisers are themselves often decision-makers with regard to how donor policies are implemented. The Guide will also be of interest to other stakeholders: **professional organisations, development banks, academics, consumer groups** and other **civil society organisations**. It draws lessons mainly from experience in Asia and Sub-Saharan Africa.

The Guide presents a range of strategies to achieve three **objectives**:

Coverage: To improve access to products and services with a public health benefit, especially for the poor, using existing or expanded private sector capacity

Quality: To limit harmful practices and improve technical quality of care

Costs: To control excessive treatment costs and exploitation of service users by PSPs.

While these objectives are integrally related, they have been separated out to help illustrate their importance and to specify the strategies available for responding to them.

Underlying this entire document is a concern to highlight **key principles and values** underpinning health care provision:

- that health care is a right,
- that poor people should have access to improved quality of care,
- that they should not pay exorbitant amounts to achieve this,
- that the state should ensure essential services are provided to poor people whatever the public-private mix of financing and provision, and
- that resources should be used as effectively, efficiently and equitably as possible.

Who are Private Sector Providers (PSPs)?

PSPs are health care providers who work outside the direct control of the state. In developing countries, those describing PSPs often include both for-profit and not-for-profit providers. PSPs may be formally trained (pharmacists, doctors, nurses and midwives) or informally trained; they may work on their own or in institutions, and they may provide health care or other products such as drugs and contraceptive supplies.

This Guide focuses specifically on **those PSPs who operate on a for-profit basis, primarily in poorer countries, and who directly interact with service users, supplying them with health care services or products**. We recognise the importance and influence of other major actors in the private health sector such as manufacturers and distributors of equipment, pharmaceuticals and supplies; as well as laboratories, diagnostic centres and hospitals. However, working with these groups requires a different set of strategies and they have therefore been excluded from this Guide.

Often there is little information about the nature of the private sector in different contexts. The characteristics of PSPs (see Figure 1 below) will be very different in terms of their legal status, training, facility base, nature and complexity of product or service provided, and proportion of time spent in private practice. Drawing on these dimensions, it is possible to examine the *visibility* of PSPs, and the ability and ease with which decision-makers are able to identify PSPs, assess their practices and work with them to improve coverage, quality and control costs to users.

In most contexts more is known about the more visible parts of the private sector, such as those providers who are more formally trained and organised. Relatively little is known about the informal ambulatory sector, despite the fact that they are often important providers of health care for the poor. It is much harder to monitor and regulate the less visible parts of the private sector.

Characteristic	**More visible** ⟶		**Less visible**
Legal status and training	Formal (trained and operating legitimately) Physicians, nurses, pharmacists		Informal (untrained and illegal) Shopkeepers, itinerant vendors
Size of facilities	Large hospitals and clinic networks (registered with licensing authorities)		Solo PSPs (often large numbers of shopkeepers, drug vendors)
Nature of service	Provide comprehensive clinical services		Sell single products such as drugs, ITNs, condoms
Public-private practice mix	Legal dual practice	Full-time private practice	Illegal dual practice

Figure 1 : Visibility of PSPs by Type *(Brugha and Hanson 2000)*

The role of non-governmental organisations (NGOs)

Although we explicitly include NGOs as PSPs in a number of places in the Guide, we recognise that NGOs usually operate on a not-for-profit basis. NGOs are also more likely than for-profit providers to value any societal benefits they achieve. NGOs thus operate under a set of incentives, influences and underlying values that may be different to for-profit providers. In some places in the Guide therefore, we present data and experience regarding the specific role of NGOs. This role may be either as providers in their own right or as intermediaries between government and PSPs.

Dual employment: public and private sectors

Many PSPs work on their own on a for-profit basis while also working within a not-for-profit organisation or in the public sector. The Guide acknowledges the frequently blurred boundaries between public and private practice. In many settings 'dual public-private practice' – where publicly employed providers also engage in private for-profit practice, legally or illegally – is common. This may result in flows of patients and resources in either direction, from public to private or private to public. Where dual practice is common and legal, these close connections between the two sectors may provide opportunities for reaching PSPs.

This Guide's approach

This Guide:

- is informed by the belief that PSP behaviour is influenced by the interplay of different actors and factors, principally:

  Policy-makers who set health priorities, enact legislation, enforce regulations, purchase health care for their populations and determine financing mechanisms, and

  People who use (or do not use) services, and who bring their knowledge, previous experiences, expectations and resources, when they seek health care or otherwise respond to ill-health.

  Other factors influence **provider** behaviour. These include:

  - their training, skills and knowledge;
  - degree of access to the resources necessary for delivering services;
  - the mix of incentives and controls which operate;
  - interactions with other providers (public and private);
  - the level of competition the provider faces; and
  - the financing system for health care.

  The Guide acknowledges that the policy context, service user factors and PSPs' responses are inseparable. Modifying one affects the others. However, strategic responses can easily overlook one of these sets of actors. We seek to avoid this by explicitly highlighting policy-makers, providers and people (service users and non-users), in turn, in the belief that this helps to avoid overlooking these critical dimensions of any set of strategies.

  This Guide:

- is cautious and critical, drawing on **existing evidence** whilst highlighting its limitations and **gaps**; it aims to provide pointers to potentially fruitful approaches.
- recognises that the selection of strategies and design of specific interventions will be highly **context dependent**, and acknowledges the constraints facing decision-makers. It does not assume that there is any generalisable correct balance in public-private health care provision.
- acknowledges that the public and private sectors each have **strengths and weaknesses**, and recommends building on the comparative advantages of each. PSPs are often considered to offer more personalised services, to provide better continuity of care, and to provide services which are more accessible and acceptable to users. The nature and scale of private sector provision is often greatly dependent on how well public sector services are performing.
- focuses on health care **provision** within existing health systems while recognising that changes in **financing** mechanisms also offer potentially important levers over provider behaviour.

SECTION 2 : WHY TAKE NOTICE OF PRIVATE SECTOR PROVIDERS

Introduction

Increasingly, decision-makers in developing countries are taking notice of the role of PSPs in health care provision. This is because PSPs are important providers of care and health care costs are a major drain on people's resources, particularly the poor. Managing PSPs is among the most complex stewardship tasks facing policy-makers; for this they require better information and tools.

Private sector providers are important providers of health care

People often choose private providers, even where public providers are available

In many developing countries, when people seek treatment for an illness they visit a PSP first. This is the case for many types of illnesses, including those that contribute most to the population disease burden such as malaria, sexually transmitted infections (STIs), tuberculosis (TB), diarrhoeal diseases and acute respiratory infections (ARIs).

- In many countries most treatment of malaria (McCombie 1996) and STIs (Brugha and Zwi 1999) takes place outside the public sector, through visits to PSPs or direct over-the-counter purchase of drugs, often from untrained shop staff, for self-treatment.
- In India, an estimated 60 to 85% of TB cases seek treatment initially from PSPs (Uplekar et al. 1998). About two-thirds of these cases stay with PSPs, rather than changing to public sector providers. Similarly, 80% of consultations for childhood diarrhoea in India are with PSPs, most of whom are not fully qualified (Berman 2000).
- Personal ambulatory (outpatient) care has the potential to address 75 to 80% of the global burden of disease. In Egypt – one of the few countries where country-level data are available – more than half of this care is obtained from private physicians (Berman 2000).

PSPs are also often the first choice for women seeking to control their fertility. Excluding India and China, one third of women in the developing world rely on private sources for family planning (Rosen and Conly 1999). This is particularly the case for temporary methods.

PSPs are active and successful competitors in most health care markets, often more popular than public sector services. Reforms such as the introduction of user charges have driven people with, for example, STIs away from the public sector (Moses et al. 1992). This can have serious implications for population coverage, equity and quality of care (Benjarattanaporn et al. 1997).

Many of the reasons people give for visiting PSPs reflect their greater responsiveness to service user preferences (Box 1):

Box 1 : Reasons for Consulting Private Sector Providers

- ease of geographic access, shorter waiting periods, longer or more flexible opening hours
- greater availability of staff and drugs; new anti-malarials such as the artemisinins, on which future malaria control strategies will rely, are widely found in private retail outlets long before reaching the public sector
- greater confidentiality in dealing with diseases such as TB and sexually transmitted infections (STIs) which carry social stigma, especially where notification of STIs by public sector services is mandatory
- perceptions that PSPs are more considerate, caring and sensitive to client concerns
- both informal and formal user charges may be levied in the public sector, making public sector services equally or more expensive
- perceptions, in some settings, that private sector services are technically superior
- continuity of care and – in the case of doctors – a belief in the value of the 'family-doctor' relationship

(Aljunid 1995; Swan and Zwi 1997)

The technical quality of care provided by private providers is often poor

PSP practices have been under-researched and few of the available studies compare public and private sector quality of care. However, the available evidence reveals serious technical weaknesses in the services supplied by many for-profit providers (Swan and Zwi 1997).

- Shortcomings in private sector TB care include: failure to test sputum, reliance on X-ray diagnosis alone, use of incorrect drugs or drug dosages, and failure to educate patients. In India, almost half of the TB patients attending private doctors failed to complete the treatment (Uplekar et al. 1998). Recent studies in Vietnam have shown similar patterns of health care provision for TB by PSPs: little use of appropriate diagnostic tests, delays in establishing the diagnosis and commencing treatment and poor referral to the best available public sector services (Lönnroth 2000).
- Studies of pharmacy, general practice and specialist STI services have shown poor quality management of STIs by for-profit PSPs. In a study from Thailand, even where users recognised that government services were technically superior, they sometimes chose a PSP to minimise embarrassment (Benjarattanaporn et al. 1997).

Lack of information and an inability to make sound judgements about the technical quality of the available types of health care – information asymmetry* – is a major constraint when people purchase care. They may find PSPs more responsive, but may not recognise their inadequacies. Poor prescribing, dispensing and self-medication practices waste scarce resources, harm individuals and contribute to the spread of infectious diseases. Where incomplete courses of drugs are dispensed or people fail to complete the treatment, resistance to the drugs that are essential for controlling infections is promoted.

Even the poor make considerable use of the private sector

It is usually assumed that the rich use private sector services more than the poor. Although this is generally the case, the differences are not great:

- In nine of the poorest countries, an average of 47% of health care visits by the poorest 20% of people and 59% of such visits by the richest 20% were to PSPs (for-profit and non-profit), rather than to public sector providers (unweighted averages*)
- A study of one district in India estimated that 84.6% of the poorest 20% visited PSPs compared with 100% of the richest 20%.

(Gwatkin 1999)

In countries such as India, where the poor predominate and most people visit PSPs, the poor, who are more in need of health care, form the greatest proportion of PSPs' workload. The poor also spend a greater proportion of their income on private (and public) care than do the rich. Information on people's choice of provider and their reasons for that choice is scarce. However, studies from a number of countries suggest that the poor have less access than the rich to the more sophisticated tertiary level public sector facilities. In addition, when they use the private sector, the poor tend to use less qualified or traditional providers, where care is often of poorer quality. The rich are more likely to have health insurance, to use the formal rather than the informal private sector, to have greater access to information and to make better-informed choices.

Health care is a major drain on poor people's resources

The poor spend more of their income on health care but get less care

A review of five national or large developing country studies from the late 1980s and 1990s showed that the poorest 20% spent 15.5% of their household income on health care compared with 5.2% spent by the richest 20% (unweighted averages*) (Fabricant et al. 1999). Expenditure by the poor is more likely to be out-of-pocket and spent on personal ambulatory care than that of the rich (Berman 2000). The poor are also less likely than the rich to obtain health care, as shown in national-level surveys from 11 Sub-Saharan African countries and population surveys from nine other countries:

- 38% of the poorest 20% obtained health care for illness or injury compared with 55% of the richest 20%
- 29% of children with diarrhoea from the poorest one third of households were brought to a health care facility compared with 41% of the richest
- 35% of the poorest obtained no treatment compared with 28% of the richest third (all figures are unweighted averages*)

(Gwatkin 1999)

The cost of health care can have catastrophic consequences for the poor

There is growing evidence that the cost of health care among the poor can lead to deeper poverty. Coping mechanisms when the poor need health care, especially hospital care for 'catastrophic illnesses', include borrowing from friends, relatives or moneylenders, sale of assets including stored food, livestock and agricultural implements, and reduced spending on food and education. The outcome in the worst cases is a downward spiral of indebtedness, loss of livelihood and further poverty. Entire communities can become more vulnerable and solidarity mechanisms may break down.

> In a 1989-90 study from Sierra Leone, 50-63% of total health expenditure was on high cost care (hospital and private provider care). This spending included 16% of the total household income of the poorest 20% who spent almost the same amount on health care as the wealthy.
>
> *(Fabricant et al. 1999)*

International policy increasingly seeks to involve private sector providers and enhance the stewardship capacity of policy-makers

In a global environment that promotes private investment in health, health policy-makers require tools to ensure that the goals of equity and population access to quality services, especially for the poor, are promoted. In the past, health ministries' attention has been directed primarily to public sector services and institutions. Their approach to the private sector has rarely gone beyond enacting legislation and issuing regulations, which are frequently not enforced or are subverted. The recent WHO World Health Report (2000), 'Health Systems: Improving Performance', has identified 'stewardship' as a central function of government in managing the complex health systems that have evolved over time. "Good stewardship needs the support of several strategies to influence the behaviour of the different stakeholders in the health system. Among these are a better information base, the ability to build coalitions of support from different groups, and the ability to set incentives, either directly or in organizational design" (WHO 2000).

Assisting national governments in developing stewardship capacity is seen as a key role of external agencies and advisers. Private service provision is greatest in poorer countries, which are also those which lack clear policies towards the private sector. The report cites the need for a range of supportive, regulatory and incentive-based mechanisms. However, evidence of the effectiveness of the different strategies is patchy; and guidance to decision-makers on which to use in their particular settings is lacking. This Guide attempts to fill this gap.

SECTION 3 : OBJECTIVES IN WORKING WITH PRIVATE SECTOR PROVIDERS

Introduction

Governments and donors need strategies for working with PSPs to promote better health care. Three important policy objectives are: to **increase coverage**, especially for essential health care priorities, **improve the quality of care** delivered by PSPs, and **control excessive health care costs** to users (especially the poor). There may be considerable overlap between these objectives, but they are presented separately to highlight the range of approaches which may be adopted. For example, making priority services more affordable or free, especially for the poor, is often central to strategies for increasing coverage (through either the public or private sector).

Decision-makers also need to be able to judge how effective a particular strategy might be in their own local context. The Guide presents a series of steps to enable readers to identify their own situation in relation to different health system characteristics and patterns. These steps (see Section 5) enable readers to consider the general features of the health system, as well as the resources and capacity available. An understanding of the characteristics of one's health system will lead to the choice of particular types of strategies.

PRIORITY OBJECTIVES

Increasing COVERAGE

Increasing the coverage of essential health care services and products, especially for the poorest, is a key public health and international health policy objective. However, increasing coverage is not a simple matter and decision-makers need to identify the economic, financial, geographic and social barriers affecting particular services in their setting. The types and mix of barriers will influence the choice of strategy.

Demand and willingness to pay

For-profit PSPs will supply services, usually curative ones, for which individuals are willing to pay. They will tend not to provide services for which little demand exists. Many of the health priorities, for which decision-makers want to increase service coverage, are *mixed public-private goods**, such as communicable disease control and family planning (see Figure 2 below). Not only do the individuals using these services benefit from them, but so does the rest of the population. For goods with these mixed benefits, people will typically demand less of them than is ideal if population health is to be protected.

Decision-makers who wish to increase the coverage of effective public health interventions where members of the community do not see them as necessary or even desirable, face a particular challenge. They need to *stimulate demand*. Where there is demand, and therefore *willingness to pay*, PSPs will be more inclined to provide these services; although government supports and subsidies may still be necessary to raise coverage to the desired level (see Strategies 2 to 5).

There is greater individual willingness to pay for, and therefore greater willingness of PSPs to provide, the services to the left of the scale in Figure 2. Those activities to the right of the figure below are least likely to be provided by PSPs, and therefore require more government intervention if they are to be provided at all.

