Consultation on the Private Health Sector in Africa

Summary of Proceedings
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Executive Summary

In September 1993, AID and some of its cooperating agencies held a consultative meeting to identify the key policy issues relating to the private health sector in Africa, in order to contribute to the strategic framework upon which the Health and Human Resources Analysis for Africa (HHRAA) project will base their research program.

The participants noted the inability of the public sector in Africa to provide complete coverage of health services, and reached the conclusion that while the private sector may be relied upon to fill these gaps, there are important demand and supply constraints which may prevent this and which need to be examined.

The following key policy themes emerged:

- How to increase the private sector contribution to the public health agenda;
- How to increase the effectiveness of public resources used to support and subsidize private providers;
- Where to substitute private for public provision, and where to reduce government provision of inappropriate services.

Describing the Private Sector

The participants discussed the need for a more complete description of what actually constitutes the private sector in health care provision. There was a general impression that the providers likely to be most important in providing basic health services to the poor are mission and NGO facilities, traditional healers, community-managed facilities, pharmacists and other medicine sellers, and not-for-profit modern physicians. Thus, any efforts to construct a typology of private health care providers which will be useful in shaping public policy towards the private sector should place particular importance on these providers, since they are more likely to form the focus of interventions. There was also concern that any efforts to categorize private providers runs the risk of excluding important sources of care:

for this reason, researchers must be wary of relying only upon researcher-defined categories and need to consider consumer perceptions of who are private providers.

While recognizing the need for more basic descriptive information about private health care providers, the group recognized that the complexity and richness of the private sector requires any typology of private providers to adopt intermediate, mixed categories not based purely on ownership or clinical orientation.

Key Issues Related to Private Health Care Providers

Having identified the most important private health care providers in terms of public health impact and utilization, the participants agreed that more study is needed to assess the quality and efficiency of privately-provided services, particularly those in the mission sector. The magnitude of public subsidies (both explicit and implicit) to the private sector also needs to be considered. Policy interventions regarding the private sector which should be assessed include the legalization of private practice, the impact of contracting out of clinical and non-clinical services, regulation of private providers and other policy experiments promoting a more important role for private provision. A more supportive approach to the private sector would also consider the information needs of private providers, ways to convey this information, as well as other aspects of the sustainability of private services. Finally, the group noted political sensitivity of many issues concerning the private sector and participants recognized the need to identify which issues are politically feasible and open to negotiation.

Key Issues Related to Consumer Demand for Private Care

While relatively more emphasis has been given to demand issues in studying the health sector in Africa, a number of key questions remain unanswered. Although there have been a number of household surveys which examine provider choice and household expenditures on health care, for most countries the magnitude of private health expenditures is unknown. The determinants of provider choice are also relatively ill-understood. More study is needed into the demo-

graphic, socioeconomic, and perceived quality dimensions of provider choice. Existing data which examines health-seeking behavior in a number of condition-specific circumstances (such as family planning services or diarrheal disease studies) provides a valuable starting point for such research. There is also much to be learned from the considerable experience of social marketing of family planning commodities, including condoms. The provision of consumer information to influence the demand for health care is relatively little-explored. Finally, there is need for longitudinal data with which the dynamic aspects of policy changes can be examined.

Current Research Efforts

Current research activities into the private sector were reviewed. These include work by the World Bank as part of the Better Health for Africa and LSMS activities, country studies supported by the public-private mix network of the London School of Hygiene and Tropical Medicine, work being carried out by Abt Associates under the Health Financing and Sustainability project, and the operations research program funded by the Bamako Initiative Management Unit of UNICEF. A number of issues are being examined through these research programs, but there is no program dealing explicitly and comprehensively with the range of policy-related questions raised in the meeting. Due to this, there was enthusiasm for the HHRAA program of activities. Someone suggested that the Africa Health Consultative Group, whose establishment was recommended at the Health Sector Reform Conference, would be an appropriate institu-

tion to help coordinate future research. Participants expressed particular concern that attention be given to enhancing research capacity in Africa.

