# Public Stewardship of Private Providers in Mixed Health Systems

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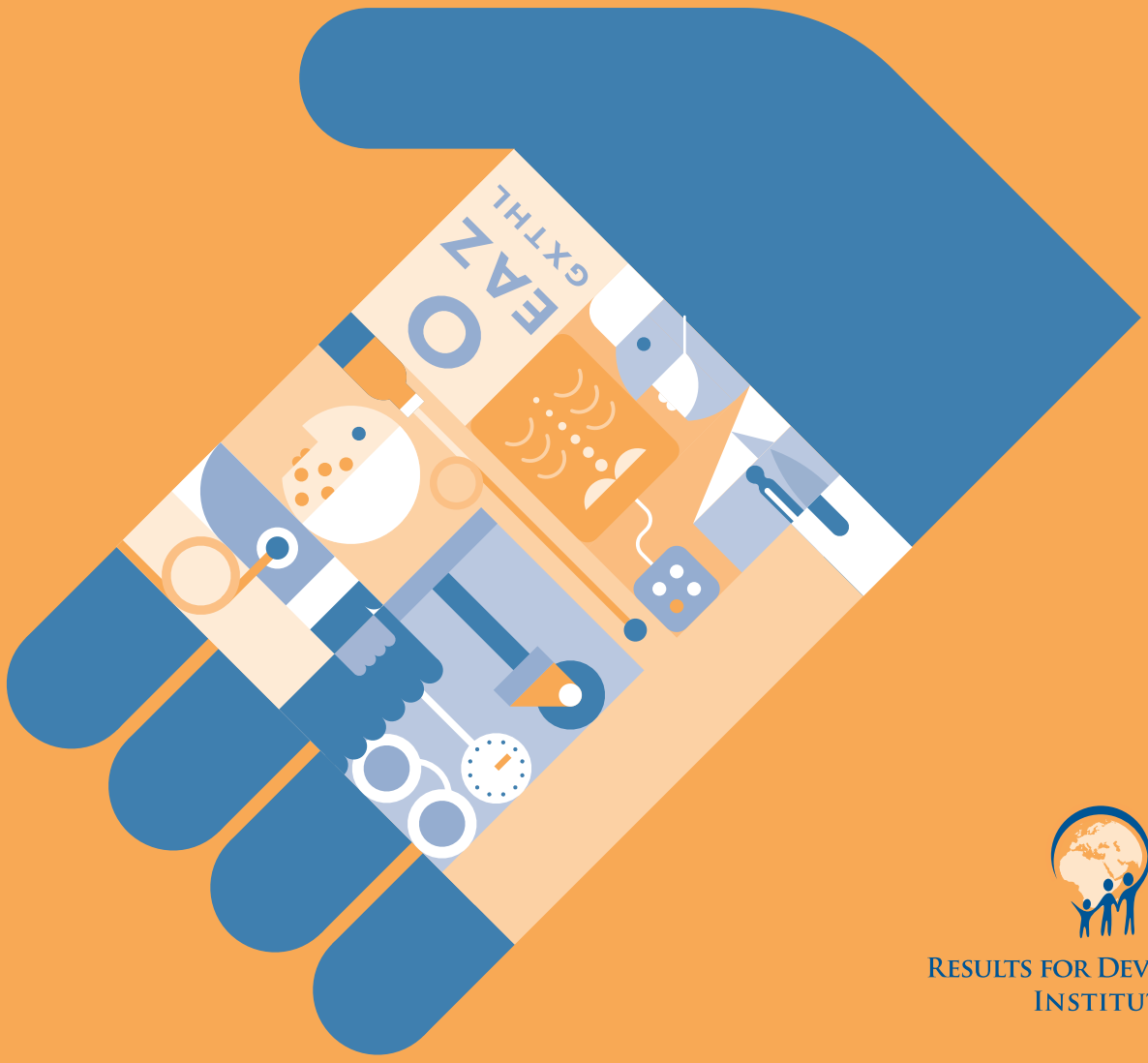
Synthesis Report from the Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries



Results for Development Institute

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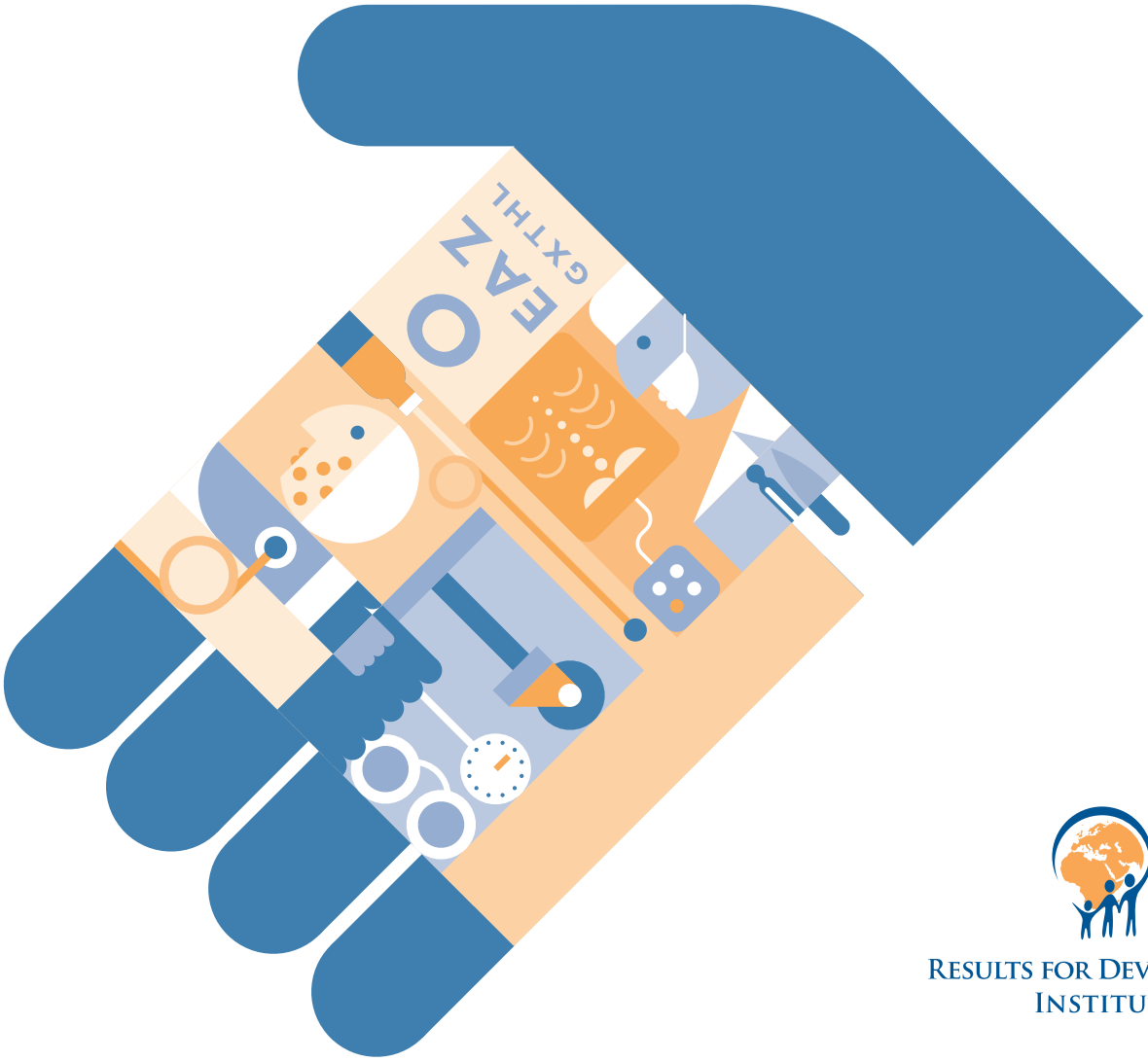

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# Foreword

This report summarizes the findings from research commissioned in 2008 by the Rockefeller Foundation, in collaboration with the Results for Development Institute and the Thai Ministry of Public Health's International Health Policy Program. This research—resulting in 14 papers by various institutions, examining the role of the private sector in health systems in developing countries—draws on multiple data sources, including, a global survey of countries' regulatory models, a scan of innovative private sector financing and delivery models, a survey of attitudes toward the private health sector, and evidence on where people receive health services. The Foundation sponsored this work as part of broader repositioning of its health strategy to address the emerging challenges of the 21st century. The repositioning led, in late 2008, to adoption of a new Foundation initiative on Transforming Health Systems to achieve high-quality, accessible, and affordable health coverage for all.

One key theme emerging from this analysis is the importance of public stewardship of the nonstate sector (that is, the private sector, broadly defined). Effective government stewardship is crucial for achieving broader health objectives, given the reality that many countries already have large, complex markets for healthcare, presenting major challenges and significant opportunities.

A second key theme is that many governments are not performing that stewardship role particularly well at present. Policy dialogue and decisionmaking—within government and with donors—are often not well informed about the huge scale and diversity of health services that exist beyond government-run facilities. Those in the public sector who should be overseeing the entire health system—state and nonstate—are not monitoring what is happening in the nonstate sector and have imperfect understanding of the forces at work in the health system in its entirety. Nor is there adequate appreciation of the fact that private out-of-pocket payments by households account for a large proportion of total health spending.

Compounding these problems are severe limitations in the data available on the nonstate sector. Basic information on what kinds of services the private sector provides, to whom, and with what results is not readily at hand for policymakers.

Discussions under way in the global health community could lead to new steps to help bring together interested parties to develop faster progress in health system strengthening and public sector stewardship. If these discussions lead to concrete further steps, this report's contents could be useful in suggesting promising lines of thought and action.

David de Ferranti, Results for Development Institute
Ariel Pablos-Mendez, Rockefeller Foundation
Suwit Wilbulproprasert, Thai Ministry of Public Health

# Technical partner papers

Much has been said and written about the role of the private sector in health, but many core questions—and the evidence to resolve them—have remained elusive. In 2008 the Rockefeller Foundation invited proposals for a review and landscaping of key topics related to the role of the private sector in health systems. The 14 resulting papers, undertaken by different institutions and consortia, produced a wealth of information, such as:

- Analysis of Demographic and Health Survey data on where people seek care for various health issues.
- A global scan and survey of countries about their regulatory models.
- A scan of private sector health delivery and financing models that some have characterized as "innovative."
- A web-based survey and in-depth interviews of attitudes toward the private health sector.
- Analysis of how purchasing and contracting models can support health systems goals.
- New thinking on stewardship and how to make health markets work better for the poor.
- Macroeconomic analysis of national public and private health spending.
- An analysis of the potential of the private sector to enhance health product supply chains.

The following list describes these papers, available separately on CD-ROM or at http://resultsfordevelopment.org. This body of work has informed the thinking that underlies this synthesis report. As always in these efforts, the views of each author do not necessarily reflect the views of all authors, the Rockefeller Foundation, or the Results for Development Institute.