Primarily private good	Mixed public/private good or service with positive externality	Primarily public good
e.g. personal curative care, such as diarrhoea treatment and ARIs	e.g. immunisations, malaria, TB and STI treatment, family planning	e.g. vector control, health education, contact tracing

reduced individual willingness to pay
reduced PSP willingness to provide
increased need for government intervention

(adapted from Swan and Zwi, 1997)

Figure 2 : PSP, service user and government response to private, mixed public-private and public goods

Ability to pay

Access to health services is also determined by ability to pay, especially for the poor. Where the cost of health care may result in impoverishment, poor people may have to restrict their expenditure to affordable but poorer quality care. They may limit their spending to immediate curative care priorities and/or restrict the use of scarce resources to specific members of the family, often wage-earning adult males. Governments may target health care priorities to the poor by providing them *free or at low cost* to all users, or by offering the poor *exemptions* from charges (see Strategy 6). Exemption mechanisms may be ineffective and/or costly to administer, however, and the poor may be unable to access them. Governments may also intervene in the health care market to make specific products and services more accessible and affordable to poorer groups through the private sector. This can be through *product and marketing subsidies* and through *removing import and local taxes* on public health commodities (see Strategies 1 and 2).

Geographical accessibility

Where services are not geographically accessible, decision-makers may improve coverage by providing public sector services, or by supporting existing PSPs in areas where these services are absent. For example decision-makers may *contract out* services to PSPs; or give them *incentives* to operate in under-served areas (through tax breaks, low-cost capital, or other additional benefits, for example). Licenses may be granted to work only in under-served areas; zoning doctors to work in these settings may help redistribute their practices (see Strategies 1 and 4).

Social accessibility

In designing interventions, decision-makers will need to understand the *social barriers* (in particular ethnic, gender, religious and caste barriers) users face when seeking access to services. These may include difficulties for a woman in accessing cash within a household to pay for health services for herself or her children. 'Gatekeepers' within the household may also restrict access to particular types of providers. Certain ethnic groups may not want to use particular providers because they feel they do not understand their customs and practices. Further, people's preference to use an informal PSP may arise from a perception that the practitioner will work within local belief systems. By understanding such social constraints, decision-makers will be better informed as to the type of PSP to select in order to improve access for a particular target group, and of the measures needed to overcome barriers to access.

Improving QUALITY of care

Knowledge about the quality of care provided by PSPs (and often that of public providers also) is often based on anecdote, rather than on reliable, systematically gathered evidence. Rigorously conducted research, though valuable, is often not feasible for decision-makers. However, data collection approaches, which combine qualitative methods with rapid surveys and facility assessments, can produce useful evidence upon which to base action.

Interviews with PSP representatives and opinion leaders and with service users and advocacy groups can also be extremely valuable. So too are surveys of PSPs' reported treatment practices, as well as facility assessments, which together can contribute useful information on service quality and its determinants. These can be complemented and corroborated using methods to examine responses to given scenarios, or simulated client* surveys of treatment practices (Madden et al. 1997). The latter require careful ethical assessment and guidance before adoption.

Even in the absence of new data, consideration should be given to the following dimensions, which influence quality of care and can assist in deciding what types of strategies are needed.

Policy and provider dimensions

PSPs may *lack information* concerning current best prevention and treatment practice: guidance disseminated through the public sector is usually restricted to public sector providers. In addition, PSPs, especially those who are medically qualified, often rely on information from pharmaceutical representatives who visit their premises. A recent South African study indicated that GPs receive up to 7 visits per week from pharmaceutical sales representatives (Seidel 1999).

In many developing countries, PSPs (especially pharmacists, other drug retailers, informal providers) provide products and services that they have *not been trained* to deliver. Decision-makers face the choice between:

- legislating and enforcing regulations to prevent and control their practices (see Strategies 7 and 9), and/or
- training them to provide specific services (for example syndromic management of STIs and malaria, supervision of TB treatment-taking), with monitoring and supervision of their practices (see Strategy 8).

PSPs may *lack the means* and resources to provide quality services. Lack of capital may mean: poor physical infrastructure and equipment; shortages of qualified staff; effective drugs that are beyond the financial reach of clients; lack of access to affordable laboratories and other support services. Decision-makers may:

- enforce regulatory controls to prevent inadequately resourced PSPs from practising (see Strategy 7), and/or
- assist or support PSPs to obtain the necessary means (for example, through subsidised supply of drugs, giving them access to public sector support services, loans for capital investment), subject to controls (see Strategies 7 and 8).

In some cases PSPs may knowingly provide *inappropriate services* (e.g. unnecessary investigations) and over-provide services (e.g. polypharmacy) as a way of maximising their incomes. This can also happen because this is what PSPs believe patients want. Decision-makers may:

- attempt to enforce pricing and other regulations to control costs to patients (see Strategy 11).
- consider purchasing services from PSPs with controls on the quality and costs of those services (e.g. through contracts) (see Strategy 4).
- use the financial leverage available through third party payers, where they are present within the health system, to control costs and influence the types of care provided (e.g. through capitation payments) (see Strategy 12).
- attempt to provide service users with the information to recognise and demand appropriate care (see Strategies 10 and 13).

People (service user) dimension

Service user experiences and *perceptions of quality* play an important part in their choice of provider. As mentioned earlier, users often base their perceptions on comments from friends, neighbours or family or on the interpersonal, rather than technical, aspects of health care. In many settings, user perceptions frequently result in a choice of private rather than public providers. This may mean that they obtain technically poor quality care, which may also be the case in the public sector. Users – particularly when poorly educated – lack the knowledge and capacity to make sound judgements about technical quality. This means that they look to providers to act in their best interest.

There is considerable interest in working on the demand side, particularly if *community education* and working with *civil society advocacy groups* can help people to recognise, demand and obtain high quality care (see Strategies 9 and 10). The evidence that users can be educated to recognise technical quality or that consumer groups can raise awareness of quality issues in health is limited, however. Most of the experience from developing countries has been around *social marketing* and *branding* of commodities, e.g. insecticide-treated mosquito nets and contraceptives (see Strategies 2 and 5); and through accreditation of providers (see Strategy 3). These strategies work by sending a 'quality signal' to users; they are not educational in themselves. In relation to *accreditation*, an accrediting body takes responsibility for monitoring and assuring quality; this can be combined with promotion of accredited providers to potential purchasers of services.

Consumer associations and other organisations of service users are typically poorly developed in most developing countries. This may be an important area, however, for institutional support and investment.

Controlling excessive treatment COSTS to users

Cost control is concerned with containing excessive treatment costs to users.

Cost escalation is due to a complex interaction between:

- people's *willingness and ability to pay* for what they perceive to be quality services;
- providers' *profit-maximising behaviour* and the *competition* they face, and;
- the *capacity of purchasers* (individual users or third parties, including government) to *recognise what constitutes value for money.*

Payment mechanisms determine scope for controlling or inflating costs. Prospective payment mechanisms, such as capitation, offer potential leverage (see Strategy 12). However, in the poorest countries, most private expenditure is through direct out-of-pocket payments to PSPs, and users lack the information to determine what constitutes value for money. *Price setting* is one mechanism available to decision-makers. However, it can be difficult to enforce and may result in PSPs providing inadequate quality and levels of care. This is an area where better evidence to guide decision-makers is needed (see Strategies 11 and 13).

In Section 4, we turn to examples of **strategies** for achieving the objectives of **increasing coverage, improving quality / protecting safety and controlling excessive costs.**

SECTION 4 : STRATEGIES FOR WORKING WITH PRIVATE SECTOR PROVIDERS

Introduction

This section presents strategies to increase coverage, improve quality of care, and control costs. They are grouped around the three types of stakeholders who are the primary focus of interventions: Policy-makers, Providers, and People (which we use as shorthand for current or potential service users). Decision-makers will usually need to act with two or more groups of stakeholders to achieve their objectives. The Guide uses colour coding and the diagram (Figure 3) below throughout this section to highlight the relevant key stakeholder and objective.

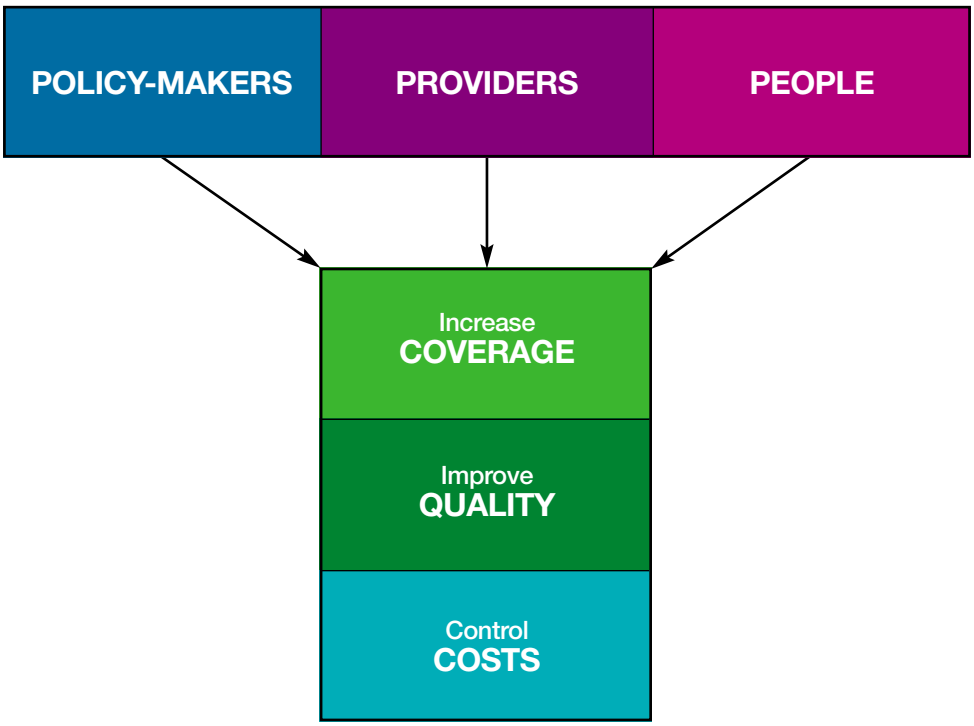


Figure 3 : Stakeholders and Objectives

The Guide presents a *description* of each strategy. *Case studies* are used to illustrate the application of the strategy in a particular context or to illustrate a particular point. *Cautions, pitfalls* and *evidence gaps* follow. Contextual *features which facilitate* a particular strategy are identified. In particular the need for and extent of public capacity, subsidies and investment to implement these strategies is highlighted here.

Some of the strategies are well known, having been tried and tested with some evidence of their effectiveness and applicability. Other strategies have been less widely used and evidence of their effectiveness is only beginning to emerge.

Following each strategy, we invite readers to engage in determining the suitability of a particular strategy to *their own contexts.* We pose *questions* to enable this judgement to be made and identify important *sources of information* that will guide decision-makers and donors towards this judgement. We draw *conclusions* as to the likely success or failure of the strategy for achieving the objective, based on the available information.

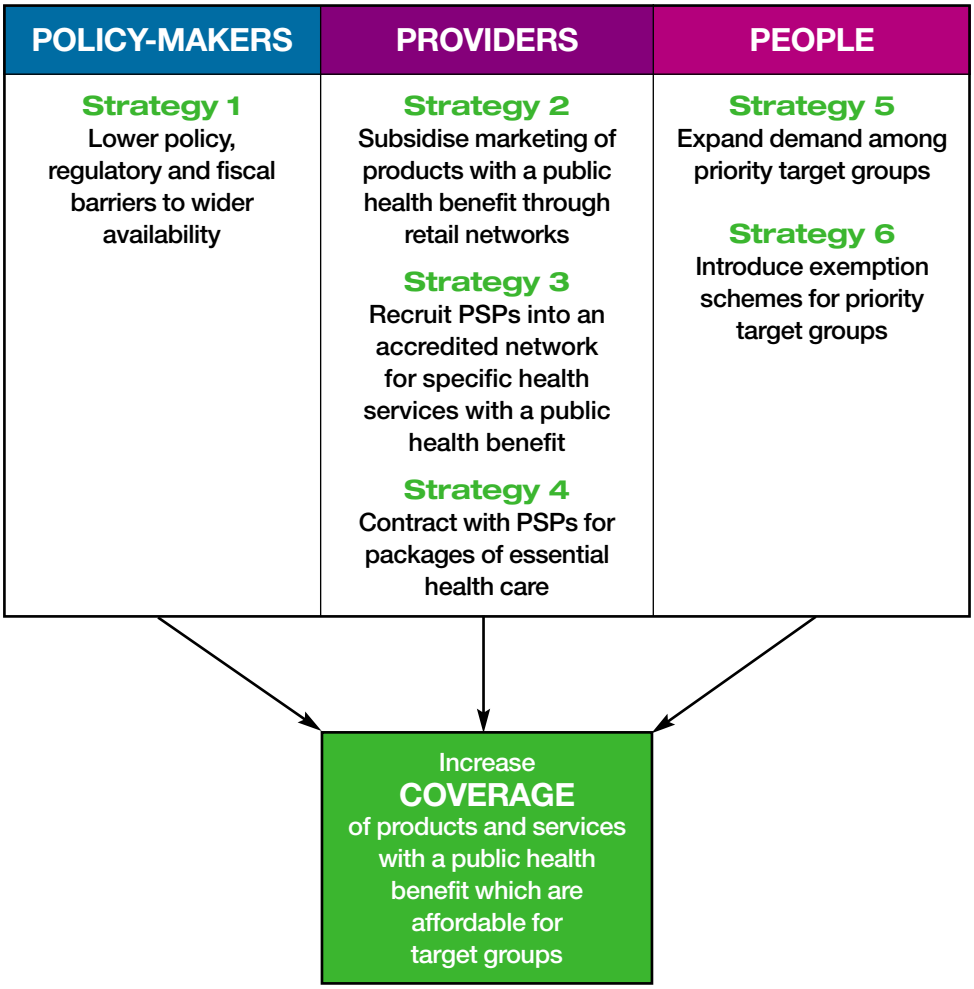
A *summary table of all strategies* for each priority objective follows (Table 1). Strategies are numbered in the order in which they are covered in this section.

	Working through **POLICY-MAKERS**	Working with **PROVIDERS**	Enabling **PEOPLE** – users, communities and their representatives
Increase **COVERAGE** of products and services with a public health benefit which are affordable for target groups	**Strategy 1** Lower policy, regulatory and fiscal barriers to wider availability *(page 19)*	**Strategy 2** Subsidise marketing of products with a public health benefit through retail networks *(page 23)* **Strategy 3** Recruit PSPs into an accredited network for specific health services with a public health benefit *(page 27)* **Strategy 4** Contract with PSPs for packages of essential health care *(page 30)*	**Strategy 5** Expand demand among priority target groups *(page 33)* **Strategy 6** Introduce exemption schemes for priority target groups *(page 35)*
Limit harmful practices and improve technical **QUALITY** of care	**Strategy 7** Enact and enforce legal restrictions and regulatory controls *(page 38)*	**Strategy 8** Provide training supports and incentives to PSPs to conform to good practice norms *(page 41)*	**Strategy 9** Enact consumer protection law and raise awareness of consumer rights *(page 45)* **Strategy 10** Increase service user knowledge through community education campaigns *(page 47)*
Control treatment **COSTS** to users of PSPs	**Strategy 11** Set PSP price levels *(page 51)*	**Strategy 12** Finance PSPs through prospective payment mechanisms *(page 54)*	**Strategy 13** Publish information to users on maximum permitted prices *(page 56)*

Table 1 : Strategies for Working with Private Sector Providers for Better Health Care

STRATEGIES AIMED AT INCREASING COVERAGE

Strategies can be summarised as follows:



Working with POLICY-MAKERS

Strategy 1 : Lower policy, regulatory and fiscal barriers to wider availability

Description of the strategy

The laws and regulations that set the framework for a country's economic activity can have a major influence on PSP practices and on efforts to widen the availability of health care. While government regulation is important to protect consumers, it may sometimes place unnecessary limits on the manufacturers, marketers and distributors of health products as well as on PSPs (including NGOs). Regulation may also place limits on the introduction of new technology (drugs or equipment). Equally, the fiscal framework may not provide sufficient incentives to make private practice attractive, especially in poorer or more remote locations, or to overcome the entry barriers facing new investors. This strategy therefore aims to ensure that government lowers any unnecessary policy, fiscal or regulatory barriers. Government may also provide incentives to encourage private practice to increase service coverage, such as preferential loans or tax breaks.