Research Design and Dissemination

Participants' suggestions about the design of studies researching the private sector included making better use of existing data, paying particular attention to the design of innovative methodologies, and ensuring that research products would be policy-relevant. They also recommended better dissemination strategies to ensure that research results would be widely known, particularly amongst public health practitioners in Africa.

Summary of Proceedings

Background

On 22-23 September 1993, AID and some of its cooperating agencies held a one and one-half day workshop to discuss policy and research issues relating to the private health sector in Africa in order to contribute to the strategic framework upon which HHRAA will base their research program.

Purpose

The workshop brought together people with expertise in health research in Africa to:

- identify the key policy issues relating to the private health sector in Africa;
- identify the gaps in information required to inform policy on these issues;
- to make recommendations to guide the design of case studies in selected African countries that would help to fill information gaps and to inform a strategic research framework.

The workshop was organized around four sessions:

- to define the private health sector in Africa;
- to assess private health care provision;

- to identify points of private sector intervention in achieving public health goals;
- and to identify research priorities.

Workshop participants included representatives from AID, UNICEF, the World Bank, Harvard University, the Support for Analysis and Research in Africa (SARA) project, Johns Hopkins University, Abt Associates, the London School of Hygiene and Tropical Medicine, the University of Arizona, Brandeis University, the International Science and Technology Institute and ICI. While it was not possible to bring representatives from Africa-based centers to the meeting, African participants did attend from many of the institutions listed.

1. Key Policy Issues

Participants agreed that the public sector in Africa is unable to provide complete coverage of health services. Our ability to identify the precise role to be played by the private sector in providing basic health services, as well as the most appropriate policy mechanisms to promote this participation, however, is tempered by the existence of important constraints on both the demand and the supply side. The key policy themes identified through the course of the discussions fall broadly into the following three categories:

- **How to increase the private sector contribution to the public health agenda**. This involves identifying those providers that are most important (both in terms of services and coverage) in the public health agenda, and determining the interventions which can encourage and support their contribution.
- **How to increase the effectiveness of public resources used to support and subsidize private provision**. Included in this agenda would be reducing the subsidy to the private provision of services that are not cost-effective, or which do not reach the most vulnerable sections of the population.
- **Where to substitute private for public service provision**. This involves careful consideration of how government can reduce its role in inappropriate service areas. It will help to change the function of the public sector into one of an enabler of the provision of health services, rather than direct provider.

Most of the areas identified by the participants as key issues for research fall into the above categories.

2. Information Gaps and Research Issues

Having agreed upon the above issues as priority areas for public policy, it was clear to the meeting that much of the basic information about the private sector required to address these policy areas is not presently available. Although many of the issues which were raised as areas in which information is needed are cross-cutting, this section is organized around the following themes: basic descriptive questions, supply-side issues, demand issues, and other research questions.

a. What Constitutes the Private Sector?

While recognizing that there is an important role for the private sector in health care provision in Africa, participants agreed that our current knowledge about private health providers is limited. Discussions during the first session revolved around the need for a typology of private providers. The construction of such a typology, which will necessarily vary by country, needs to strike a balance between strategic needs - that is, responding to important policy questions and focusing on those providers likely to be of strategic importance from an intervention perspective - and the collection of basic descriptive information about all parts of the private sector, much of which is not currently available. There is also a need to distinguish between those parts of the private sector which are direct providers of health services, and those which play a role in the production of intermediate services, such as diagnostic and ancillary services. The former should focus on those providers which are of actual or potential importance in the provision of services which form the basis of the public health agenda, whilst the latter are of significance because of their present or potential contribution to the reallocation and increased efficiency of public expenditures. There was concern that descriptions of the private sector, while necessary, not be a purely "academic" exercise.

There was a general impression that the providers most likely to be important in providing basic health services to the poor are not formal, for-profit physicians and hospitals providing modern care, who are mainly urban-based providers of curative services. Rather, research should focus on the key providers in a strategic sense - that is, those elements of private provision likely to be more influential in providing basic health services to the poor. These providers are believed to include the following groups:

- mission and non-governmental organization (NGO) facilities
- traditional healers
- community-managed facilities
- pharmacists and other medicine sellers

A starting point for any typology of private providers should include the following information:

- Who are the private providers: what types of providers are included?
- How many are there, and what is their geographic distribution?
- What services do they provide?
- What are the qualifications of their personnel?
- Who is their clientele (by demographic and socioeconomic group)?