## New data on the private health sector

1. **Limwattananon, Supon. 2008. "Private-public mix in woman and child health in low-income countries: an analysis of demographic and health surveys." International Health Policy Program, Thailand.**

   The paper presents a comparative analysis of the two most recent waves of Demographic and Health Survey data, with a focus on private provision of care to women in reproductive ages and children. Overall findings reveal a wide variation in the role of informal private, formal private, and public sector actors.

2. **Hozumi, Dai, Laura Frost, Chutima Suraratdecha, Beth Anne Pratt, Yuksel Sezgin, Laura Reichenbach, and Michael Reich. 2008. "The role of the private sector in health: a landscape analysis of global players' attitudes toward the private sector in health systems and policy levers that influence these attitudes." PATH and researchers from the Harvard School of Public Health.**

   Employing qualitative and quantitative research methodologies, the report assesses the attitudes of global and national stakeholders toward the private health sector in developing countries.

3. **van der Gaag, Jacques, and Vid Štimac. 2008. "Toward a new paradigm for health sector development." The Brookings Institution and Amsterdam Institute for International Development.**

   The paper seeks to explain the very large differences in per capita spending on healthcare across countries and determines that almost all (more than 90%) of these differences can be explained by variation in per capita income (gross national product). It looks at potential mechanisms to increase healthcare spending to above the level predicted by per capita income and investigates whether a larger public share of overall spending "buys" better health outcomes.

## Innovative service delivery

4. **Bloom, Gerald, Claire Champion, Henry Lucas, David Peters, and Hilary Standing. 2008. "Making health markets work for the poor: improving provider performance." Institute of Development Studies and Future Health Systems Consortium.**

   The paper develops a framework for designing and implementing healthcare delivery innovations aimed at making markets work better for poor people. Focusing on the social contract between providers and users, it reviews several arrangements that have emerged, with a particular focus on the providers largely used by the poor.

5. **Bhattacharyya, Onil, Anita McGahan, David Dunne, Peter A. Singer, and Abdallah Daar. 2008. "Innovative health service delivery models for low and middle income countries." University of Toronto.**

   The report reviewed the literature on a number of innovative service delivery models, isolating business processes that could be applied more broadly, including marketing strategies (communications, customer orientation, franchising), financing strategies (reduced operating costs, high volume/low cost, cross-subsidization, capital funding, revenue generation), and operating strategies (human resource management, knowledge-development, telemedicine). The authors find that successful organizations tend to innovate across several of these business processes.

## Pooled financing

6. **Lagomarsino, Gina, and Sapna Singh Kundra. 2008. "Overcoming the challenges of scaling voluntary risk pools in low-income settings." Results for Development Institute.**

   The report discusses the challenges of introducing and scaling smaller, voluntary risk-pooling programs in an attempt to constructively consider how to overcome these challenges. It presents six major hurdles that risk-pooling programs are faced with and highlights various mechanisms that program implementers are currently experimenting with to overcome them. It concludes with lessons from successful cases of small programs being scaled up to the national level.

7. **Mallipeddi, Ravi, Hanna Pernefeldt, and Sofi Bergkvist. 2008. "Andhra Pradesh health sector reform—a narrative case study." ACCESS Health Initiative, Haseltine Foundation for Medical Sciences and Arts.**

   The State of Andhra Pradesh in India has recently taken several innovative approaches to improve access to healthcare. This report presents the major initiatives, including health

insurance and contracting arrangements for health services, and describes underlying motives, challenges, and opportunities associated with the reform.

## Government and self-regulation

8. **Tangcharoensathien, V., S. Limwattananon, W. Patcharanarumol, C. Vasavid, P. Prakongsai, and S. Pongutta. 2008. "Regulation of health service delivery in private sector: challenges and opportunities." International Health Policy Program, Thailand.**

   The paper examines the literature on governments' capacity to regulate health providers. It identifies key constraints to government ability to implement regulatory policy, including corruption, administrative constraints, and informational constraints.

9. **Balabanova, Dina, Valeria Oliveira-Cruz, and Kara Hanson. 2008. "Health sector governance and implications for the private sector." London School of Hygiene and Tropical Medicine.**

   The paper develops an analytical framework—applied to India, Uganda, and Afghanistan—for conceptualizing the governance/stewardship function within health systems and the role of government in the context of an expanded role for private service provision and financing. The paper begins by reviewing the approaches to conceptualizing and operationalizing stewardship, drawing on recent literature, and then explores typologies of governance, with a focus on working models of engagement and collaboration between major public and private sector actors in achieving public health goals.

## Purchasing and contracting

10. **Eichler, Rena, and Ruth Levine, with contributions from Paul Gertler and Kristiana Raube. 2008. "Performance incentives in provider purchasing and contracting arrangements: rationale and experiences." Center for Global Development and the University of California, Berkeley.**

    The paper describes performance-based incentive contracting schemes that have been implemented to improve results for a range of interventions from time-limited immunizations to chronic conditions that require significant lifestyle changes, such as diabetes. It finds that limited interventions with results or actions that can be measured and that require minimal changes in lifestyle seem to be well suited for performance-based incentives. It argues that performance incentives are a viable and potentially more powerful solution than typical input-oriented approaches to dealing with underutilization, poor quality, and low efficiency.

11. **England, R., and the HLSP Institute. 2008. "Provider purchasing and contracting mechanisms." HLSP Institute.**

    The paper reviews various purchasing models and the advantages each offers for purchasing from the private sector. It then identifies the key challenges to successful implementation of these models, and discusses improvements needed in the contracting mechanism itself. It determines that the purchasing mechanism can create new incentives for providers, payers, and consumers on a national scale, but it may require that changes be made in the health sector as a whole for new programs to be successful.