Case studies

A : Lowered Restrictions on Contraceptive Advertising Contribute to Increased Take-up

In **Pakistan**, regulations around advertising contraceptive methods and branded contraceptive products restricted the 'Key' Social Marketing (KSM) project (managed by Futures Group Europe) from promoting its hormonal contraceptives – pills and injectables. A number of different ministries had powers to control television (TV) advertising, including the Ministry of Population Welfare (MPW) and the Ministry of Information (MoI). Other groups also exerted an influence including politicians and religious groups. In 1997, KSM responded to these restrictions by packaging an audio cassette giving essential information about hormonal contraceptives, with the project's products. These were sold at retail outlets exhibiting the project logo – a Key. Initially, the authorities permitted the project to promote the cassette and the product retailers on TV. The project continued to test the limits of the restrictions by building alliances with supportive and influential stakeholders. In 1999, the MPW and MoI approved method-specific and brand-specific TV advertisements for the first time. The authorities also permitted other marketers of hormonal contraceptives to advertise. However, restrictions on specific advertisements are still subject to periodic enforcement.

The contribution of advertising to the continuing growth in the take-up of all hormonal contraceptives (not only Key products) is difficult to isolate. However, overall take-up has increased steadily, with the rate of growth significantly higher than before focused advertising was permitted. In a 1999 Punjab Population Welfare Survey on Media Effectiveness, TV was clearly a leading source of information for public sector clients. Significantly, the clients at public sector outlets are aware of both Key and other private sector products that have been advertised on TV.

For KSM, the impact has been particularly evident. In calendar year 1999 Key pill sales volume grew 26% compared to 1998. Sales of Key injectables grew by 52%. Typical sales growth of commercial hormonal products before the Key project was less than 5% a year.

(Futures Group Europe 2000)

B : Successful and Unsuccessful Experiences in Removing Import Duties from Contraceptives

In **Zimbabwe**, NGOs advocating expanded access to reproductive health care successfully lobbied for the elimination of import duties on condoms and reductions of 5 to 10% in tariffs on other contraceptives.

In the **Philippines**, health officials proposed exempting oral contraceptives from an across-the-board import tariff on drugs. Analyses indicated that, at lower commercial prices, a large number of public sector clients would shift to purchasing pills from pharmacies. This in turn would reduce the demand for subsidised supplies from government health facilities and generate savings that would more than offset the loss in revenues from eliminating the import tariff. However, government revenue officials successfully opposed the change.

(adapted from Rosen and Conly 1999)

C : Changes to Regulations Governing Providers' Improved Access to Injectable Contraceptives

In **Egypt**, following dissemination of findings of a donor-funded study that highlighted constraints to the private sector provision of family planning (FP), the government changed the law to allow general practitioners to administer injectable contraceptives. Previously only obstetricians/gynaecologists were allowed to do so.

(UNFPA 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **Policy and regulation first:** policy towards the private sector, a regulatory framework and enforcement capacity should be in place before Governments encourage private sector expansion in health care. Without them, serious side-effects – rising inequities, uneven quality of care and inefficiencies – may arise and these effects are difficult to remedy after private sector expansion has occurred.
- **Stakeholder support is vital:** in attempting to change policies and regulations, it is essential to build a coalition of support among all stakeholders with an interest in and influence on the decision (see Philippines example in Box B above). However, regulators must strive for a balance between maintaining productive dialogue with private interests and avoiding regulatory capture*.
- **Training and monitoring of health workers:** where changes in regulations allow products and services to be delivered through additional categories of health workers, adequate training, monitoring and supervision is needed to ensure that quality is not compromised.
- **Public accountability:** any changes in policies or regulations should be made in a transparent and accountable manner.
- **Hidden obstacles** to change may include officials who are using the current situation to obtain illegal revenue through levying hidden charges, in place of official taxes.

Contextual features which facilitate this strategy

- Willingness of the government, manufacturers, distributors and professional organisations to engage in the debate around the conditions and safeguards required to improve access to needed products and services.
- Detailed working knowledge about existing regulations, incentives, taxes and tariffs and how they are enforced, and the operation of the commercial distribution system.
- Adequate resources for a co-ordinated and well-conducted advocacy campaign for change, which may involve building a coalition of support among NGOs and others.

Questions for decision-makers

- Who are the key stakeholders that need to be involved? They are likely to include government ministries (including Finance, Commerce and Health), professional organisations, the commercial sector and politicians.
- Of these, who might advocate for – or oppose – change?
- What is the current capacity of stakeholders to achieve their objectives (e.g. capacity of statutory organisations to enforce regulations, of government to raise revenue through these channels, of programme managers to meet population needs)?
- In which areas do the interests of stakeholders conflict? Around what may coalitions of mutual interest be developed?
- What kinds of stakeholder resources could be mobilised to bring about and implement a positive change in policy?

Key information sources

- **Documents:** legislation and regulations; ministry, NGO, professional organisation and donor reports.
- **Informants:** programme managers, representatives of professional and community groups.

Conclusions

Making products and services more widely available is feasible in many settings, as is providing information about them. Where the necessary quality controls to protect consumers are in place and a convincing argument can be made to politicians and policy-makers, this strategy has a good chance of success. Failure is often because those pushing for change have not identified important stakeholders and mobilised their support. Incentives to PSPs to expand provision are also often successful, but a clear policy on the role of the private sector and accompanying regulatory capacity needs to be in place before incentives are offered.

Working with PROVIDERS

Strategies 2, 3 and 4 : Introduction

Strategies to improve service access and product uptake – especially by the poor and other priority groups – usually require actions to simultaneously stimulate demand and support provision. Therefore, separating them into Provider and People components is somewhat artificial. However, this can help clarify the different elements that contribute to successful strategies. Ensuring quality and controlling costs to users are also often integral features of these strategies. We focus here on the coverage aspect of work with providers.

There are a range of strategies to improve coverage that involve working with PSPs, including *social marketing* of products (Strategy 2), *accreditation* (including *franchising*) (Strategy 3) and *contracting* (Strategy 4). All involve recruiting or contracting selected groups of PSPs to deliver products or services to a defined minimum standard. The degree of complexity of the product or service provided differentiates these strategies (see Figure 4 below). Complexity can range from a simple product (such as a condom), through a product with a service element requiring the provision of information or a service (STI diagnosis and treatment), to an essential health care package delivered by a more qualified provider. The nature of the product and service (along with prevailing regulations) determines the appropriate PSP to deliver that service.

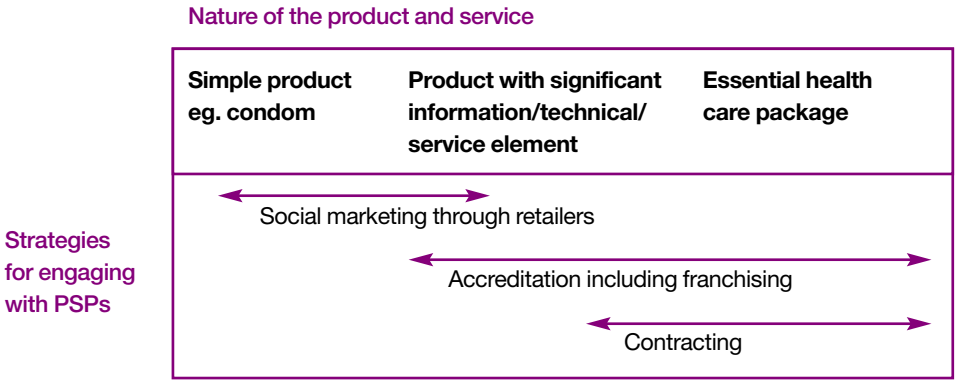


Figure 4 : Strategies are differentiated by the complexity of product or service provided

Simple products can be most widely distributed through **retail networks**. With training, some categories of retailer (for example, pharmacists) may sell more complex products, such as pre-packaged STI drugs. Clinical services will require an **accredited network of trained providers** (which may be a **franchised** network) who are expected to conform to a defined minimum quality standard, with standards monitored externally. More complex packages of services are often delivered through networks of clinics (owned and managed privately or by NGOs) where quality is assured through protocols and in-house or external clinical audits. Governments may choose to expand coverage of essential health care packages through **contracting**, where contracts specify the type, quality and cost of the services PSPs should provide.

Other strategies for increasing coverage, especially in under-served areas, are tax-breaks and the provision of subsidised capital to PSPs who set up services in these areas. Schemes for recently qualified professionals often specify a minimum period of service in an under-served area as a pre-condition for provider registration (see Strategy 1).

Working with PROVIDERS

Strategy 2 : Subsidise retail product marketing

Description of the strategy

Social marketing programmes (SMPs) engage the resources, techniques and dynamism of the private commercial sector to make products with a public health benefit widely available and affordable. Social marketing encourages their use through communications using both mass media and interpersonal techniques. It mobilises private financial resources (mostly out-of-pocket payments) and uses a subsidy from public sources to lower prices to users and cover wider programme costs. The activities of SMPs are wide-ranging, and not confined solely to expanding supply and creating demand. They may also be engaged in lowering regulatory barriers to access (see Strategy 1) and assuring service and product quality.

SMPs sell products, often at subsidised prices, through a variety of public and private channels. The choice of channel is determined by: its accessibility for the target group, regulations governing the sale of the product, and the availability and willingness of suitable PSPs to participate. Social marketing has been used for over 25 years, primarily to make condoms and other temporary methods of family planning available. In 1999, 55 countries had significant contraceptive social marketing programmes. Social marketing is also used for a wide variety of health products suitable for retail sale including vitamin A and insecticide-treated mosquito nets (ITNs).

SMPs operate through the agency of a specialised social marketing organisation (SMO), usually an NGO. The SMO provides a link between product manufacture, product distribution and retail sale. The SMO usually takes responsibility for all aspects of marketing including pricing, promotion and choice of PSP (including NGOs) through which to deliver the product, and any necessary training. The incentives for wholesalers and retailers to participate in social marketing schemes are determined by the profit margins on the products they buy and sell and sales volume. High volume sales are thereby encouraged.

There are broadly two rationales for social marketing which relate to coverage:

- It can improve accessibility and affordability of products with a wider public health benefit for groups for whom these products are currently inaccessible and/or unaffordable.
- It can be used to reach important target groups who are not served by other delivery mechanisms.

Costs to the user are generally controlled through subsidy and/or labelling products clearly with the retail price (see also Strategy 13). Quality control is exercised through product quality checks, and training and monitoring of PSPs.

SMPs are classified as either *own brand* or the *manufacturer's* model. In the former, the SMO imports, packages and promotes its own brand and has its own sales force. The SMO can choose how to price and market its product and can target specific groups. In the manufacturer's model, the SMO links up with a manufacturer to market existing brands. Manufacturers agree to lower their retail prices for a period while the SMO works to build market share. In the own brand model the SMO has greater freedom to set low prices to stimulate demand for contraceptives from the existing level and to match the means of the (often low income) target group. The own brand model is therefore often more appropriate to countries with low product usage and with low average incomes.

Case studies

D : Social Marketing Project Improves Access to Contraceptives for all Economically Active Target Groups in Nigeria, through an 'Own Brand' Model

A donor-funded social marketing project is promoting improved reproductive health through subsidised marketing of condoms and oral contraceptives. An 'own brand' model was adopted because Nigeria has a low contraceptive prevalence and high levels of poverty. It is not yet an attractive market for commercial companies. Accessibility to contraceptives in the public sector is also poor. The SMO is a local NGO supported by a US partner.

The project has widened contraceptive choice among urban and rural populations. It has achieved this by utilising existing channels of retail distribution which are accessible to the target groups: licensed pharmacies serve poorer people (but also middle and upper income groups) in large urban areas; in smaller urban and rural areas, patent medicine stores, stalls and kiosks provide contraceptives to low-income men and women and to younger people. Contraceptives distributed through the programme account for 80% of all contraceptives used in Nigeria. Monitoring shows that the programme is reaching all socio-economic groups with the exception of the very poorest. In the absence of mid-priced condoms in the commercial sector, there is evidence that higher income groups are benefiting from a subsidised product. It is thought likely that a fully-priced product would not inhibit take-up in this group. However, where HIV spread is a public health concern, this may be an appropriate use of public subsidy.

(UNFPA 1999 and internal donor reports)

E : Social Marketing of Insecticide Treated Mosquito Nets in Tanzania Increases the Overall Market for Nets

Donor resources are being used to stimulate demand for and increase access to mosquito nets and net treatment to limit the impact of malaria. The SMO is working with three local manufacturers to produce mosquito nets. Private, public and NGO outlets sell the nets at subsidised prices, with or without an insecticide treatment.

The project has not only resulted in increased coverage of households with project nets but also stimulated increased commercial sector activity – an example of 'crowding in'. The market for nets has doubled to one million in 3 years and a third net manufacturer has entered the market. Through commercial marketing, consumers are benefiting from reductions in prices by net manufacturers, wider choices of nets and greater awareness about the efficacy of ITNs.

(Population Services International 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **Social marketing is unlikely to reach the very poor,** unless products are very heavily subsidised. The poorest are likely still to rely on the public system, although they may continue to experience significant barriers to access (supply shortages, staff absence, long travel and waiting times).
- **Crowding out may be a problem:** the availability of cheaper or free products (often in the public sector) may 'crowd out' demand for the product from the private sector, which the intervention is often trying to encourage, although evidence of this is scarce. While coverage of the socially marketed product may improve in the short term, in the longer term, the availability of cheaper or free products undermines the potential for sustained demand of the socially marketed product. A further danger is that the subsidised socially marketed product displaces demand for any existing full-priced commercial product. This may lead to the reduction of the existing product's market share and promote the inefficient use of public subsidy. A good understanding of the existing market (both demand and supply) is critical when designing programmes to minimise this possibility (Hanson et al. 1998).
- **Take care with conflicting objectives:** there may be lack of clarity amongst decision-makers over the objectives of social marketing. This can result in conflicts between equity, efficiency and expanding access to particular groups. For example, it may not be clear who the target group is and whether it is defined by health vulnerability or economic vulnerability. In the Tanzania example (see Box E above), the subsidised net is available to pregnant women and children under five; but this does not take into account the ability of some households with pregnant women and under-fives to pay. Precise definitions of target groups should be clarified and agreed between stakeholders during project design.
- **Long-term commitment may be needed:** social marketing aimed at groups who cannot afford fully-priced products requires the use of subsidies over the medium to long term.
- **Who gets the subsidy?:** product promotion may increase demand among groups who would otherwise buy an unsubsidised product – an inefficient use of resources – although there is little evidence of this. SMOs need to monitor the economic status of those buying socially marketed products to identify who is benefiting from the subsidy (see Box D above).

Contextual features which facilitate this strategy

- An unfilled need for the product.
- A supportive policy and regulatory environment: adequate government support and no unnecessary barriers to the importation, manufacture or promotion and sale of health products.
- Absence of rival products in the public and/or private sectors.
- Evidence of existing demand (willingness and ability to pay) or that demand can be stimulated within specific target groups.
- A commercial sector which is willing and able to take commercial risks, able to supply and distribute the products, either with or without the support of subsidies; and a stable money-based economy, a functioning banking system and relative social stability.
- Institutional requirements include: an efficient SMO with an appropriate mission, product suppliers, a functioning wholesale and retail distribution network (including suitable PSPs) and market research and promotion capability (including access to mass media).
- Donor or government support for product subsidy and other programme costs may be needed over the medium to long term, where this use of public funds continues to be consistent with meeting priority health needs for lower income groups. Donors and policy-makers need to consider the likelihood, costs and mechanisms for long-term sustainability before embarking on such a programme.

Questions for decision-makers

- What is the level of unmet population need, both overall and in particular population segments (especially among the poor or vulnerable rural populations)?
- Which commercial organisations (importers, manufacturers, distributors and retailers) are currently serving the market? Depending on the existing market for the product, is the 'own brand' or 'manufacturer's' model more appropriate? What effect will an SMP have on existing products' market share?
- What level of resources will be required, from where will these resources come, and what is the potential for developing a sustainable system that is not reliant on external funding? Is achievement of financial sustainability appropriate given the proposed target group?
- What is the exit strategy and who owns the brand?

Key information sources

- **Documents:** recent demographic health surveys, information on current market shares (commercially sensitive information which it may be possible to access through key informants).
- **Informants:** major commercial sector players and officials in the Ministry of Commerce or Trade and Industry.

Conclusions

There is increasing evidence of the effectiveness of social marketing as a means of increasing the coverage of public health products. However, free public sector supply systems may still be needed to reach the very poor who cannot afford the cost of socially marketed products. Careful design can result in the stimulation of demand that creates new opportunities for suppliers ('crowding in'). In the most favourable situations, social marketing not only increases demand for its own branded product but also creates a demand-side 'halo effect' *, where overall knowledge and awareness of and demand for the product category increase. Social marketing has been applied to a wide range of health products with a public health benefit such as ITNs to prevent malaria, oral rehydration salts and Vitamin A. Social marketing is less suitable for more complex products and services (see Strategy 3).