Based on participants' knowledge and experience in African countries, discussions about the construction of such a typology demonstrated the complexity and nuanced distinctions of the private sector in Africa.

The Meeting Explicitly Addressed the Following Topics:

Parastatal Sector

There is a need to include services provided in the parastatal sector such as government-owned companies. Some of these may be directly provided, while some parastatals contract out clinical services to private providers.

Differences By Type of Service

The importance of the private sector is likely to differ by service. In Nigeria, for example, it is believed that up to 80% of family planning services are provided by NGOs, and that 60% of immunization services are provided privately.

Official Versus Real Activities

There is also a need to distinguish between officially recognized and real activities. Pharmacists may diagnose and prescribe, providing functions beyond the conventional ones. The informal sector may provide injections and other "modern" health services. The official/real distinction is clearly seen in the example of Tanzania, where until the recent legalization of private practice, private for-profit practitioners existed extra-legally, providing services under the umbrella of NGOs.

Public-Private Overlap

The private and public sectors may overlap significantly: public providers may see patients privately, either officially or unofficially. These consultations may take place within public institutions, during working hours or afterwards, or outside at health workers' homes or private offices. The different nature of a private transaction may have important implications for practice patterns and the quality of care. It was noted that while working publicly, a physician may prescribe ORS, while the same individual working privately may prescribe antibiotics for the treatment of diarrhea.

Plurality of Clinical Orientation

Our conception of clinical orientation may not match the reality of service provision in the private sector. Although the endpoints of the continuum are traditional and modern care, the practices of individual providers may span a number of healing systems, combining both modern and traditional or herbal medicine.

Community-Based Facilities

Hybrid organizations, such as community-managed facilities, do not fall easily into the public-private distinction: although health workers may be paid by the government, community involvement in the man-

agement of facilities makes the traditional distinction on the basis of ownership not very revealing.

Intermediate Services

Finally, even within public institutions, private firms may be involved in non-clinical intermediate services such as management and fee collection, cleaning, food services and laundry. This involvement by the private sector needs to be considered also, although it is more relevant for examining questions of increasing the efficiency of public expenditure.

Together these factors mean that there is considerable richness needed in the construction of a typology of private providers which can help to inform public policy. The adoption of intermediate, mixed categories may be needed rather than focusing on a dichotomous notion of public and private based upon ownership alone.

b. Key Issues Related to Private Health Care Providers

The questions underlying discussions about supply-side issues largely involved the information needed to address the policy issues outlined in the first section. It was noted that existing research has largely focused on the demand side, and that much of the information needed to address supply issues is unknown. Even those areas which have been relatively well-studied in Africa, such as the impact of user fees and other resource mobilization mechanisms, have not adequately addressed the impact on quality of services and efficiency.

Which are the Key Actors?

Clearly, as identified in previous sections, there is a need to identify which public health interventions are provided by which parts of the private sector. This assessment must include the magnitude of the existing contribution to utilization, as well as considerations of the extent to which there is excess capacity in the private sector, and what incentives can be used to encourage new entrants into the market.

Quality and Efficiency in the Private Sector

Although there is scattered evidence about the quality and efficiency of services provided privately, particularly those provided by the mission sector, more study is needed to assess this systematically. This information should be used to identify a) those areas where private providers are more efficient and should be encouraged to substitute for public provision; and b) lessons which can be adopted by the public sector in terms of management structures and incentives to improve the efficiency of public provision where private providers are unwilling to substitute in the provision of these services. This should include an assessment of the constraints to adoption of innovative management and incentive structures in the public sector.

Public Subsidies to the Private Sector

Little systematic study has been made of the magnitude of the explicit and implicit public subsidy to the private sector. Participants noted that there may be significant efficiency gains from getting public money out of the private sector where the services provided are either not cost-effective, or are serving primarily elites. One example of this was the magnitude of expenditures on emergency evacuations, but there was a feeling that the explicit and implicit subsidy to inappropriate services may be substantial.