12. **Mudenda, Dale, Christopher Mapoma, Bona Chita, Abson Chompolola, and Webby Wake. 2008. "Provider purchasing and contracting for health services: the case of Zambia." University of Zambia.**

    The study identifies and characterizes a number of contracting models that exist in the Zambian health sector and their impact on access to health. It reveals that the contracting mechanism is prevalent in Zambia, as evidenced by several contracting-in examples (such as different levels of the referral system within the public health sector contracting each other for services) and contracting out arrangements (such as FBOs and NGOs providing care on behalf of the government). It finds that the impact of these programs on the quality of services has remained mixed.

## Innovative supply chain

13. **Dalberg Global Development Advisors and the MIT-Zaragoza International Logistics Program. 2008. "Private sector role in health supply chains: review of the role and potential for private sector engagement in developing country health supply chains." MIT-Zaragoza and Dalberg.**

    The report sets a baseline understanding of healthcare supply chains and characterizes the current private sector role in supply chains in lower middle income countries. It is informed by in-depth case studies of Ghana and Zambia, as well as interviews of over 40 supply chain and health experts in 12 countries about private sector initiatives in those countries. The major findings characterize supply chains, analyze the potential to invest in private sector initiatives, and make recommendations for key stakeholders.

## Case studies of innovative financing and delivery models

In addition to the technical partner papers, a companion report presents descriptions of 33 innovative models. This is available in print, on CD-ROM, or at http://www.resultsfordevelopment.org.

14. **Dimovska, Donika, Stephanie Sealy, Sofi Bergkvist, and Hanna Pernefeldt. 2008. *Innovative Pro-Poor Healthcare Financing and Delivery Models. Examples from Mixed Health Systems.* Results for Development Institute.**

    The report describes 33 innovative pro-poor healthcare financing and delivery programs in South Asia and Sub-Saharan Africa that are led by or engage the private heath sector. The programs were selected based on their relevance to broader health systems and potential to achieve positive impact for poor people. While these programs range from donor-driven initiatives to large-scale government-subsidized efforts to for-profit businesses, they all involve the private health sector. These programs complement key elements of countries' healthcare financing and delivery platforms, and national governments, donors, and development agencies may consider these or similar programs as stepping stones toward longer term health system reform.

# Acknowledgments

We thank the many individuals who contributed to this synthesis report and to the broader body of work commissioned in 2008 by the Rockefeller Foundation on the topic of the private health sector.

The Working Group on the Role of the Private Sector in Health Systems, convened by the Rockefeller Foundation, provided invaluable advice and insights through its three meetings and many side discussions. The Group is chaired by David de Ferranti (Results for Development Institute) and Suwit Wilbulproprasert (Thai Ministry of Public Health). The Group's members include Eduardo Aninat (ISAPRES, Chile), Kathy Cahill (Bill & Melinda Gates Foundation), E. A. Elebute (Hygeia, Nigeria), Carissa Etienne (World Health Organization), Anne Mills (London School of Hygiene and Tropical Medicine), Sania Nishtar (Heartfile, Pakistan), Ariel Pablos-Mendez (Rockefeller Foundation), Sangita Reddy (Apollo Group, India), Julian Schweizter (World Bank), Marie-Odile Waty (French Development Agency), and Miriam Were (AMREF).

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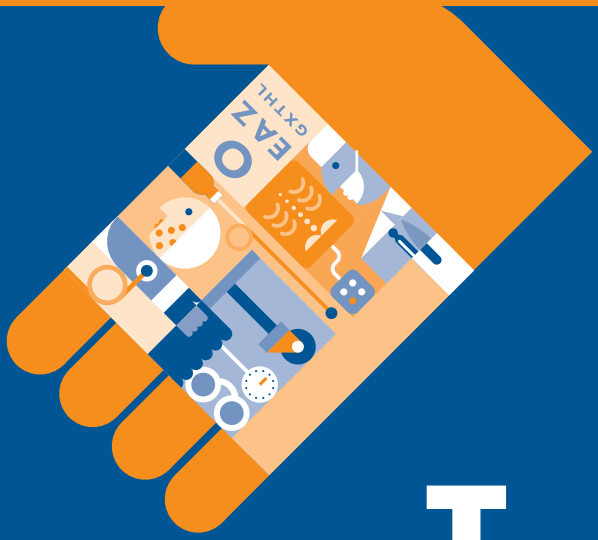
# Executive summary



This report is about the role of the private sector in mixed health systems. Mixed health systems have centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services, which often existed long before the creation of national health ministries and have grown organically.[1] In such mixed systems the private sector encompasses a vast diversity of providers and other actors apart from those owned or operated by government entities, and thus includes everything from NGO health clinics to local pharmacy shops to traditional healers to high-end for-profit hospitals and to a plethora of other types between the extremes. Some observers refer to all this as "the nonstate sector."[2]

Drawing extensively on the findings of a 2008 review sponsored by the Rockefeller Foundation (resulting in 14 papers) and on the vast other literature on the private health sector and health systems, the report emphasizes the importance of effective stewardship by governments of their country's health system, especially given the reality that the private (nonstate) part of the system is large and complex, with major challenges and significant opportunities.