Working with PROVIDERS

Strategy 3 : Recruit PSPs into accredited networks

Description of the strategy

This strategy recruits PSPs into a network and provides training in the delivery of a product or a service to a minimum standard in order to make it more widely available. Providers' skills and/or premises are assessed and accredited and their services are promoted to potential users. This can be through the promotion of a recognisable brand, which may be a name or a programme logo, or accredited providers may qualify for third party payments from prepayment schemes (see Strategy 12). Accreditation is for a time-limited period and compliance with minimum standards is externally assessed.

Examples of products and services delivered in this way include: injectable contraceptives, STI diagnosis and treatment, insertion of intra-uterine devices (IUDs), TB diagnosis and treatment, voluntary counselling and testing for HIV and basic mother and child health care packages. Products are often subsidised to make them affordable to target groups.

This strategy is distinguishable from social marketing by the complexity of the product or service provided and because the provider rather than the product is accredited. The PSP usually requires a recognised training qualification, suitable facilities or premises, and minimum level of knowledge and skill to deliver the product or service effectively. Consequently, mechanisms to ensure quality levels are needed, including training and external monitoring.

Programme design and the nature of the arrangements within networks are context-specific, and depend on:

- the barriers to access that exist for the target groups
- the nature of the product and services and any regulations surrounding their provision
- PSPs being willing to participate in the network and meet the network's requirements
- the types and capacities of institutions available to manage and co-ordinate the programme (the accrediting body or franchisor).

Some examples of this strategy are referred to as 'franchising' *, with a for-profit or not-for-profit organisation acting as franchisor and PSPs as franchisees. In franchising, PSPs (which may also be NGOs) deliver services in accordance with the franchisors' specifications. Franchisees are then promoted to users through the franchisor's branding. Franchisees typically receive training and subsidised supplies in return for conforming to the franchisor's standards. (Smith 1996).

Case studies

F : Private Medical Practitioners (PMPs) in Zimbabwe

A de facto accreditation system has been established through the National Association of Medical Aid Societies (NAMAS). Standards have been agreed and NAMAS will undertake inspections of PMPs who wish to be eligible to receive payments from NAMAS's member organisations.

(Hongoro and Kumaranayake 2000)

G : Expanding Coverage through an Accredited Clinical Network in Pakistan

This programme was designed to overcome the constraints faced by low income women in urban and peri-urban areas in accessing longer lasting family planning methods (especially injectable contraceptives and IUDs). It formed part of a larger social marketing and franchising programme. Constraints were identified as the lack of women doctors trained in FP counselling and FP methods, especially IUD insertion and injectables. Cultural norms in Pakistan generally prohibit male doctors from inserting IUDs.

The project utilises the spare capacity in a doctor's private practice and supports the effort through targeted marketing of the 'Green Star' brand. Doctors are trained and their practices and results monitored through visits and data returns. Compliance with the project's standards allows the PSP to continue to display the Green Star logo on the premises. The project has now recruited over 2500 women doctors, among other providers, into the 'Green Star' clinical network nationally. The project has demonstrated its effectiveness in overcoming social, financial and geographic barriers to access for lower income women seeking longer-term temporary methods of family planning.

(Agha et al. 1997 and internal project reports)

Cautions, pitfalls and evidence gaps of this strategy

- **Accredited services are unlikely to reach the very poorest,** unless some form of exemption for this group is built in, as they will be expected to pay a fee when visiting a PSP.
- **Third party payment organisations are not likely to be interested in improving coverage** for the poor unless funding is assured; they are usually more interested in controlling costs.
- **Accreditation is resource intensive,** both initially and in the medium to long term as it involves the establishment of a brand, brand maintenance, monitoring compliance with standards and maintaining quality assurance systems.
- There is **no evidence as to the sustainability** of this strategy, once external funding ceases.
- **Qualified franchisors may be scarce:** identifying a franchisor that is willing and able to enforce the franchise contract and where necessary impose the sanction of removal from the network may be difficult.
- **Recruitment may be difficult,** where there is little information on the number and location of PSPs. Accreditation must provide clear advantages to participating PSPs. In other words, service users need to place a high value on and be able to trust the logo or brand; and this needs to be translated into increased sales. There may also be a limited number of PSPs who qualify for accreditation.
- **PSPs require capacity,** especially time to give to training, record keeping and data reporting. Busy PSPs may not have the time, or other capacity, for this unless it is appropriately funded. Schemes of this kind are often more attractive to younger, less well-established PSPs.
- **Perverse outcomes may occur:** for example, subsidised inputs such as pre-packaged drugs may be valuable commodities in the local market and may be split and sold separately; PSPs outside of the network may copy the logo or sell fake branded products.
- **Conferring legitimacy?** Where only one part of a PSP's practice is accredited, the programme logo may confer unwarranted legitimacy on other parts of his or her practice. Where more than one scheme operates there may be a danger of multiple standards being set, and quality assurance systems operating outside the MoH's regulatory functions.

Contextual features which facilitate this strategy

- Government policies which are conducive to working with the private sector.
- Existence of PSPs and private facilities with spare capacity or an interest in participating in the scheme.
- An environment which is conducive to regulation and external monitoring.
- A high level of capacity on the part of the franchisor or accreditation body, whether it be an independent or statutory body.
- In industrialised countries, accreditation is usually self-financing through contributions from those seeking accreditation. In the poorest countries, external (e.g. donor) funding is usually necessary and may not be sustainable in the long-term.

Questions for decision-makers

- What is the level of unmet need and are there suitable PSPs (or NGOs) who could be supported to meet this need? Are there PSPs who would offer a comparative advantage over existing public sector providers in meeting the target group's needs? Are they interested and can they be strengthened to achieve the required standards?
- What level of resources will be required, from where will these resources come, and what is the potential for developing a sustainable system which is not reliant on external funding?
- Does the necessary capacity exist in the local context for the introduction of accreditation?
- Is there a suitable organisation or body that could manage a franchise or accreditation scheme?

Key information sources

- **Documents:** search the literature for examples and models of accreditation from other countries
- **Informants:** representatives of professional and community groups

Conclusions

Where there are important target groups who do not have access to priority services, the accreditation of specific services provided by accessible PSPs (both for-profit and NGOs) can be an effective way of increasing coverage and meeting these needs. However, they are heavily resource intensive, both financially and in requiring an organisation with high capabilities to manage them. More comprehensive accreditation of PSPs requires a high level of capacity in the accrediting body and among PSPs, as well as considerable resources. The potential for this approach in poorer countries that have many solo PSPs has not been demonstrated.

Working with PROVIDERS

Strategy 4 : Contract out essential health care packages to PSPs

Description of the strategy

There is growing interest in developing countries in contracting out health services to increase coverage of essential health care packages. As governments review their role in ensuring the provision of health care, there is a shift from provision to purchasing services from private providers (both for-profit and not-for-profit). Providers may include doctors, other health professionals, health centres, hospitals or any combination of these.

The body with responsibility for providing health services to a designated population, usually the government, can choose to contract services from public, private for-profit or non-profit providers. This can be done through a competitive process – 'tendering' – or through choosing a reputable or established provider as a contractor. The client and contractor (the provider or an organisation that will ensure service provision) enter into an agreement (a contract). This specifies what is to be provided: type of service, coverage, cost and quality (England 2000). Financing can be from a combination of public and private sources, for example the client pays the contractor to undertake the contract; but the contractor may also recoup costs through user fees at the point of service delivery. The impact of different types of contracts on costs to users, for example the use of a capitation payment system, is considered later (see Strategy 12).

In developing countries – especially in Sub-Saharan Africa – there has been a long history of simple or informal contracting between governments and not-for-profit mission and church organisations. These have been major providers of health services for decades, often with designated responsibility for supplying comprehensive district-level services. In return, governments have usually paid the salaries of mission hospital staff. More recently, contracts between governments and church NGOs have been formalised, with more detailed specification of outputs to be delivered.

Case studies

H : Contracting to Control Health Care Costs

In **Lebanon**, 90% of hospital beds are in the for-profit private sector. Consequently, the Ministry of Health contracts with almost all private hospitals for a predetermined number of beds to serve public patients. However, the government does not use the contractual relationship to encourage efficiency as its reimbursement policies allow unnecessary hospitalisations and overuse of services. This arrangement has resulted in escalating costs and private sector demands for further investment in the sector.

(WHO 2000)

I : Contracting Out District Level Services in Cambodia

The Ministry of Health developed a system for contracting health services to improve coverage and service quality of essential health care packages in five districts. This is a pilot project undertaken by the MoH with financial and technical support from a development agency. The MoH acts as purchaser in this instance. By the end of 1998, five contracts had been awarded to NGOs through competitive tender (although some of the bidders were for-profit firms). Two contracts were for 'Contracting Out'. Under this system, the provider is completely responsible for the management and delivery of health services to a district population, through health centres and a district (referral) hospital. Three other contracts were for 'Contracting In', where the management of services is contracted out, while the district health staff who provide services remain under the control of the MoH. In all contracts, the MoH has specified the delivery of a defined package of health services and the service coverage to be achieved within the four year contract period.

Although the contracts have some way to run, the evidence so far from the MoH monitoring systems is that contracted out districts have performed significantly better in terms of service coverage, compared to control districts. This is believed to be partly due to more effective managerial control over staff. However, the quality and efficiency gains of the contracting approach in this setting have yet to be established. Obstacles to fulfilling their contractual obligations, reported by contractors, include the MoH's inability to supply vital diagnostic and health care equipment in a timely manner to the contracted districts.

(Fronczak 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **Government may lack the capacity to contract:** governments which lack the capacity to provide services, may also lack the capacity to fulfil their own contractual obligations (see Cambodia example in Box I, above); and may be at a disadvantage in negotiating and monitoring contracts involving sophisticated providers.
- **There may not be sufficient competition:** there may be a lack of suitable providers with which to contract; potential monopoly situations can be tackled by sub-dividing contracts into smaller parcels (although this will increase transaction costs). Performance-based contracts place greater risk on the contractor; this is a disincentive and contractors may demand financial compensation for taking on this risk.
- **Providers may be inflexible:** efficiency gains come from providers having cost structures that are flexible. Gains are unlikely to be realised if providers have rigid cost structures.
- **Transaction costs** (the cost of managing and administering contracts) may wipe out efficiency gains.

Contextual features which facilitate this strategy

- A well-developed private sector (for-profit and/or not-for-profit) with sufficient interested and potentially suitable contractors to ensure competitive bidding at an initial tender and at contract renewal.
- Government needs to be seen as a trustworthy organisation with which to contract. Where government payment or other systems are under-developed or unreliable (see Cambodia example in Box I above), this is likely to put off potential bidders from seeking or renewing contracts.
- In the broader context, contracting is facilitated by a functioning legal and banking system and the possibility of transparent government procedures that are not vulnerable to corruption or patronage.
- Contracting requires that governments have sufficient capacity in a number of areas: population needs assessment, contract specification, negotiation skills, accounting and financial management, standard setting, service monitoring and data collection and analysis. They need to be able to take steps to protect the needs of populations, where contracts are not being fulfilled.
- Contractors also require many of the same skills and capacities as governments, as well as the capacity to provide and assure the quality of services delivered. Often, contracts are awarded to a higher cost – not the lowest cost – bidder, who provides evidence of having the capacity to deliver the specified outputs.

Questions for decision-makers

- Who are the key stakeholders? What are the number, type, location and capacity of providers with a potential interest and the capacity to enter and fulfil a service delivery contract with government?
- What capacity and experience of contracting is there in the health ministry? Is the capacity and experience to be found in other ministries? Can donors assist in developing capacity through technical assistance?
- What are the priority areas where private sector contracting may confer advantages over public sector provision?

Key information sources

- **Documents:** sectoral studies, reports of contracting from other countries
- **Informants:** associations of for-profit health providers, NGO forums, consumer groups, (other) donors

Conclusions

The potential for contracting services to the private sector is highly context dependent. Contracting out is worth considering where levels of staffing in the public health sector are considerably in excess of those in the private sector; and where altering staffing levels, terms and conditions of government service is politically difficult. Where there is a shortage of qualified health personnel, contractors may not be competitive with government. In settings where the for-profit or not-for-profit private sector is well developed, or covers areas or populations not reached by public services, contracting may be an attractive strategy. However, all contracting requires a high level of capacity and can result in high transaction costs to both clients and contractors (Mills 1997).

Enabling PEOPLE

Strategy 5 : Expand demand among priority target groups

Description of the strategy

A key component of any intervention to increase coverage and take-up of products and services in the private sector is the promotion of behaviour change among potential users, and especially among priority target groups. Behaviour change communication (BCC) may be designed to:

- increase overall demand for products with public health benefits (for example oral rehydration therapy),
- direct those with some ability to pay to private sources of supply,
- encourage more effective health seeking behaviour in the private sector (for example appropriate malaria treatment), or
- encourage adoption of healthy lifestyles (for example safe sex practices).

BCC needs to be informed by an understanding of barriers to care at local or target group level, which implies that tailored rather than generalised approaches are more successful. To bring a health benefit, communication to increase demand must be combined with measures to ensure access and supply of the desired product or service in the public and/or private sectors.

Case study

J : Social Marketing of Condoms in Mozambique

A study examined the effectiveness of condom social marketing in increasing safer sex practices among men and women at risk of contracting HIV in Mozambique. The study tested the hypothesis that exposure to programme interventions (communication and improved access to condoms) would increase condom use with non-regular partners. A large network of peer promoters delivered key messages. Community-level drama was reinforced by radio and TV spots. Take-up, following the social marketing programme, was high; multivariate analyses show that exposure to the advertising and communications was associated with higher levels of condom use with non-regular partners.

(Agha et al. 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **Behaviour change may not be sustained:** sustainability of behaviour change in the absence of a sustained communication programme and promotion and advertising strategy may be limited.
- **Populations may be not be reached:** important target groups may not be reached through the media used.
- **The very poor may not be able to afford** even modest charges in the private sector.
- **Mass media may be inappropriate:** mass media marketing strategies for some products, for example hormonal contraceptives, may be inappropriate because of existing negative attitudes towards them. One-to-one counselling which allows potential users to discuss the advantages or disadvantages of a product in relation to their lifestyle may be important for continued use.

- **Promotion may backfire:** communication that promotes culturally unacceptable values and behaviours may be counter-productive and cause a hardening of attitudes towards the use of the product.
- **Participatory approaches may work where mass media fails:** BCC approaches based on building skills in problem identification, communication and negotiation are more likely to work than those solely based on imparting information. Difficult to reach groups may therefore benefit more from participatory BCC as opposed to mass media.

Contextual features which facilitate this strategy

- Regulations that permit mass media and other types of advertising of relevant products (see Strategy 1, Box A)
- Market research and advertising capability, including social research capacity
- Opinion leaders who can attract the attention of and influence the target group (nationally known sports people, musicians, popular politicians, etc.)
- Availability of and access to mass or other media which will reach high proportions of the target audiences (however see cautions above)
- Sustained donor or government resources for promotion and advertising

Questions for decision-makers

- Who are the stakeholders? They are likely to include: government (ministries of health, education, community development), communication media, donors, NGOs and other groups working in the community.
- What are the information barriers to access among target groups? What belief and behaviour change is needed to stimulate demand / change other health-related behaviour?
- What are the sources of information, types of media and opinion leaders that can reach the target groups? Which sources of information are credible to potential user groups and will influence behaviour change?
- What level of resources will be required? From where will these resources come?

Key information sources

- **Documents:** national policies, reports of NGOs and donors, recent project/research reports, recent demographic health surveys, data on market share and types of population reached by different communication media
- **Informants** are likely to include: NGOs and community groups working with the target groups, potential beneficiaries, commercial advertisers, representatives of different types of national media (TV, radio, newspapers) and social marketing organisations

Conclusions

Demand creation, as part of social marketing, has been effective at increasing the uptake of clearly identifiable products, such as condoms and ITNs, where product supplies have been ensured (see Strategies 2 and 3 above). Knowledge of how different segments of the population can be reached and influenced is necessary if the behaviour of hard-to-reach priority groups, such as commercial sex workers and their clients, is to be changed.