Legalization of Private Practice

A number of countries have recently legalized private practice (Malawi and Tanzania, for example). The implications of this for service quality, cost, equity and efficiency should be studied. This an area where a "natural experiment" has occurred and the dynamic impact of policy change can be studied.

Contracting Out

The contracting out of clinical and non-clinical services is an area which has received attention recently as a way to encourage more efficient use of public resources. In Nigeria, for example, parastatals have experimented with the contracting out of clinical services. In Zimbabwe, private firms have been hired to improve the efficiency of fee-collection and billing in public hospitals. The Namibian government hospitals contract out both patient meals and laundry services. A key issue in this area is the capacity of governments to design and monitor effective contracts.

Private Provider Associations

Little is known about private sector organizations. Many countries have associations of traditional healers, but it is not known what proportion of providers belong to such institutions. Which private groups and organizations exist at the national and local level, and what are their roles and functions? How do they interact with the public sector?

Public-Private Interactions

More broadly, the nature of public-private interactions is not well understood. This includes the provision of subsidies to the private sector, as discussed above, but also extends more broadly to include both official and unofficial interactions. To what extent do public sector providers also provide services privately, and does legalization of part-time, private practice enable governments to make the best use of physicians? In many countries non-governmental organizations play an important coordination role. For example, in Rwanda, pharmaceutical imports are coordinated by a not-for-profit NGO. Zaire also has had interesting experiences with NGO coordination of health services. In other countries there have been direct efforts to encourage public-private collaboration, for example, by having joint training or supervision activities. Haiti was one example cited of successful collaboration between private and public providers in training activities.

The nature of market interactions between the public and private sectors is also not well understood. It was suggested that public provision might have an important role to play in generating competition, particularly in urban areas where private providers may monopolize service provision.

Regulation

Regulation is a key area where the public sector interacts with the private sector. Participants noted that the regulatory function in Africa has been seen as a means of controlling rather than enabling private provision. Although most countries have regulations controlling the quality of services, the extent to which these are effectively enforced is mixed. Rwanda is one of the few countries to have experience with price controls. The official fee schedule for private providers is published in the government gazette, and providers are obliged

to post the fee schedule on the door. In addition, there have been efforts to establish maximum mark-up levels for pharmaceuticals. This has been less successful because of difficulties in monitoring, as well as the shortage of pharmacy inspectors. In Nigeria, the licensing of patent medicine sellers has been decentralized from state to local government area level in an effort to make monitoring more effective. Little is known about the cost of regulation and monitoring the activities of private providers, and there are concerns that existing public structures do not have the capacity for effective regulation.

Policy Interventions

Although experience with policy interventions to support private provision is limited, a number of countries have adopted innovative mechanisms to encourage private providers. In a number of countries, governments with limited capacity to absorb medical graduates into public service have established loan programs to private physicians who locate outside of urban areas (Madagascar, Mali). In Benin, unused infrastructure has been transferred to groups of physicians who are under contract to the community. Government facilities have been sold to private providers in Morocco. In Egypt, the Ministry of Health encourages physicians to establish health maintenance organizations (HMOs).

There was some concern that subsidies to the private sector to promote the provision of public health services could result in "phantom services" if not carefully monitored. In Ghana, however, there has been experimentation with in-kind subsidies, through the provision of vaccines to private physicians.

Private Sector Information Needs

More attention needs to be paid to the information needs of the private sector: What information do private providers require to support public health goals?

Participants raised the issue of sustainability of the private sector. Almost nothing is known, for example, about the number of private sector bankruptcies.

Training

Another area noted by participants was training: questions remain as to how to better design, deliver and evaluate health care training programs for public and private health care providers.

Technology

What role can be played by locally-produced, appropriate technology in improving health care services?

Importance of Political Factors

Finally, participants also reminded each other about the political environment in which discussions about increasing the role of the private sector occur. "Privatization" through transfer of ownership of

Service Availability	***Public Services Only***	***Both Public and Private Services***	***Private Services Only***
Service Use			
Use public services only			
Use both services			
Use private services only			

facilities has been a particularly sensitive issue in many countries. Care is needed in identifying those issues which are open for negotiation and those which are politically unfeasible. For example, it was suggested that much of the potential efficiency gain from privatization can be gained at a much lower political cost from instituting managerial autonomy rather than actually selling public facilities.

c. Key Issues Related to Consumer Demand for Private Care

While relatively more emphasis has been given to demand side issues in studying the health sector in Africa, many questions remain unanswered. The following section outlines some of the key areas identified by participants as needing additional research.