The literature on the private sector in health is voluminous and not devoid of controversy. Some authors have sought to document the existence, size, and scope of the private health sector.[3] Some have described discrete interventions that can harness the private sector, such as contracting, franchising, social marketing, and insurance.[4] And some have written about how the private sector can (or should not) deliver particular interventions, including bednets, tuberculosis treatment, antiretrovirals, and family planning services.[5]

Many have considered the appropriate roles of the public and private sectors, but the debate on this has not been settled.[6] In late 2007 an International Finance Corporation report, *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*, confirmed the size and composition of the private health sector in Africa and recommended how to better harness it.[7] In February 2009 an Oxfam International report, *Blind Optimism*, was critical of private mechanisms, calling for a focus on government provision of services for the poor.[8] Several journals have recently published debates on this topic among various prominent global health researchers and development organizations.[9]

Keeping in mind all that has come before, as well as the salience of this debate, the target audience for this report is primarily policymakers and practitioners—in countries and among their development partners—who may not be familiar with all the literature and may not have been engaged in the health sector for extended periods.

The report pays particular attention to how governments can improve their stewardship of the nonstate components of the health systems they oversee. The report is not about how the private sector can enhance delivery of a specific intervention or a single national priority health program. Nor is it about whether an ideal health system would be predominantly public or predominately private. Instead, it recognizes the reality that many countries already have large private markets for healthcare (as demonstrated by their large numbers of private providers and by the high degree of out-of-pocket spending as a percentage of total health expenditure). It also recognizes that these large private healthcare markets are unlikely to go away in the short term. So, it concentrates on the barriers to stewardship of the private sector and on the options for reform. The aim is to be practical and evidence based, not to advocate for a larger or smaller private sector in any setting but to argue that existing institutional arrangements can be improved to achieve health system goals through stepwise reform to enhance the public sector's stewardship of the private sector.

The goals that health system stewards pursue are obviously important in all this. The World Health Organization, in its *World Health Report 2000,* defines the desired goals of health systems as the improvement of health status, financial protection, and responsiveness to the expectations of the population.[10] The key intermediate goals include access, quality, efficiency, and equity.[11] This report accepts the WHO definitions.

## Large and complex private markets for healthcare

The private sector is large and complex in many developing countries. The public-private mix greatly varies by country, and data to accurately quantify this mix are scarce. But in at least 19 countries in Asia and 15 countries in Africa—including many of the world's most populous nations (Bangladesh, China, India, Nigeria, and Pakistan)—more than half of total health expenditures are private out-of-pocket transactions. And private providers outnumber public providers in many places. For example, in Madhya Pradesh, India (67 million people), approximately 75% of all providers operate in the private sector. Private markets this large are unlikely to go away any time soon.

The structure of health markets is complex, with the lines between public and private often

unclear, making strict public-private distinctions difficult and overly simplistic. Large and complex health markets come with advantages and disadvantages. They are associated with poor financial protection and uneven quality—especially given the limitations of developing country capacity to regulate these markets. The private sector may fill some of the gaps in public sector delivery, while offering greater convenience and accessibility. But without the proper incentives for quality, equity, and affordability, and without adequate monitoring, health markets can produce poor outcomes.

Health markets also face the challenge of equitable distribution of care. Health markets favor wealthier segments of the population. When the wealthier have more access to preventive and curative care, the health needs among income segments begin to vary considerably. Without a mechanism to intervene and control health markets, this distribution of wealth and disease perpetuates the inequitable delivery and financing of care.

## Policies for better stewardship of mixed health systems

Most high income countries, and a growing number of middle income countries, have policy mechanisms to steward both public and private actors. They have private markets for healthcare, but they have avoided many of the potential negative outcomes because their governments engage in stewardship of the whole health system, including the part not under direct government control. These stewardship policies for mixed health systems attempt, with some success, to harness the private market to achieve key health system outcomes, while recognizing the need for strong state interventions in the market.

Stewardship mechanisms for mixed health systems include:

- Regulatory policies that monitor quality effectively and mitigate the worst health market failures.
- Financing policies that minimize out-of-pocket payments and increase access by pooling risks across populations with subsidies for the poor.
- Purchasing policies that create incentives for quality and for delivering high impact interventions and services to the poor.