Enabling PEOPLE

Strategy 6 : Exempt priority target groups from payment

Description of the strategy

Priority groups (the very poor, infants, pregnant women and commercial sex workers) may be offered low cost or free care to increase coverage. Targeted exemptions may be limited to services for specific priority public health problems, such as STIs. In the case of some priorities, such as TB and immunisations, free care may be offered to all who require it. Exemptions are most commonly used where target groups use public sector services, but may also be employed where they choose to use the private sector. Target groups may be exempted from paying contributions to pre-paid health insurance schemes. Alternatively they may be exempt from paying service fees when they visit a PSP (including NGOs). The provider is then later reimbursed – by the government or other purchaser – for the cost of care supplied. Vouchers are one mechanism for ensuring that target groups obtain free care at the point of delivery.

Case study

K : Voucher Scheme in Nicaragua

Between 1996 and 1999, 6,000 vouchers were distributed to female sex workers in Nicaragua, which could be used by them to obtain free STI care from a variety of contracted public, private and NGO health facilities. 39% of the distributed vouchers were used to obtain care from 17 service providers. The scheme is administered by a voucher agency, the Central American Institute of Health (ICAS). "ICAS invites clinics to participate in the scheme; reviews their credentials and capacity to provide the service package, negotiates contracts, trains medical (and other) staff in the appropriate management of STIs and…monitors quality of service provision." During this period, there were reported improvements in the technical quality of care provided by private clinics. The average price per consultation paid to participating clinics compared favourably with the cost of existing public sector services.

(Sandiford et al. 2000)

Cautions, pitfalls and evidence gaps of this strategy

- **False reporting may occur:** where PSPs can recoup the cost of care supplied to service users, it can lead to false reporting of patients (ghost patients) as a way for PSPs to maximise their income. In addition, decisions about qualification for exemption may be made for the wrong reasons.
- **Vouchers may be diverted from the target group:** vouchers which allow free or reduced price access to services may become a 'traded currency' and be used by people outside the target group. This can reduce the intended impact of the strategy on the priority target group.
- **Monitoring and quality assurance systems** need to be in place to ensure PSPs' quality of care.

Contextual features which facilitate this strategy

- Target group dissatisfaction with existing (often public sector) services and preference for using other providers. STIs are an example where both the nature of the health problem and the type of target group who are most at risk confer a particular advantage on PSPs, when compared to public sector services (see Section 2, page 8). These factors mean that vouchers that can be utilised to obtain private sector care can contribute to increased coverage in the target population.
- Providers, including PSPs, who wish to participate in the scheme.
- An organisation with the capacity to manage the scheme – including the ability to train, monitor services and service utilisation, implement quality assurance, and financial management.
- Resources to set up and manage the scheme.
- PSPs who can achieve the required quality of care standards.

Questions for decision-makers

- Who are the stakeholders? They are likely to include: government, existing providers, donors, the target groups and their representatives, insurance companies or other pre-payment scheme managers.
- From where will come the resources to manage such a scheme and will funding be sustainable in the long-term?
- What are the levels of stakeholder interest and capacity for implementing this strategy?

Key information sources

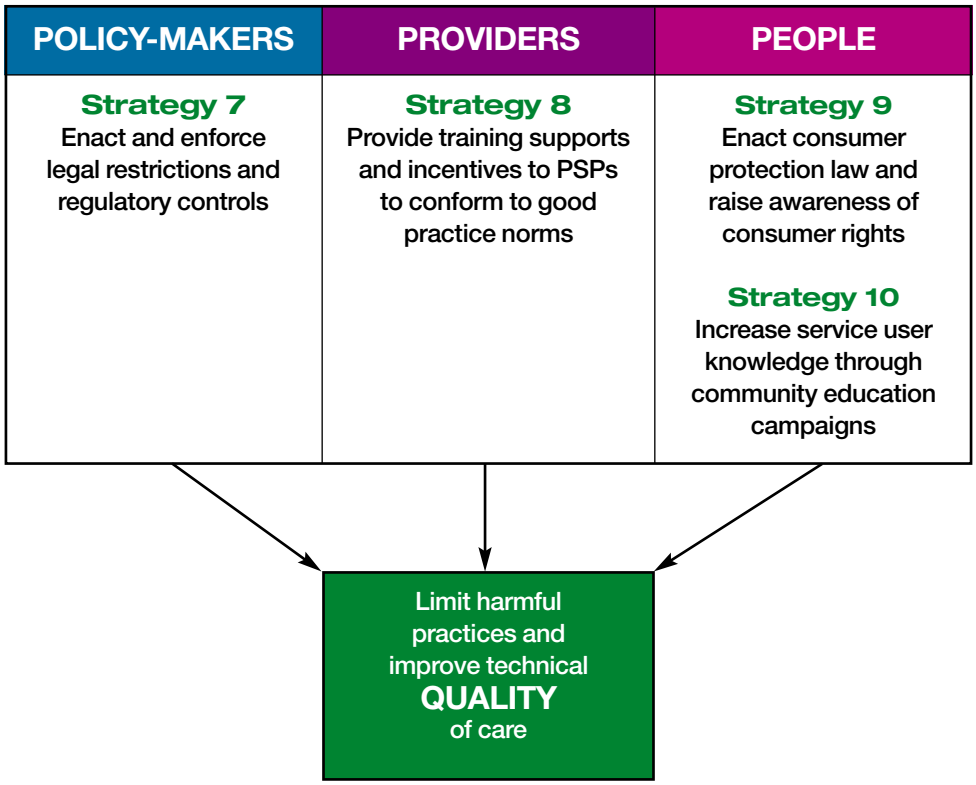
- **Documents:** research outputs and population surveys showing current health service utilisation patterns for the target group
- **Informants:** disease control programme officers, consumer or other advocacy groups working with the target group, target group opinion leaders

Conclusions

Exemption schemes are easier to monitor and control when they involve public sector providers. In the private sector they involve transaction costs, both for managers and providers. Control systems are needed to ensure that payment is made only for services that have actually been delivered to the target group. Voucher schemes have been effective in reaching target groups and improving the quality of care available to them from a range of providers, including PSPs. Where they are used alongside measures to improve the quality of care for priority diseases, such as STIs and TB, they can contribute to achieving important policy goals. Management costs may be high, which raise questions about long-term sustainability and scaling up of projects to the national level.

STRATEGIES AIMED AT IMPROVING QUALITY

The strategies may be summarised as follows:



Working through POLICY-MAKERS

Strategy 7 : Enact and enforce legal restrictions and regulatory controls

Description of the strategy

This is the **'stick' approach** (Bennett et al. 1994)[1]. Legal restrictions and regulatory controls are designed to ensure safety, prevent dangerous and unethical practices, and thereby guarantee quality. They include restrictions on practice entry (for example to qualified professionals), on the importation and distribution of drugs, and facility registration. They reflect government's role as overall co-ordinator and regulator of the health sector. Ideally, PSPs must conform to legislated requirements or face penalties of some kind (for example exclusion from practice). The enforcement of regulations governing health personnel is usually delegated to professional councils. Enforcement requires reliable information on regulatory transgressions. Government officials may conduct facility inspections or these may be delegated to another body. Drugs are regulated though licensing for drug manufacture and/or importation, and through restrictions on prescribing and dispensing over the counter.

Case studies

L : Limited Capacity to Enforce Regulations

A study examined the enforcement of regulation of practitioners in **Malawi** after they were allowed to enter private practice. While the Medical Council made initial inspections of premises on registration, stringent monitoring was not maintained. A later survey found that nearly three-quarters of practitioners did not conform to the government's minimum quality standards for equipment and drug use.

(Ngalande-Banda and Walt 1995)

Ad hoc Enforcement of Regulations

In **Pakistan**, in the face of weak enforcement of the regulations on pharmacies, the Chief Minister of Punjab established an ad hoc task force. Of 6,700 pharmacies inspected by the task force, 590 were immediately closed (for sub-standard storage or lack of trained personnel or a pharmacy license). Cases were registered against a further 1,738 pharmacies.

(Association for the Rational Use of Medicine in Pakistan 1999)

M : Regulatory Interventions against One Drug can Lead to Further Irrational Prescription Practices

In June 1990 in **Pakistan**, paediatric formulations of six antimotility drugs to treat diarrhoea were de-registered. This action followed a number of recorded cases of fatalities from paralytic ileus in children under two, all of whom had been given paediatric Imodium. It was assumed that this action alone would address the problem of inappropriate treatment of childhood diarrhoea, but cases of paralytic ileus continued. A survey was conducted to assess the effectiveness of the regulatory intervention. It concluded that while the de-registered products had been successfully withdrawn from nearly all retail outlets, the banned drugs were still available on the black-market. In addition, throughout the country, the banned paediatric formulations were being substituted by adult formulations of the same drugs. The authors recommended that 'top-down' regulatory measures be accompanied by interventions with providers and the public.

(Bhutta and Balchin 1996)

1 Bennett et al. (1994) refer to 'carrots', which are incentives and rewards for good practice, and 'sticks', which are penalties for bad, dangerous or illegal practices.

Cautions, pitfalls and evidence gaps of this strategy

- **Regulation is costly:** within the context of a weak public sector, the demands on the state to regulate and enforce regulation may be unrealisable (see Box L above).
- **Regulations are blunt instruments:** even where they are effectively implemented, they are not designed to influence clinical practice, prevent over-supply of investigations and drugs, or address problems of poor technical quality of care provided by PSPs.
- **Professional bodies act in the interests of their own members:** where self-regulatory mechanisms are in place, they may be reluctant to enforce professional standards and act against their own members.
- **The imposition of regulations may result in perverse outcomes:** see Box M, above.
- **Regulations may be undermined** through, for example, bribery of inspectors. This is known as regulatory capture (Kumaranayake 1997).

Contextual features which facilitate this strategy

- A strong public sector health system is required to ensure there are the necessary skills to manage the private sector; it can provide functioning monitoring and quality control systems.
- Government must have the political will, organisational capacity and resources to enforce regulations (inspect premises, monitor practices, and penalise health workers and establishments which transgress regulations).
- Professional organisations must have the political will to co-operate with and support the enforcement of regulations which may be used against their members.
- Professional councils and other designated organisations must have the capacity, resources and political will to administer registration and licensing processes, and to enforce regulations governing health worker malpractice.

Questions for decision-makers

- What regulations are enforced? How are they enforced? What are the obstacles to enforcement: an inadequate regulatory framework, lack of political will, lack of capacity, lack of resources, regulatory capture, opposition from professionals or other factors?
- What level of resources will be required? From where will these resources come? Is there potential to underpin and reinforce regulations through other avenues, e.g. through consumer advocacy?
- What are the opinions of key informants on the potential for strengthening regulatory frameworks, strengthening enforcement, and utilising other strategies to underpin and support regulations (for example, incentives, professional self-regulation, accreditation)?

Key information sources

- **Documents:** legislation governing professional councils and regulatory boards; newspaper reports of medical malpractice and negligence cases
- **Informants:** office holders of professional councils and regulatory boards, office holders of professional representative bodies, consumer groups with an interest in health

Conclusions

The effectiveness of regulation as a tool is context-dependent. In settings where regulations are enforced, they provide an important basis for ensuring safety and preventing malpractice. Even where they are not enforced, a basic regulatory framework is necessary to define minimum safety standards. Given that they focus on minimum standards, they are not useful tools for promoting quality. Where the objective is to improve quality of care, regulations need to be supplemented and supported by other, frequently more co-operative strategies for working with PSPs (see Strategy 8 below).

A particular difficulty faced by public sector managers (or others) lies in extracting and testing the accuracy of information provided by PSPs. Routine data return systems involve transactional and opportunity costs for busy PSPs. These factors are exacerbated by the reluctance of PSPs to divulge data on charges and service user volume, often from fear of state interference, including taxation of income. This may be a particular problem where private practice is covert. The validity and reliability of such data are therefore uncertain. The effectiveness of regulation may be enhanced by increasing users' awareness of good practice or using alternative judicial channels (see Strategies 9 and 10).

Working with PROVIDERS

Strategy 8 : Train and incentivise PSPs

Description of the strategy

This is the **'carrot' approach** (Bennett et al. 1994). A range of interventions including training, provision of supports and incentives may be used to reduce harmful and promote good practice by PSPs (see Section 3). This approach arises from an understanding of the complex range of factors that determine provider behaviour. Box O provides an example where continuing medical education (CME) of providers proved more effective when it was reinforced by an intervention involving service users. Identifying the factors that are most important in the local situation can help in the selection of strategies (see Section 3 and the following table for some examples):

Factors	Strategies
Lack of knowledge and skills	Providing PSPs with up-to-date locally relevant evidence and training **(Box O)**
Engaging in practices for which there is community demand but for which PSPs are not trained	CME and training leading to incorporation in provider networks, accreditation schemes or eligibility for payments by third party payers **(Box N)**
Lack of access to necessary drugs or investigations	Access to subsidised supplies, subject to controls **(Box N)**

Case studies

N : Clinic and Pharmacy Staff Provide Pre-packaged STI Treatment in Uganda

Drug shop owners and private clinic nurses were trained in the syndromic management of male urethral discharge and supplied with pre-packaged drugs (ciprofloxacin and doxycycline) to provide to symptomatic customers. The service was socially marketed among potential STI service users. In a follow-up survey, there was a significantly higher reported cure rate (84%) compared with the baseline survey (47%); and more frequently reported condom usage. In simulated client* visits, most PSPs provided appropriate health messages and sold the product at the recommended retail price. The project had the 'almost universal approval of…policy makers, health workers and patients'.

(Jacobs et al. 1999)

Private GPs Provide Pre-packaged STI Treatment in South Africa

Training in the syndromic management of male urethral discharge, with the provision of pre-packaged drugs, proved highly successful among public sector health workers in Hlabisa. Implementation of a similar strategy with private GPs (doctors) was unsuccessful. Many GPs used the drugs for other purposes.

(Wilkinson 1999)

Pharmacists Provide Pre-packaged STI Treatment in The Cameroon

A project, which successfully trained pharmacists in syndromic STI diagnosis and the dispensing of pre-packaged drugs in Cameroon, was not scaled up to programme level and was abandoned. This was partly due to the opposition and influence of the powerful medical lobby on policy makers.

(Henry 1995)

O : Training Users and Providers Together

In **Indonesia**, service users and PSPs 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 practitioners 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. Prescribers expressed the need for peer norms to reinforce and support improvements in practice.

(Prawitasari Hadiyono et al. 1996)

Shop Keepers Trained to Advise Customers on the Most Appropriate Treatment for Childhood Fevers

Most early treatments for fever occur through self-medication with shop-bought drugs. In rural **Kenya**, lack of information to the community on appropriate OTC drug use for children led to widespread ineffective treatment of fevers, increased risks of drug toxicity and accelerating drug resistance. In 1996, shop keepers serving a population of about 3,500 were trained in how to give information to customers about the most effective combination and use of drugs for childhood fevers (antimalarials and antipyretics). There was strong support for the intervention from the community. The study showed a large shift in the behaviour of customers in the use of these drugs as a result of shop keepers' verbal advice and printed visual information given to customers to reinforce the advice. The shop keepers' revenues increased as a result of customers' buying an increased amount of more costly drugs as a result of improved awareness of appropriate treatments. Shop keepers' perceived status in the community was also raised.

These findings suggest that a shop keeper may be an appropriate channel of information to the community on appropriate drug purchase and use. However, it should be recognised that shop keepers are primarily concerned with increasing the profitability of their business, not providing health advice. This study showed that rural shop keepers can be motivated to take on an advisory role in the community where this does not diminish their income. In fact, in this instance the combination of shop keepers' increased knowledge, consequent increased social status and potential for increased profits, proved a powerful combination. The change in purchasing behaviour among customers appears to have been sustained, even though this resulted in the community bearing overall increased costs of treatment.

(Marsh et al. 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **Engaging the interest of PSPs may be difficult,** unless they see benefits from participating in training and CME sessions and in compiling data for government or other bodies.
- **On going monitoring and supervision is resource-intensive** and may not be feasible or sustainable in scaled-up programmes; perverse effects may occur (see Box N, South Africa).
- **Community and service user education is often required** to underpin provider training; otherwise discrepancies between provider knowledge and practice develop, due to providers' actual or perceived expectations of what clients want.
- **The support of powerful stakeholders is needed** in interventions which authorise PSPs to provide treatments that they are not qualified to provide. They can otherwise block them from being scaled up to national programme and policy levels (see Box N, Cameroon).