Private Health Expenditures

First, although there have been a number of household surveys which examine provider choice and household health expenditures, for most countries the magnitude of private health expenditures is unknown. Furthermore, the distribution of expenditures amongst socioeconomic groups and the composition of services purchased has received relatively little attention. Without this information it becomes very difficult to estimate the importance of private providers in household health-seeking behavior. As discussed in the next section, considerable amounts of information can be collated from existing sources, for example, from the disease-specific studies of health-seeking behavior which have been undertaken in many countries. Participants felt that a lot of past studies could be found in different ministries, NGOs and donor agencies. Information could also be found from commercial medical and pharmaceutical firms, and marketing and advertising agencies.

Determinants of Provider Choice

Second, we know remarkably little about the determinants of provider choice: which services do people seek from which providers and for what reasons? Although demographic and socioeconomic characteristics, perceived quality, accessibility, and illness type are believed to play an important role in determining provider choice, the relative importance of these factors has been little studied. The extent to which preferences are shaped is also influenced by the availability of alternative providers, and this factor needs to be taken into account when studying provider choice. As in the previous discussion about supply-side factors, this information would play two roles: it would help to identify the lessons that the public sector can learn from the private sector, as well as help to shape interventions intended to increase the use of privately provided services.

Again, existing studies may not yet have been fully exploited. One example of such information is DHS surveys. A recent review of DHS provider choice data revealed some of the important covariates of private provider choice for family planning services. Women most likely to use private family planning services tend to be better educated, urban and employed. Unfortunately, the DHS questionnaires do not collect information about incomes or expenditures, so we do not know how provider choice is affected by income group. Other program/disease-specific studies may help us to better understand the impact of age and gender on provider choice.

Perceived Quality

The role of perceived quality was generally believed to be particularly important. Facility-based studies in Cameroon and Rwanda have found much higher levels of client satisfaction with mission services than with government ones. This was found to be largely attributable to differences in private provider sensitivity and responsiveness to consumer preferences. Participants expressed some concern, however, that this focus by private providers on perceived quality may be at the expense of technical quality. They noted emphasis on injections rather than tablets and use of expired drugs in some mission facilities.

Most studies which look at the role of quality in determining willingness to pay for health services tend to measure quality in quite "blunt" ways, such as drug availability. There is a need for more study of the determinants of quality perceptions, using anthropological and other qualitative research techniques.

The relationship of health services with other community institutions, such as markets, that attract users from outside the immediate catchment area needs to be considered in analyzing the "packaging" of health service delivery mechanisms.

Learning from the Mission Sector

There may be much to be learned from mission services about the roles of on-site, personal supervision, managerial authority, incentives and commitment in improving perceived quality. As noted previously, study of these factors needs to be accompanied by consideration of the constraints to adopting these mechanisms in the public sector.

Lessons about consumer satisfaction can also be learned from traditional practitioners. Urban traditional healer practices were suggested as a rich area for possible study.

Social Marketing Programs

There is much to be learned about the factors shaping demand for health services from experience with social marketing programs for family planning commodities and condoms in the context of sexually transmitted disease (STD) control programs. More recently in Cameroon, efforts have been made in social marketing of STD treatment kits.

Consumer Information

Another demand-side intervention which has received little attention is the provision of consumer information to increase the demand for public health services. Consumer education programs have traditionally received low government priority. Effectiveness of health education programs appears to be mixed, and the extent to which they create lasting changes in behavior is uncertain. Study of the conditions underlying the success of community-based and mass communication strategies is needed.

Longitudinal Studies

Finally, there is a need for more in the way of longitudinal studies of health-seeking behavior which will help to better understand the dynamic aspects of the demand for health care. The group emphasized the need for caution about balancing short-term operational requirements with longer-term strategic information.