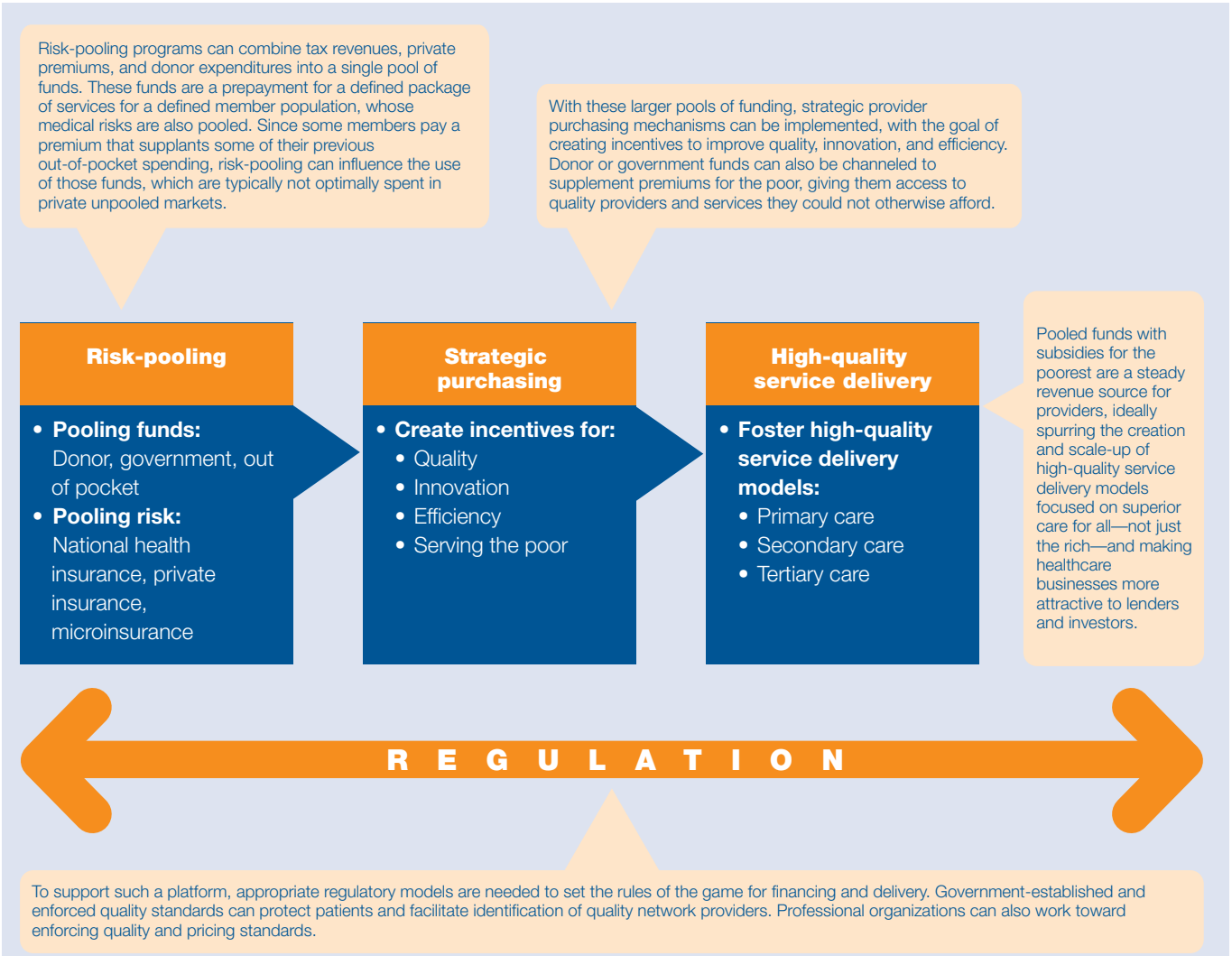
Mixed health system stewardship mechanisms—regulation, risk-pooling, and purchasing—can build reinforcing incentives for private health actors to focus on the major health system goals (figure 1). Combined, these mechanisms can promote better health outcomes and financial protection, as well as higher quality and more equitable private health service delivery. Variations on this model have produced good outcomes in a number of high income countries (such as France, Germany, Japan, Korea, the Netherlands, and Switzerland) and in an increasing number of middle income countries (such as Chile, Colombia, and Thailand).

But these mechanisms, successful in the developed world, have not been fully adopted in most of the developing world, especially in low income countries. Governments in low income countries face significant constraints, which impede implementing such mechanisms, including a lack of information, weak capacity, and a failure to set a high priority for the stewardship of whole health systems. So, experimentation with these mechanisms is still limited, evidence on best practices is weak, resources to build capacity are scarce, and thus the ability to scale up is minimal.

## Ideas for accelerating progress toward better stewardship of mixed health systems

This report offers several ideas for overcoming the barriers that developing countries face in stewarding the nonstate portion of their health systems (table 1).

Figure 1 **Conceptual model for mixed health system stewardship**




## Invest in information about health markets

Having more systematic information about health markets is a key first step in any reform. Data about private markets are crucial for national health stewards who seek to regulate key aspects of care such as quality and price, to promote effective health interventions across the entire system, and to ensure access for all populations. For example, the following information would be useful:

- Who is providing care (public providers, private providers, formal providers, informal providers)?
- What services are being provided to what type of patients (rich or poor; urban or rural)?
- How much do patients pay for various services?
- Why and for which services do patients use the private sector or the public sector?
- What kinds of providers make up the informal sector?
- What is the quality of services delivered in the public and private sectors, both technically and as perceived by patients?

**Table 1** **Ideas for accelerating progress toward better stewardship of mixed health systems**

| Challenge | Suggestion |
|---|---|
| Lack of data | Invest in information about health markets |
| Lack of government capacity | Support innovative models that can serve as "stepping stones" to broader reforms |
| Lack of stewardship as a priority | Develop a "roadmap" for mixed health system stewardship |

Collecting health market information is an area where donors and technical agencies could make a difference in the short to medium term. Donors could provide resources for collecting basic data on health markets. And technical agencies such as the WHO could encourage countries to make collecting and using this information a priority. Ideally, countries would exercise leadership in collecting it (or at least welcome and use data collected by third parties). While information collection can be expensive and time intensive, it does not require major political fights or major expansions in government capacity. So, it may be the easiest of the three recommendations to implement.

## Support innovative models that can serve as "stepping stones" to broader reforms

In the absence of near-term government capacity for broad stewardship of health markets, governments and private entities can foster models that harness private markets and address their failures by reducing provider fragmentation, creating incentives for quality, providing subsidies for targeted populations and high impact interventions, and using technologies that expand access and improve quality. These models—such as stronger professional associations, provider networks, franchises, vouchers, community-based health insurance, social marketing, and telemedicine—are not necessarily systemic solutions. But in situations of limited government capacity, they may achieve some of the benefits of government-led regulation, risk-pooling, and purchasing, while producing faster near-term outcomes even if for narrower populations. They may also serve as stepping stones and stimulants for comprehensive government-led reform, as well as long-term components of a comprehensive health system.