Contextual features which facilitate these strategies

- National policy makers and other powerful stakeholders willing to try innovative approaches to improving PSP quality of care.
- Policy-makers with the political will to involve a wider range of PSPs in providing services, including prescription-only drugs, which they are not currently licensed to provide.
- PSPs are currently providing services which are popular among service users, compensating for gaps in public sector provision (through providing greater geographical or social access, or more acceptable services for priorities such as STIs or TB).
- PSPs are easily identifiable, either in full-time private practice or legally engaging in dual public and private practice; registers of PSPs of professional councils and professional representative bodies are available.
- Where PSPs are already organised into professional bodies that provide training/CME to their members, it may be logistically easier to work through these bodies.
- Training, ongoing monitoring and quality control require high capacity. Government either needs to be able to carry out effective monitoring to detect perverse outcomes and take preventive measures; or contract this task to another body, such as a NGO.
- Provider self-regulation, peer audit and review approaches require a high level of capacity and the commitment and the willingness of professional organisations to undertake them.

Questions for decision-makers

- What are the different types of PSPs who are currently providing priority services (treatment of malaria, diarrhoea, ARIs, STI, TB, etc.)? What are the quality of care deficiencies that need to be addressed?
- What level of resources will be required? From where can these resources be mobilised?
- What avenues exist for working with PSPs: either directly, through their professional bodies, or through independent bodies with the capacity to train and monitor PSP practice?
- Is there potential to underpin and reinforce training and incentives using other approaches, e.g. through consumer advocacy groups or community education?
- What do key informants think about the potential for using these strategies with different types of PSPs? Find out at an early stage who (e.g. powerful professional groups) is likely to oppose them, both at the pilot stage and – equally important – if successful pilots are to be later scaled up to national programmes.

Key information sources

- **Documents:** constitutions of professional bodies, national surveys and research outputs
- **Informants:** office holders of professional councils and professional bodies, consumer groups with an interest in health

Conclusions

There is growing evidence of the effectiveness of demonstration projects in improving the practices of pharmacists and shop keepers. Examples include training and supplying them with pre-packaged drugs for syndromic management of conditions such as STIs and malaria. Two problems have emerged: perverse effects such as the misuse of drugs occur; and powerful stakeholders such as the medical profession block the scaling up of successful projects. Working with private medical practitioners is a more complex endeavour. Examples of successful strategies from developed countries have been reported. Few have been tested in the poorest countries where decision-makers frequently lack the tools and evidence of what will work (Brugha and Zwi 1998).

Enabling PEOPLE

Strategy 9 : Enact consumer protection law and raise consumer awareness

Description of the strategy

The consumer protection movement recognises eight consumer rights, including the right to satisfaction of basic needs, to safety, to information, to consumer education and the right to 'expeditious, fair, inexpensive and accessible' avenues for redress. These rights arise from the UN Guidelines for Consumer Protection (to which many developing governments are signatories). The Guidelines articulate consumer rights in health, especially in relation to essential and safe pharmaceuticals. Some developing countries have adopted consumer protection policies and enacted legislation to enshrine consumer rights in law.

This strategy uses consumer protection legislation and its accompanying mechanisms for redress (for example consumer courts or appeals to regulatory authorities), for occasions when service users have experienced medical negligence or malpractice. Consumer protection approaches to improving the quality of health care are based on the premise that consumer and community expectations of the type of treatment clients expect to receive can influence the behaviour of PSPs. It requires that service users are aware of their rights, can identify when they are not receiving adequate quality care and are socially as well as legally empowered to take action. The media and consumer advocacy groups each have an important role to play in raising awareness.

Case study

P : Consumer Protection Legislation Applied to Private Health Care: The Experience in India

Case law has brought private medical practice under India's 1986 Consumer Protection Act (COPRA). There is high awareness of the Act among private doctors; and a significant use of the law by consumers to pursue grievances in commercial sectors, but also in medicine. However, there is a significant backlog of cases awaiting adjudication which makes redress slow. Experience so far indicates that COPRA, on its own, has limited effectiveness for changing provider behaviour to improve quality standards.

A survey among practitioners showed that there are concerns among medical practitioners that COPRA will result in:

- more defensive medicine being practised, including an increased reluctance to treat emergency cases
- an increase in fees and the unnecessary use of diagnostic tests
- service users taking false cases against doctors, as there is no penalty against this.

However:

- a significant number of doctors believed that the Act would encourage them to improve the way they communicate with service users.

(Bhat 1996, 1999)

Cautions, pitfalls and evidence gaps of this strategy

- **It is costly:** consumer redress through the courts is costly for the state.
- **Medical professionals have been unwilling to participate** in judicial processes which are not mediated through medical councils; lack of information and technical expertise has hampered the courts in making judgements about quality and safety.
- **Justice may not be done:** judicial systems in many developing countries have inherent flaws and thus do not always deliver impartial justice.
- **Consumers may not have the means** to pursue redress. Many consumers, especially the poor and uneducated, may not have the resources, be aware or empowered to use the available avenues of redress.
- **Capacity may be insufficient:** consumer or other courts may not be able to handle a significant volume of cases efficiently.

Contextual features which facilitate this strategy

- National consumer policy and legislation which can be applied to medical practice.
- Supportive professional representative organisations and professional councils.
- Effective civil society consumer organisations and media to raise awareness of consumer rights.
- The institutional machinery of consumer protection (consumer courts or other low-cost avenues for redress) is accessible, with the capacity and speedy mechanisms for processing complaints and dealing with cases.

Questions for decision-makers

- Are there functioning mechanisms for consumers to obtain redress against providers of services and products?
- What is the potential to use or adapt existing mechanisms? What resources and whose support would be necessary for such mechanisms to be effective? Whose opposition might prevent the development of this strategy and how could they be mobilised to support it?
- What are the views of key informants? Ascertain their opinions as to the potential for using consumer and judicial routes. Try to identify and build consensus on how the medical professionals could support this strategy.

Key information sources

- **Documents:** consumer legislation, relevant successful and unsuccessful court cases which may often be accessed through media reports (newspapers).
- **Informants:** legal professionals, NGOs and consumer groups with an interest in health, medical and professional council representatives.

Conclusions

The Indian COPRA is the best known example of using consumer protection legislation to deal with medical malpractice and negligence. Despite its limitations (the inability to make judgements about technical quality and various capacity constraints), there is a higher awareness among PSPs of this legislation than of other regulations. PSPs believe it can have positive as well as negative effects, through making them more responsive to consumer needs and rights.

It is likely (although there is limited evidence) that raising awareness amongst consumers of their rights in relation to the purchase of health care products or services will translate into demand for better quality, more appropriate treatment.

Enabling PEOPLE

Strategy 10 : Increase service user knowledge

Description of the strategy

Accurate, relevant information may enable users to select the best strategy for preventing and managing particular health problems, and contribute to enabling them to demand appropriate care. This could be through the public or private sectors. Education programmes may provide reliable information on how to self-treat common conditions such as cough, fever and diarrhoea; and on when people have a serious condition requiring the use of a trained provider. Social marketing and promotion of accredited providers guide service users towards quality assured providers for different health problems.

Information can be provided through a number of channels, including community leaders, peers, NGOs, user groups, public sector providers and mass media. Communication channels that do not require literacy will be important for those who have not been to school; these can include the use of radio, discussion groups, visuals, word of mouth and local performing arts. Uganda is often cited as an example of effective community education to reduce the stigma of HIV and promote preventive practices.

Approaches involving community participation can be used to enable community groups to discuss the factors that influence their health-seeking behaviour, provide additional information, and seek the best options for preventing and managing illness. People can role-play both existing interactions with providers and their desired interactions, and explore ways to influence the service providers. This might be through individual negotiation or collective action. The Indonesia case study (Box O, above) is an example where service users and PSPs were educated together.

Case study

Q : Poor People Would Like to Learn More about How to Find Good Quality Care

In **Cambodia**, community members in poor squatter communities have expressed great interest in learning more about how to self-treat and how to select the most appropriate providers. They often visit a PSP to obtain an initial diagnosis and explanation of correct treatment for an illness; they then attempt to save money by using this knowledge for self-treatment in subsequent illnesses. Reliable information and explanations of the diagnosis, prevention and treatment were valued highly in ranking quality factors used as criteria for where to seek care.

On the whole, NGOs were valued highly for providing information; for-profit PSPs, especially those without training, were rated low because they did not provide information to the client. In terms of choice of high quality for-profit PSPs, recommendations from friends and relatives who had used the service had far higher credibility than marketing approaches; people believed that for-profit PSPs were only interested in profit and 'fostered disease so that they could benefit'. This is in contrast to NGOs who were thought to 'love the poor' and serve them well because they have good salaries and equipment. 72% of parents with children under 10 years suffering from diarrhoea were reported to have given the child oral rehydration therapy (ORT) correctly. They learned about ORT from local NGOs.

(Gordon 2000)

Cautions, pitfalls and evidence gaps of the strategy

- **Good quality care may be unaffordable:** poor people may know the characteristics of a high quality service but simply be unable to afford it (see Section 2). For example, in the baseline demand survey in Cambodia (see Box Q above), people were well aware that untrained drug sellers gave poor quality care. However, they chose these more affordable alternatives up to the point where the illness became demonstrably serious.
- **Social barriers may be too great to overcome:** social barriers to access relate to gender, education, ethnicity, language, status, caste and poverty. Independently of income, they inhibit users from demanding higher quality care from providers who are usually of higher status. The information, power and status asymmetry between PSPs (including NGOs) and users may make it impossible for negotiations about quality to take place.
- **Service providers may withhold information** from users to maintain their position of power and react negatively to users who question their diagnosis or treatment. This situation may be exacerbated if the user is poor, uneducated and unable to pay a higher fee.
- **People who are ill are vulnerable.** The nature of patient-provider interaction is such that people who are ill may find it more stressful to assume responsibility for demanding good care rather than to trust in the health 'expert'.
- **The strategy may be too risky.** The strategy may put an unacceptable burden and risk on those least able to influence the quality of care and result in hostile responses from PSPs.
- **Some quality aspects cannot be influenced by users.** Quality of care may be related to factors that community members and providers have no control over. For example, drug supply, drug quality, appropriateness and quality of investigations.
- **PSPs may be seen as only interested in profit** so any educational programme associated with them may not be credible.

Contextual features which facilitate this strategy

- PSPs who are open to dialogue with service users.
- Level of popular political involvement: the success of this kind of initiative may be linked to society-wide democratisation efforts, the presence of user and target group advocacy organisations (e.g. women's groups) and NGOs.
- Higher levels of education of users: sufficient percentage of community members, particularly women, who have attended school to at least primary level.
- NGOs and government have the institutional and technical capacity and adequate resources to undertake effective health education.
- There are appropriate channels for communication with the potential users.
- The community is motivated and has the capacity to establish user groups or other mechanisms to demand high quality care.

Questions for decision-makers

- What are the sources of information and types of media that will reach the users? Which ones are credible to users?
- What types of roles can NGOs and community based organisations take on in relation to PSPs and what might be needed to prepare them for this?
- How do such organisations relate to existing health services, PSPs, local governments, NGOs and provider interests?
- What level of resources will be required, from where will these resources come, and what is the potential for developing a sustainable system that is not reliant on external funding?

Key information sources

- **Documents:** donor, academic and other reports on patterns of health care demand and health seeking behaviour
- **Informants:** community based organisations, NGOs and consumer groups with an interest in health

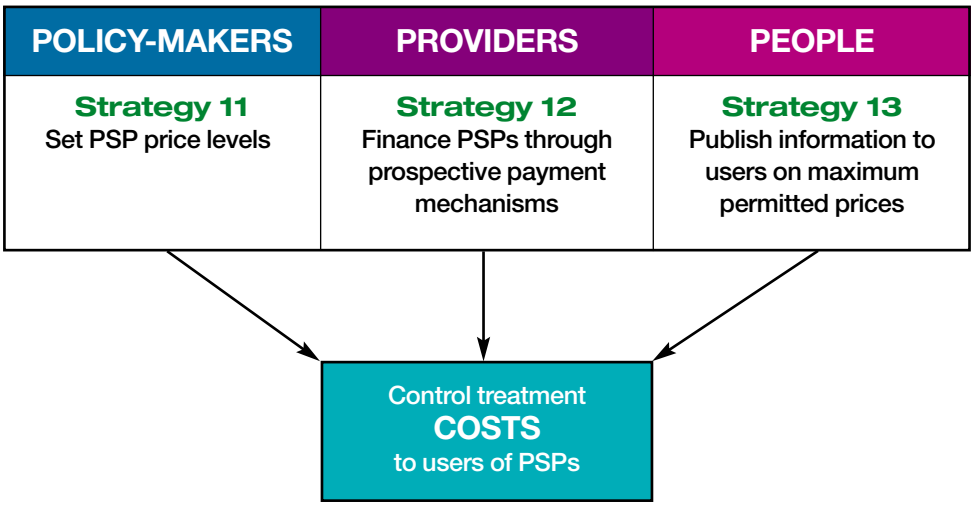
Conclusions

Evidence of the potential for community education to result in more effective health seeking behaviour and better use of available health resources comes mainly from the public sector and NGOs. For example, studies have shown that health education and promotion in the community has resulted in increased uptake of: immunisation, maternal and child health care and family planning services, prompt treatment for serious illnesses such as ARI and delivery by trained midwives. Increasing user knowledge of the best strategies for managing different signs and symptoms could enable users to use available health resources more effectively, but only if high quality care is available at affordable prices. Collective mechanisms and the use of *community advocacy groups* may be more acceptable and effective than placing the responsibility on individuals, for negotiating better care from PSPs.

Participatory processes may have the potential for building the capacity of communities to negotiate with professionals, strengthen accountability and improve health service outcomes. There is, however, inadequate knowledge to assess how well this might work with for-profit PSPs (Bloom et al. 2000; Cornwall et al. 2000).

STRATEGIES AIMED AT CONTROLLING COSTS TO USERS

Strategies may be summarised as follows:



Working with POLICY-MAKERS

Strategy 11 : Set PSP price levels

Description of the strategy

Governments generally do not attempt to set prices for health services in the private sector. This is because of the difficulty in determining an appropriate charge where what constitutes appropriate investigation and treatment cannot be clearly defined. There are also difficulties in deciding how service charges should be displayed and how price control would be monitored. There is often significant resistance to price control by powerful groups of PSPs, and no evidence that increased numbers of PSPs (for profit and not-for-profit) and public providers creates market pressure to lower service prices. In India, for example, physicians work in a highly competitive private sector market, especially in urban areas. A recent study showed that they use a variety of strategies to increase revenue including ordering investigations and prescribing medications that are unnecessary and splitting fees with other providers or with diagnostic laboratories (Bhat 1999).

However, most curative and many preventive health actions depend on drugs (medicines). In poor countries over 50% of household expenditure on health is spent on drugs, often bought over-the-counter from untrained retailers and dispensers (WHO 2000). In these countries, price control of drugs, if effective, could be an important strategy to control treatment costs to users (and to increase affordability). Price control is often combined with an essential drugs policy and promotion of generic rather than branded drugs. Essential drug policies, where enforced, can ensure that only generic forms of essential drugs are available in the public and private sector and that expensive proprietary (named) brands are not imported. The prices of generic drugs are easier to control than branded drugs. In practice, it is difficult to prevent parallel imports of branded products through the private sector.

In a study of 33 developing countries, only seven had no price control, eight had limited controls and 18 had substantial controls. Drug price control may be exercised both through the control of producer prices and/or of distribution margins. Producer prices and final user prices are usually set at the point of registration, importation or marketing of a drug and are reviewed periodically. Governments often link price increases to other price indices (WHO 1997).

Case studies

R : Drug Price Control in Colombia and Bangladesh

Colombia has had experience of drug price controls since 1968, although the regulations have gone through a number of forms. Since 1992, the system has combined price freedom for a wide range of products with price control for a limited number. Essential drugs with fewer than five suppliers and so-called 'critical drugs' (in total about 20% of the market) have been subject to 'monitored freedom'. 'Monitored freedom' means that producers or importers can change the maximum selling price to the public, but must inform the Ministry of Development in advance. The Ministry can require manufacturers to produce cost analyses in support of price increases. It can also override the producer and impose the price level it deems appropriate.

In 1994, however, the Colombian government dropped the experiment with monitored freedom and returned to a system whereby prices to the consumer for monitored drugs had to be less than 3.4 times the production cost of the drug. The principal reason for this turnaround was lack of government capacity to monitor price changes.