Integrating Demand and Supply

The following matrix was suggested as one approach to integrating supply and demand side factors into an analysis of the market for health care:

3. Current Research Efforts

Participants reviewed current research activities into the private sector. These include work by the World Bank as part of the Better Health for Africa and LSMS activities, country studies supported by the public-private mix network of the London School of Hygiene and Tropical Medicine, work being carried out by Abt Associates under the Health Financing and Sustainability project, and the operations research program funded by the Bamako Initiative Management Unit of UNICEF. A number of issues are being examined, but there is no research program dealing explicitly and comprehensively with the range of policy-related questions raised in the meeting. Because of this, there was enthusiasm for the HHRAA program of activities. Participants suggested that the Africa Health Consultative Group, whose establishment was recommended at the Health Sector Reform Conference, would be an appropriate institution to help coordinate future research.

Participants expressed particular concern that attention should be given to enhancing research capacity in Africa. Ministries of Health generally place low priority on research, and have limited capacity for study design and implementation. Participants discussed the role to be played by donors in building research capacity, but reached no clear conclusions.

Participants recognized the need to balance long-term strategic research needs with short-term programmatic ones. Similarly, the need for synthesis of existing knowledge, including extending this information to other environments, needs to be offset against the need to address new issues in health service delivery.

4. Recommendations for HHRAA-Sponsored Research on the Private Sector

The group agreed upon a number of principles for the design and conduct of the case studies currently being funded by HHRAA:

Bring Together Existing Data

To the extent possible, the case studies should bring together existing data before undertaking new data collection activities. This includes locating studies which have already been completed, finding new uses for studies designed for other purposes, and making better use of the output of routine health information systems.

Develop Research Methodologies

Natural experiments, local level demand studies, and case studies of existing community-level projects are all possible approaches to research design. There is need for more in the way of longitudinal studies to enable a deeper understanding of the dynamic effects of policy change and interventions.

The difficulty of studying the informal sector was raised: providers may be reluctant to provide information which may lead to greater government control over their activities. This also applies to the private sector more generally.

Quantitative studies must be combined with qualitative data collection techniques. The use of focus groups and other qualitative methods to study determinants of perceived quality was recommended.

In addition, the research strategy should aim to arrive at an analysis of how different approaches and methods work, and the circumstances underlying success: the research should aim to provide some guidance on what mix of qualitative and quantitative methods is most appropriate for answering different types of questions.

Basic Descriptive Information

Although there was considerable debate on this point, the overall feeling of the meeting was that there is a need for more collection of basic descriptive information, particularly that which refers to providers of key strategic importance. Such information can feed into field studies and form the basis for analytic research examining the design and impact of policy interventions.

Be Action Oriented

Research should be applied to specific operational problems relating to quality, equity, efficiency and accessibility of public and private services.

Be Prescriptive

Research activities should produce recommendations on how to link existing and proposed data to policy issues and decision alternatives.

Follow-up Activities

Case studies should include recommendations regarding the timing and sequence of follow-up data collection and analysis.

5. Dissemination

All agreed that strengthening the processes of dissemination of research results was essential, particularly within Africa. While a large number of studies had been carried out in Africa and were mentioned in the meeting, only a few individuals knew about most of them. Suggestions for effective dissemination strategies included the following:

Plan

There is a need to plan for dissemination.

Confidentiality

Ease the restrictions on data access and flow.

Length

Reduce the length of documents: policy makers only want one page.

Clarity

Reduce the technical complexity of data presentations.

Multi-media

Disseminate data in different forms - conferences, workshops, pamphlets, videos to supplement written reports. Use existing fora in Africa for multi-media presentations.

Prescriptive

Report for impact: research products should recommend to policy makers what action should be taken on the basis of findings.

Pre-testing

Research products should be pre-tested on others before wide dissemination takes place, for example, health sector officers of other agencies.

Audiences

Dissemination strategies should include practitioners, and not be restricted to senior managers. Multiple audience strategies should be developed to reach technical officers and mid-level managers in government structures in which there is high turnover amongst top decision-makers.

Communicators

Better training should be provided to health communicators to support in-country dissemination.

Database

A database on all policy-relevant research and experiences in the area should be compiled and disseminated.

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