Despite the relative lack of comprehensive efforts for stewardship of mixed health systems by developing country governments, private organizations in many low income countries have implemented innovative models that begin to address some of the failures of health markets. Such models, ideally supported by governments, could make health markets more effective and equitable in five ways:

- *Reduce fragmentation.* Interventions that reduce provider fragmentation include franchising, professional associations, provider networks, and integrated models (such as chains of drug stores or health clinics). These models can make it easier to monitor quality, provide oversight, facilitate greater coordination and continuity across providers (improving quality and efficiency), and potentially facilitate government regulation.
- *Change provider incentives and increase monitoring.* Interventions that change the incentives of private providers or monitor their quality include: network models, accreditation or licensing through professional associations or other independent entities, franchises, and any public or private demand-side financing payment mechanisms (insurance, vouchers) coupled with purchasing mechanisms to improve quality. When successfully implemented, these models can give providers incentive to focus on higher impact services and higher quality care—and not on providing large quantities of low quality products and services.

- *Provide subsidies for targeted populations and high-impact interventions.* Models that provide subsidies for specific interventions or populations, such as subsidized public and private insurance and vouchers, can increase both demand and supply for effective interventions. Such subsidies can encourage high quality providers to serve lower income markets that they might not be able to serve in the absence of subsidies.
- *Educate and incentivize patients to demand the most beneficial services.* Interventions that increase patient demand for effective care include social marketing, conditional cash transfer programs, leveraging rural cooperatives and other existing communities, and trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations). These models may increase the supply of high-quality services by private providers and reduce inappropriate provider behavior.
- *Use technologies that expand access and improve quality.* Technological innovations such as medical advice call centers, telemedicine, mobile diagnostic devices, and healthcare kiosks, many pioneered by private social entrepreneurs, can provide higher quality and more consistent care to hard-to-reach populations, while increasing efficiency.

Governments should make it a point to know what private innovations are occurring in their countries and consider how these programs can complement existing government services. Ideally, they should view high impact models that harness and improve the performance of health markets as a part of the health system, considering direct contracts with successful programs. And implementers of innovative models that harness and manage the private sector should be aware of national health goals and determine how their program will contribute. They should work to form relationships with government and integrate with existing public services.

In the absence of direct government funding, donors should create additional, long-term, sustainable financing mechanisms for privately implemented programs that improve health market functioning. They should revisit the definition of "sustainable" and recognize the need for ongoing subsidies, whether provided by donors or ultimately by governments through purchasing mechanisms. Funding for these models should be more flexible and more focused on strengthening broader health systems and health markets, rather than just on delivering specific interventions.

Meanwhile, program implementers should consider how to better link demand-side financing models (such as insurance and vouchers) with innovative delivery models (such as franchising) to improve incentives and control over performance.

Donors should consider supporting the systematic cataloguing, documentation, and evaluation of innovative private programs, while also supporting networks of implementers of similar programs so that common challenges and best practices can be identified and jointly addressed. Networks could jointly undertake operations research on how to make certain program models most successful and then share findings across programs and countries.

## Develop a roadmap for mixed health system stewardship

Progress toward stewardship of mixed health systems—especially the nonstate sector—is a long-term aspiration rather than a short-term goal. Any reforms are likely to be gradual, stepwise, and subject to political pressures. Given the complexity of reform processes, it is important for ministries of health in countries with large health markets to develop a clear roadmap for building a strong stewardship model.

In creating a roadmap, policymakers will need to consider how the health system will ultimately address the challenges and opportunities of health markets. The challenges include how to achieve financial protection given high out-of-pocket payments for numerous services (including those not deemed a priority intervention from a public health standpoint) and how to ensure quality when many patients seek care from unmonitored providers on a fee-for-service basis.

Several stewardship mechanisms can improve the functioning of health markets by increasing quality, availability, and affordability of healthcare for poor people in developing countries. Regulatory models can improve quality by setting and enforcing standards. Risk-pooling and health insurance have been shown to protect individuals from catastrophic health expenses, increase use of beneficial services, and ultimately improve health status. Provider purchasing and contracting can improve quality and availability of private providers by aligning payment incentives with desired outcomes, while establishing and monitoring quality and efficiency targets. Meanwhile, the privately implemented "stepping stone" interventions—such as professional associations, provider networks, franchises, vouchers, community-based health insurance, social marketing, and telemedicine—can be fostered and integrated into the health system using these stewardship mechanisms.

However, developing a roadmap implies that health system stewards focus as much on the *how* as on the *what*. In addition to identifying desirable policy options, efforts should be made to strengthen a process of reform in which initial success informs and strengthens coalitions, enabling further steps to deepen and broaden these efforts.

Governments and donors may consider some generic steps before embracing a full reform process toward better stewardship of the private sector. It is important to view this process as evolutionary, and not revolutionary (figure 2). The first steps should focus on gathering the necessary information and completing the key analysis. A second set of steps involves developing a vision of a desired state for the overall health system and priorities for desired reforms. Third is a set of steps for capacity-building. The reform process should avoid overwhelming the institutional and financial capacities of national governments and donors and enable the building of political support for reforms as they are undertaken.