(WHO 1997)

Bangladesh's National Drug Policy, adopted in 1982, prohibits importation and sale of all non-essential drugs. As a result about 1,666 products were judged to be ineffective or harmful and were banned, while 300 were approved for marketing. The government also oversees production quality of all manufacturers and provides training to drug retailers on rational drug use. The impact of this approach has been significant. Through a combination of public sector supervision and private initiative, essential drugs have been placed within reach of large numbers of the population and there are reasonable and stable prices for drugs produced locally.

(WHO 1995)

Cautions, pitfalls and evidence gaps of the strategy

- **Most of the evidence comes from developed countries.** Decision-makers in developing countries should be cautious in interpreting the results of these studies and applying them in their own contexts.
- **Opponents of drug price control believe that it is cumbersome and open to manipulation:** for example, it could lead to real or artificially-created scarcities, may stifle competition and innovation, and encourage misleading accounting practices among producers and importers.
- **Implementation is difficult:** for example in setting prices for imported drugs during times of high inflation or exchange rate fluctuations. Government capacity in economic and financial analysis may be limited compared to drug producers and importers.
- **Price setting itself poses challenges.** If drug prices are set at less than a competitive price, there are likely to be shortages of the product and parallel markets with unregulated prices will develop. Alternatively prices could be set too high, further damaging affordability. Cheaper drugs may not be safe or quality assured.
- **PSPs may side-step price regulation:** for example, by charging a dispensing fee for a prescription or by charging a fee for administering a drug by injection.

Contextual features which facilitate this strategy

- A competitive drug market with drug quality control systems.
- An essential drugs policy in place.
- A transparent policy for setting drug prices and mechanisms for altering prices promptly in response to market changes.
- Government capacity to analyse producer costs, negotiate with drug producers and importers and to enforce price controls.
- Capacity to enforce drug quality control.
- Capacity to enforce essential drugs policy in the private sector, including restrictions on undesirable parallel imports.

Questions for decision-makers

- Who are the stakeholders? They are likely to include Ministry of Health, Trade and Industry or Commerce, Pharmacy Board, local and international pharmaceutical companies.
- How will drug distribution, prescribing, dispensing and consumer behaviour change in the face of price controls?
- What are the potential risks of price regulation in the local context?
- What capacity is there to monitor price adjustments and enforce controls?

Key information sources

- **Documents:** national drug policies, donor and other reports on producer and retailer drug prices
- **Informants:** representatives of Ministry of Health, Trade and Industry or Commerce, Pharmacy Board, local and international pharmaceutical companies, and consumer groups

Conclusions

It is difficult to regulate and control health care service prices and overall costs to users. Regulation of drug prices is more promising. Where price regulation has been enforced, it has been shown to control both individual drug prices and increases in drug prices, though not overall drug expenditure. Lowering individual drug prices may be offset by prescribing and dispensing greater quantities of drugs or a different (and more costly) selection of drugs.

Control of distribution margins (the difference between producer and retail prices) is a sensitive issue because it strongly influences dispensing incentives and advice at the point of purchase from PSPs. For example, pricing control mechanisms that use a fixed percentage mark-up over producer prices may achieve reductions in individual drug prices, but they retain a strong incentive for retailers to dispense more expensive drugs. These systems result in lower mark-ups for generic and/or essential drugs and thus are likely to discourage rather than encourage dispensing of these lower cost drugs. It is possible that price regulation may have more favourable public health benefits for lower-income countries and lower-income populations. However, government's capacity to negotiate with pharmaceutical companies and to enforce price levels may be insufficient to be effective (WHO 1997).

Working with PROVIDERS

Strategy 12 : Finance PSPs through prospective payment mechanisms

Description of the strategy

Where people pay for their health care out of their own pockets at the time of receiving treatment, poor people are likely to have limited access to the care they need and little control over the costs of that care. In addition, some interventions of public health importance would not be financed at all if individuals had to pay for them (see Section 3). In prepayment (or prospective) schemes, funds for health care are collected from a population, combined and used to purchase care for that population. Under these schemes, providers (for-profit and not-for-profit PSPs and public) are paid for the commitment to provide defined packages of care to members of the scheme. In this way, financial risks associated with health care costs (which can be so catastrophic for the poor) are shared (or 'pooled') between members of the same scheme.

Funding for a prepayment scheme, depending on whether it is a government, social insurance, employers' or private voluntary scheme, can be from any combination of government (through taxes), employer and individual subscriptions. In employer-based schemes, contributions can be deducted from the employee's wages. Where people are not in formal employment, community or provider-based prepayment schemes may be created, although these are difficult to sustain (Bennett et al. 1998).

The way in which a provider is paid (provider payment mechanisms) will have a direct impact on the provider's incentives to control costs. Purchasers have a range of funding arrangements from which to choose, each of which is more or less successful in meeting health needs and controlling costs to scheme members. Where care is purchased on a capitation basis, a fixed annual payment is made to a provider for each user. Capitation payments are used to avoid the cost-inflation that occurs through the over-provision of services under a case-based or fee-for-service reimbursement system. They also provide an incentive to the provider to prioritise less costly preventive approaches (WHO 2000).

Case study

S : Capitation Payments in Thailand

The government of Thailand introduced a compulsory social health insurance scheme following the enactment of legislation in 1990. All employees of companies with a workforce of 10 or more are entitled to hospital and ambulatory care under a scheme funded equally by contributions from employees, employers and government. Eligible public and private hospitals, that is those which meet specified standards, can register to become 'contractors'. Workers are free to choose where to obtain care from among the contracted hospitals. Contractors receive fixed annual capitation payments for a commitment to provide care to eligible individual workers. The scheme has stimulated the development of networks of providers who are sub-contracted to provide services. Private hospitals have responded more rapidly than public ones, and increased their share of the market from 17% to 55% between 1991 and 1998. Capitation appears to be an effective mechanism for controlling costs, but concerns have been raised about a potential fall-off in quality of care, especially among private hospitals.

(Mills et al. 2000)

Cautions, pitfalls and evidence gaps of this strategy

- **PSPs may not wish to participate:** PSPs and private hospitals are reluctant to change from fee-for-service to capitation or case-based payments, as this transfers the risk on to the provider.
- **PSPs may under-supply services,** reducing quality of care, as a way of maximising profits.
- **Monitoring and quality-assurance systems need to be in place** to detect and prevent quality declines.
- **Small purchasers may be disadvantaged:** large purchasers can take advantage of economies of scale and better bargaining capacity regarding price and quality.

Contextual features which facilitate this strategy

- Policy on the role of the private sector (including NGOs) and health care financing.
- Defined quality of care standards for a range of medical conditions.
- An organisation with the capacity to manage the scheme (in Thailand, the scheme is managed by the government social security office). This includes the collection, pooling and purchasing functions.
- Monitoring and quality assurance systems which can ensure that appropriate care is provided; ideally health outputs, as structural indicators of quality are not sufficient.
- Sufficient numbers of large facilities with the capacity to manage contracts.

Questions for decision-makers

- Who are the stakeholders (government, social security office, employers, professional organisations, hospital management, NGOs and consumer advocacy groups)?
- Are there sufficient numbers of large facilities that can manage contracts? Are there organisations that can manage the scheme, including setting payment rates, monitoring and assuring service outcomes?
- What are the levels of stakeholder interest and capacity for implementing this strategy?

Key information sources

- **Documents:** examples of schemes from other countries
- **Informants:** Ministry of Health, social security office, large employers

Conclusions

Self-financing prepayment schemes are most successful where cover is provided to working adults who are generally healthy and do not require large amounts of expensive health care. PSPs will be less willing to participate in schemes that commit them to providing care to children, the elderly and those with chronic illnesses.

Schemes will be easier to administer where there are a sufficient number of large providers, such as public and private hospitals (including NGO providers), with the capacity to manage contracts. They will be less feasible if they involve contracting to large numbers of small size or solo PSPs, which can increase the transaction costs including increased costs of service monitoring and quality assurance. Under-provision of services, where the provider has been paid in advance, may lead to deterioration in quality. Eligibility requirements for PSPs, such as minimum numbers of beds, training levels of staff, quality of facilities, may be used to set minimum quality of care standards.

Enabling PEOPLE

Strategy 13 : Publish information for users on maximum permitted prices

Description of the strategy

This strategy is the user-oriented counterpart to price regulation for drugs (see Strategy 11). Information is provided to consumers about the prices of branded and generic drugs to enable them to exert pressure on prescribers and dispensers. Methods for communicating price information include listing of prices in pharmacies, regular publication of a pricing guide (for example, in Colombia see Box U below), publication of selected drug prices in the media and the printing of maximum retail prices on drug packages themselves. This latter strategy is used widely in India and Pakistan. NGOs and other community-based organisations such as Village Health Committees can also play a role in communicating information on prices to consumers.

This strategy is part of a wider strategy of involving people in making decisions about their health care – what and how much to buy, where to go and what to pay – which can include diagnostic, curative and preventive services as well as drugs. Consumer sensitisation to these issues happens in a wider social context. The media, consumer advocacy and community-based groups can all play an important role in promoting awareness of consumer rights, including fair pricing (see also Strategy 10). There is some evidence to suggest that in franchised networks of PSPs providing well-defined services (such as family planning and abortion), widespread publication of prices to users and potential users does bring pressure to bear on PSPs to contain their prices to pre-set levels (Janani 2000).

Case studies

T : Displaying Service Price Information in Cambodia

PMPs reported that they preferred not to 'post' prices at their surgery so that they could alter prices downwards (presumably with a reduction in services provided), where patients could not afford higher charges.

(Gordon 2000)

U : Drug Price Information in the Philippines and Colombia

The national drug policy in the **Philippines** has encouraged price competition through generic substitution rather than price control – the prices of selected generic drugs are regularly publicised in the media.

In **Colombia,** efforts to promote generic prescribing included publication of a WHO-supported price comparison guide. The guide proved popular and the Ministry of Health soon took over its publication. Because the guide was effective in drawing consumer attention to the price advantage of local products, publication of the guide was eventually taken over by the local manufacturers' association. Thus its regular publication became sustainable without public subsidy.

(WHO 1997)

Cautions, pitfalls and evidence gaps of this strategy

- **Social barriers may be too great:** the information, power and status asymmetry between PSPs and users may make dialogue about drug costs between PSPs and users difficult.
- See also Strategy 11.

Contextual features which facilitate this strategy

- An independent media and an active and responsive consumer advocacy movement.
- See also Strategy 11.

Questions for decision-makers

- What levels of stakeholder interest and capacity are required to implement this strategy?
- How can the media be engaged with these issues on behalf of consumers?

Key information sources

- **Documents:** national drug policies, reports on the affordability of essential drugs to consumers
- **Informants:** Ministry of Health, pharmaceutical manufacturers and importers' associations, consumer advocacy groups

Conclusions

Publication of price information is generally limited to PSP products. Especially where prices are printed on drug packages, this strategy is likely to enable consumers to control the amount spent on particular drugs, although there is no evidence to suggest that overall spending on drugs is contained (WHO 1997). Where there is general awareness of health care costs through the action of the media and civil society, consumers can be sensitised to issues of what to buy and what to pay for particular health services.

Introduction

The Guide highlights an increasingly important issue: how to work with the private sector to achieve key health sector objectives – increasing coverage, improving quality of care, and controlling treatment costs to users. Its focus has been particularly on the way the poor use PSPs.

The Guide suggests a number of strategies to fulfil the objectives. The strategies focus on *policy*, the *providers*, and the *people* who use – or don't use – services. As has been stressed throughout this Guide, many strategies involve two or all three of these stakeholder categories; and, similarly, act to achieve more than one objective. However, focusing on *coverage, quality* and *cost* – and on *policy, providers* and *people* – serves as a helpful *aide-memoire* to ensure that all these dimensions are routinely considered in deciding how to move forward. In addition, for each of the strategies we identified *market, policy, resources* and *capacity* features that facilitate or obstruct their implementation; and *pitfalls, cautions* and *evidence gaps* for each.

In this last part of the Guide, we suggest several steps that decision-makers can take to assist in strategy selection. The first step is to gather information on the existing health care market, from both a user and a service provision perspective. Secondly, identify and access information sources to fill current information gaps. This information can then be used to prioritise policy objectives around coverage, quality and/or control of excessive costs. An inventory of existing policies, capacity and financing mechanisms is useful to guide decision-makers towards the strategies that are most likely to succeed in their settings; it will also identify where the system requires strengthening. We then suggest tools and approaches for taking this information forward with the different stakeholders. Finally, we give some pointers to how different health systems patterns can direct decision-makers towards particular strategies.

Step 1 : What information do you need about your health care market?

Size and form of the health care market

Provision and utilisation are two sides of the same coin. Data on each provide insights into how private and public health care markets are structured. Characteristics of PSPs include for-profit or not-for-profit status, legal status and training, size of facility, nature and complexity of product or service provided, and proportion of time spent in private practice or illegal dual practice (see Figure 1, page 5). Many of these characteristics determine the extent to which PSPs are visible and accessible to decision-makers. This, in turn, influences the feasibility of identifying them, assessing their practices (for the range of products/services provided and quality of care), and identifying the people that use the different types of PSPs. Often there is limited information about how the private sector is constituted in different contexts. In particular, relatively little is usually known about the distribution and supply aspects of the informal ambulatory (outpatient) sector, especially drug retailers. This is often the main source of care for the poor and is harder to monitor and regulate than the more visible parts of the private sector.

Where there is low visibility of and access to PSPs, decision-makers should consider working more actively with civil society organisations, such as consumer groups and the media, to develop a role for service users in driving quality improvements. Where the media and civil society organisations can be mobilised, it may be possible to influence providers by pressuring them on behalf of users. Consumer protection policies and legislation may

support this approach. A strong and effective regulatory system, combined with high quality and responsive public sector and/or formal private sector services, offer the best control and counter-balance to poor quality informal PSP services.

Coverage, quality and costs of private sector care – influence on supply and demand

Coverage, quality and cost determine the impact of services on individuals and different segments of the population. They also influence supply and demand. Where PSPs are located in areas not reached by public services, the coverage of particular types of services can be raised through social marketing, accreditation or franchising; or by contracting with NGOs or PSPs. Through which providers is care typically provided for priorities such as malaria, TB and STI control, and immunisations and family planning? If most of this care is provided by certain types of PSP but is of variable quality, then there is a need to work with these PSPs to improve quality. Additionally, decision-makers may prioritise public sector provision of these services. Many people may have little access to trained PSPs; retaining *public sector capabilities* to deliver care to these populations is therefore desirable.

Where the poor use particular types of PSPs, there may be a need and opportunities to target resources – training, subsidised drugs and other incentives – to these PSPs to overcome some of the obstacles to access. The supply of health care providers will greatly affect the feasibility and likely success of these schemes. An oversupply of doctors allows a more competitive market to become established which, with the right incentives, may help drive quality up. In a highly competitive market, providers may be willing to enter more innovative arrangements with financiers of services to deliver care, at an agreed standard, within agreed constraints of quality and monitoring, in exchange for guaranteed earnings. Where there are very few providers, and all are used heavily, it will be far more difficult to engage with and influence them.

On the demand side, what is the coverage, quality and costs of services accessed by different segments of the population? In particular, what kinds of health care do poor people obtain? What social, financial or geographic obstacles do they experience? Do they have the resources – information, skills, finance and time – to overcome these obstacles? What kinds of user fees and other charges, both formal and informal, exist in the public sector? How do these charges compare with those in the private sector? Demand-side constraints may be overcome by addressing the information and social constraints within specific target groups of the poor (young people, pregnant women, infants and children), or by targeting exemptions to them.

Step 2 : Identify sources of information on the health care market[2]

As a general principle, one should review existing available information, especially national and population-based data, identify information gaps and then seek to fill these gaps. *Demographic and Health Surveys*, available for approximately 66 countries, are national household surveys that contain information on the utilisation of reproductive and child health services. In some cases these now include data on the types of facilities available, with some **separation** into public or private. World Bank *Living Standard Measurement Surveys*, available for about 21 countries, contain information on household expenditures on health care and services utilised. *National Health Accounts* separate out health expenditure by types of services funded and usually include a description of the different types of public and private providers that are utilised. Increasingly, national level household surveys are providing data that relate socio-economic status to health status, service

2 This section is based on an early draft of Module 2 (Conducting a Private Health Sector Assessment) of Private Sector Participation in Health Handbook, edited by April Harding and Alex Preker, World Bank, forthcoming.

utilisation and household expenditure on health services (Gwatkin 2000). Registers of PSPs can be built from professional registration councils and professional associations; however, especially where the focus is on the less visible ambulatory sector, these will often need to be supplemented by on-the-ground mapping of providers.

The forthcoming World Bank *Private Sector Participation in Health Handbook* will provide a more detailed account of national population databases. Pending this, a list of the principal web-sites where these can be obtained is included in the reference section at the back of this Guide. The World Bank Handbook will also provide detailed guidance for decision-makers on how to conduct in-depth interviews and focus group discussions with PSPs, government officials and service users. The qualitative information obtained in this way can be used to fill many of the gaps that are usually present, especially with regard to how the health care market is structured, quality of care and costs. Such information can also identify the constraints that different PSPs and service users experience in providing and obtaining health care, and their perspectives on how these constraints could be overcome.

In addition to these sources of information, a literature review – including the list of references at the back of this Guide – will provide pointers to the types of strategies available for working with PSPs to achieve policy objectives. Discussions with key informants including donors and NGO representatives may turn up additional country-level project reports and useful research outputs. Building up the local evidence and information base on how to work with the private sector forms the basis for adapting **to the local context** lessons learned in other settings. Ensuring good documentation and dissemination of experiences, positive and negative, anticipated and unanticipated, is essential. Analysing innovative approaches and ensuring that the results of such analyses are placed in the public domain and debated openly will promote more effective learning, policy-making and interventions.

Step 3 : Prioritising objectives

When these steps are taken, decision-makers should have a clearer idea about which policy objectives they wish to prioritise. Data on coverage can be used to set objectives for:

- working with particular types of PSPs;
- priority diseases and services – for example malaria, STIs, TB, family planning and childhood illnesses – for which PSPs are commonly utilised; and
- particular segments of the population, especially the poor, that are under-served or which commonly utilise the less qualified and informal private sector.

Information on quality and costs is usually more scarce. However, the limited evidence available on the quality of care obtainable from PSPs for conditions of public health importance, combined with data gathered from local stakeholders, will usually be sufficient to identify the areas in which major quality deficiencies and barriers to access exist.

Step 4 : The local policy, financing and capacity context

The types of strategies that are most likely to succeed in promoting policy objectives will depend on the existing policy framework, available resources and financing mechanisms, as well as on the capacities of local stakeholders – especially government.

Policy context

What is the policy and legislative context within which PSPs operate? What roles are recognised for PSPs? Are there any specific plans for drawing PSPs into service provision? Do any health-related policies set guidelines or limits to working with PSPs? What organisational reforms have been undertaken which may affect how services offered by different providers are planned, financed and co-ordinated? To what extent has decentralisation to districts and local governments taken place? To what extent do these bodies have control over resources that can be used to purchase health care from the private sector? Is there a consumer protection policy and related legislation that may assist consumers to assert their rights in health care? The absence of a coherent policy framework in relation to the private sector suggests that assisting in the development of such a framework would be a good place to start.

Financing mechanisms

How health care is financed and who does the purchasing are important determinants of what strategies to adopt. Are social and independent health insurance schemes present or emerging? What proportion and segments of the population do they cover? Is there a purchaser-provider split, with the state and other purchasers buying services from different providers? Where there is existing capacity to purchase services on behalf of service users, typical only in more mature health care markets, a variety of levers may be employed to influence both provider and user behaviour. The best protection for service users may be to bring more of them into such insurance schemes, using the power and resources of the purchaser to address coverage (for essential service packages), quality and cost containment objectives. Where independent insurance schemes are emerging, setting ground-rules around risk-pooling and minimum service packages will help to promote policy objectives.

Stewardship capacity

The government needs to have sufficient stewardship capacity to manage the complex negotiations, policy changes and interactions with bodies representing PSPs and the public. Does the public sector have the capacity to monitor, regulate, subsidise and purchase contract service provision? The need for this capacity has been a recurring theme throughout the strategies for working with PSPs. Strategies that require sophisticated management skills should not be attempted in the presence of limited resources and public sector capacity. Development of this capacity to manage the private sector, which will require considerable resources and often external assistance, is a prerequisite for many of the suggested strategies. In its absence, decision-makers and donors may consider engaging specialist organisations, such as NGOs, to undertake specific programmes with the private sector such as social marketing, contract management, accreditation, or managing targeted exemption schemes.

Other stakeholder capacity

How well established are professional representative organisations (e.g. medical, nursing, pharmacist associations) and what values do they represent in the local setting? These organisations exist to promote the interests of their members, which may, at times, conflict with other policy objectives. However, if professional interests can be allied to improving quality, extending coverage, and controlling treatment costs to users, then it may be feasible to work with them. The effectiveness of provider self-regulation will depend on obtaining the support of such independent bodies. The extent to which PSPs are organised will determine the scope for negotiating with them as a group. The extent and nature of dual public-private practice by PSPs will influence the *setting* in which interventions are best directed at them. Where dual practice is illegal but common, explicit recognition of it will allow for more open debate and effective policy responses.

Step 5 : Who are the key stakeholders and how can they be mobilised?

In taking forward any of the strategies presented earlier, we need to think not only about their content, but also about the processes for taking them forward with the key stakeholders in different contexts. It is important not only to identify the range of organisations involved, but also to understand their objectives, perspectives and concerns. Around what issues is there support or scope for collaboration, and around which ones is there conflict? Tools such as political mapping (Reich 1994) and stakeholder analysis (Brugha and Varvasovszky 2000; Varvasovszky and Brugha 2000) can be particularly useful in assessing levels of stakeholder importance and influence, managing areas of conflict, identifying where consensus can be reached and in identifying what resources can be used for taking strategies forward. For example, health insurance companies will be mainly concerned about controlling costs in purchasing services from PSPs. Mobilising their support to monitor service quality (such as the use of evidence-based treatment protocols) may be possible if they can be convinced that better treatment outcomes can reduce costs. Professional representative bodies may be mobilised to support continuing professional education programmes if their involvement offers them channels for influencing the policy making process, and if their commitment to enhancing quality receives the attention of policy-makers, providers and the media.

Step 6 : Patterns of private sector provision and their influence on the choice of PSP strategies

Finally we describe two general patterns of private sector provision in developing countries and how these will influence the choice of strategies for working with PSPs. These patterns are based on the information gathered, as outlined in this final section: the nature of the health care market, available resources and leverages, and the capacity of the stakeholders, especially that of government and the public sector. Increasingly, in developing countries these patterns are diverse and complex. For example, the types of PSPs that are utilised, coverage for specific services, quality of care and value for money will vary to some extent between countries, between urban and rural settings, and between different segments of the population in the same setting. In recommending strategic responses to these different patterns, we refer back to the strategies described earlier in Section 4.

Pattern A

Large **urban areas** in the poorer countries are particularly complex, with urban poor slum dwellers often mainly served by informal, untrained and unregulated PSPs, who provide a mix of allopathic drugs and traditional remedies. This is a similar private sector pattern to that still found in many **rural areas.** In both urban and rural settings, public sector and NGO providers often operate alongside PSPs, and are frequented by users in turn or simultaneously. The poor are disadvantaged by their absolute poverty, lack of information, lack of affordable choice (including formal and informal public sector charges), geographical and social barriers, and the lack of responsiveness of non-PSP services. Each of these factors, taken with lack of education, impedes the poor from seeking and demanding quality care. This pattern of provision typically corresponds with weak public sector capacity and often a total lack of protection and quality assurance of the services that users obtain.

Response

In the absence of affordable and accessible alternatives, the enforcement of regulations to eliminate informal PSPs from the health care market is an inadequate and usually fruitless response. However, building up enforcement capacity will make sense if it accompanies and *follows on* the provision of such alternatives. Where the objective is to increase **coverage** for specific **quality-assured** products and services (coverage is an objective that is linked to quality, as stated in Section 3), strategies to consider include:

- lowering unnecessary barriers to product availability (**Strategy 1**)
- social marketing of quality-assured products and services (**Strategy 1** and **Strategies 2, 3 and 5**)
- exemption schemes for priority target groups, lowering costs to service users who cannot afford to purchase priority services (**Strategy 6**)
- ensuring the availability of appropriately trained providers through:
  – providing incentives to trained PSPs to work in these areas (**Strategy 1**)
  – contracting out service provision to NGOs (**Strategy 4**)
  – training lesser qualified staff to provide basic packages of services at an affordable price (**Strategy 8**)
- if quality-assured providers are present, affordable and accessible, strengthening regulatory controls to eliminate harmful or ineffective PSPs (**Strategy 7**) should then be considered.

Pattern B

Wealthier urban areas, even in some of the poorest countries, more closely resemble the more mature private sector pattern found in middle income and some higher income countries. Formally trained and licensed PSPs operate solo, in clinics or group practices, and in private hospitals. They are more visible than the PSPs in Pattern A settings. They fall, to varying degrees, within an enforced regulatory system of professional licensing. They are often linked in informal networks or are members of professional representative bodies. In some cases, especially where there are larger practices, third party payers (independent health and social insurance schemes) purchase a proportion of PSP services on behalf of users. They are also utilised by the wealthier, formally employed and better-educated segments of society; and they occupy market niches not served by the public sector. Where the public provision sector is weak, as in urban India, they dominate the health care market. In countries such as South Africa they may find themselves competing directly with a relatively strong public sector. Strategies for working with formally trained and organised PSPs will depend greatly on the availability of financing leverages and the degree of public sector capacity.

Response

In working with PSPs in Pattern B settings, strategies may be available for addressing all three policy objectives. Some of the strategies listed above for Pattern A can be adapted to Pattern B settings.

Coverage for specific essential products and services may be increased through:

- relaxation of regulatory controls to allow a wider range of PSPs to enter the market (**Strategy 1**)
- ensuring that essential service packages are included in contracts with PSPs (**Strategy 4**) and working with the managers of health insurance schemes to incorporate essential packages as reimbursable items covered under such schemes (**Strategy 12**);
- promoting consumer demand (**Strategy 5**); in Pattern B settings there will be scope for a more competitive retail market to supply those who are able and willing to pay.

Quality objectives can be promoted by working with the more organised PSP sector found in Pattern B settings, including:

- working with PSP networks and professional bodies to provide training, supports and incentives to PSPs to conform to evidence-based practice norms (**Strategy 8**);
- recruiting PSPs into accreditation schemes that may involve quality assurance and monitoring of a broader range of services than that outlined in **Strategy 3**;
- education of service users to recognise and look for service quality features (**Strategy 5**), which can be linked, but not necessarily so, to accreditation;
- enforcement of regulatory controls (**Strategy 7**), depending on government capacity;
- using consumer legislation to underpin service user approaches (**Strategy 9**), depending on the capacity of the legal system and the willingness of medical professionals to participate.

Cost control objectives are more easily achieved in Pattern B than in Pattern A settings, by:

- use of prospective capitation-based payment systems (**Strategy 8**), where services are purchased by third party payers;
- setting and controlling prices (**Strategy 11**) and providing information on price norms to potential service users (**Strategy 13**) and supporting the media in drawing attention to excessive profiteering and poor service provision by some providers.

Conclusion

This Guide should be seen as a starting point. It has sought to:

- identify some of the reasons for working with PSPs, especially as they impact for good or bad on the health of the poor.
- highlight the pre-eminent role of the state in working with PSPs and setting the policy framework within which they operate.
- relate strategies to the central objectives of *increasing coverage*, *improving quality,* and *controlling treatment costs* to users, especially the poor. We reiterate that building public sector capacity, and ensuring adequate resources, to provide essential services should always remain at the forefront as a way of taking forward these objectives.
- present an aide-memoire that highlights the central roles of the *policy* framework and context, the *providers* who offer services and the *people* who use or don't use them.
- describe and evaluate the utility of a variety of strategies that can be used for working with the private sector.
- suggest initial steps for decision-makers and programme managers in deciding what strategies to select and how to take them forward. These steps will assist not only in deciding how to work with PSPs, but also in identifying gaps that public sector provision needs to fill and ways in which its own services need to become more responsive.
- describe two broad health systems patterns, which may exemplify some of features of health systems in which decision-makers are operating, and which can assist in selecting strategies that are most likely to achieve policy objectives.
- stress the importance of carefully analysing, documenting and evaluating experiences and placing these insights in the public domain so others can benefit from them.

We hope the Guide has gone some way to achieving these purposes. It is only a starting point. We look forward to receiving comments, suggested modifications and documented experiences. Our intention is to contribute to disseminating such lessons more widely so that others too can learn from you.

Accreditation
a third party endorsement and assurance of the quality of service and care provided by a health provider. To be effective, the third party must have some credibility in the eyes of potential users.

Crowding out
the possibility that demand in the private sector for subsidised or fully priced health products may be undermined by the provision of free supplies in the public sector. Its importance is likely to vary enormously across country settings. At low levels of use, free or highly subsidised products may create demand which socially marketed or fully-priced commodities can then fulfil *('crowding in').*

Externalities
a spill over of benefits or harms from one individual to another. Communicable diseases (e.g. STIs, TB, malaria) controls have positive externalities in that they confer benefits on the whole population and not just on the individual service user.

Franchising
an arrangement whereby a marketer of a product or service (the franchisor) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a certain period.

Halo effect
where promotion of a branded product results in overall increase in demand for that product category and not just the branded product.

Information asymmetry
for market principles to hold, the purchaser of a product or service needs to have sufficient information to judge quality and value. In the health care market, patients lack the necessary information to make such judgements.

Private goods
are those which benefit only the individual who uses them.

Public goods
are non-rival (i.e. service consumption by one person does not reduce the service available to others) and non-exclusive (i.e. one cannot exclude others who have not paid for the service from benefiting from it). Examples include vector control, water and sanitation services. TB and STI control are examples of mixed public-private goods.

Regulatory capture
subversion of regulators and the regulatory system by vested interests.

Simulated client visits
this is a procedure used to check how health providers are really treating clients. A trained person pretends to be a client and consults the provider; the simulated client then reports back how s/he was treated.

Social marketing
although social marketing, as the name suggests, involves the stimulation of demand for a product or service among potential users, it has a strong component of working with the product manufacturers, distributors and/or the potential retailers to support and ensure the supply of the product or service.

Unweighted averages
averages calculated without taking into account the different population sizes of these countries; i.e. each country is given equal weight.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute respiratory infection
BCC	Behaviour change communication
CME	Continuing medical education
FP	Family planning
GP	General practitioner
HIV	Human Immuno-deficiency Virus
ITN	Insecticide-treated nets
IUD	Intra-uterine devices
MoH	Ministry of Health
MoI	Ministry of Information
MPW	Ministry of Population Welfare
NGO	Non-government organisation
OTC	Over the counter
PMP	Private medical providers (doctors)
PSP	Private sector provider
SMO	Social marketing organisation
SMP	Social marketing project/programme
STI	Sexually transmitted infections
TB	Tuberculosis
TV	Television

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USEFUL WEBSITES

Household surveys provide useful information on private expenditure on health and use of private sector providers. Demographic and Health Surveys (DHS) – now available for 66 countries – can be accessed via: **www.measuredhs.com**

World Bank Living Standards Measurement Surveys provide information on health care utilisation, and household expenditure on health care. Data on 21 countries can be accessed via: **www.worldbank.org/lsms**

Demographic and Health Surveys increasingly include Service Provision Assessments (SPAs). These provide information on the types of reproductive and child health facilities operating in individual countries. SPAs can be accessed via the DHS site: **www.measuredhs.com**

National Health Accounts (NHAs) typically disaggregate health expenditure by type of service. Analysis of how service users spend their money gives an excellent indication of the extent of private sector participation in any country. NHAs generally also include a description of providers, both public and private. Information about NHAs can be accessed via: **www.who.org** and **www.phrproject.com**

Policy briefs on private sector assessments conducted by the World Bank can be obtained via: **www.worldbank.org/html/extdr/topic-psd.htm**

Information on the laws and regulations which provide a framework for NGO participation in the health sector can be found in the World Bank NGO Handbook. This can be downloaded from: **www.icnl.org**

MEDLINE and POPLINE databases give access to a wealth of information on health and health sector issues. The databases can be used to conduct searches for information which will provide insights into the private sector. Both databases can be accessed via: **www.nlm.nih.gov**

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We look forward to receiving comments, suggested modifications and documented experiences. Our intention is to contribute to disseminating such lessons more widely so that others too can learn from you. Please direct your comments and contributions to the authors.

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