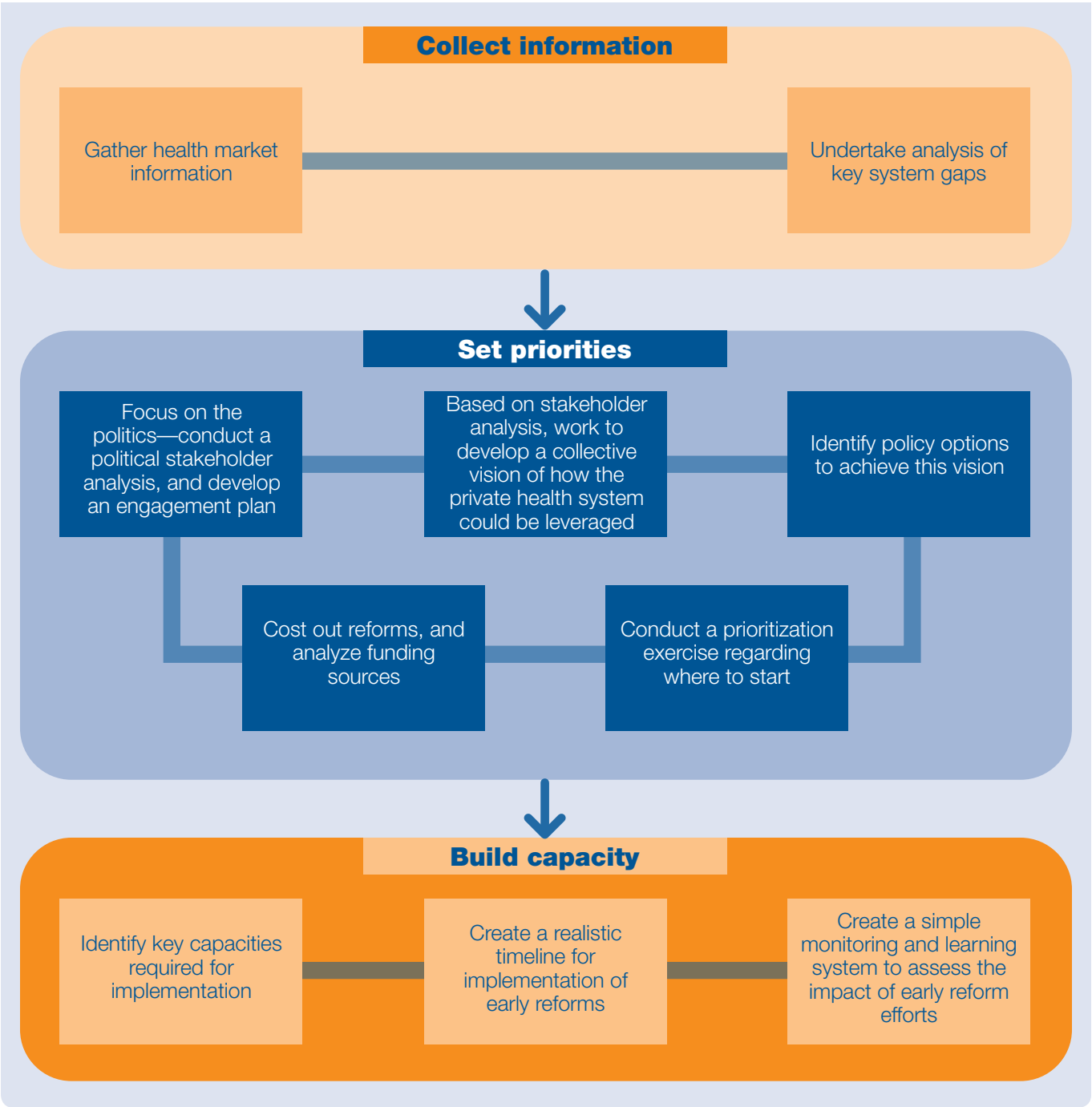
The exact policy choices and country-level reform processes will be determined by the existing context—the financing and delivery arrangements, the skills and capacities, and the political economy (which will determine how much political space exists to plan and undertake reforms). There are no normatively correct policy choices or reform processes that every country should undertake. Instead, countries should match their specific endowments and needs to develop a roadmap appropriate for their purposes, with a focus on learning and feedback, and perhaps less stress on putting together a technically perfect set of policies.

Above all, there is a need to focus pragmatically on how to ensure that health markets are contributing to key health goals, such as the Millennium Development Goals, as well as financial protection goals such as universal coverage. Aspects of health markets that contribute to key goals should be nurtured, and those that detract should be diminished through regulation. Each context is different, with countries falling along a continuum of public and private participation in health systems. Those with large private healthcare markets are likely to need the most attention in addressing the complex problems of mixed health systems.

## How this report is organized

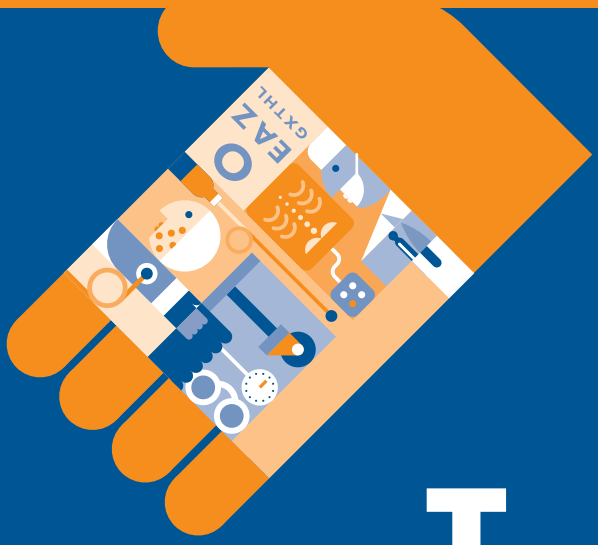
The report's first section provides context by summarizing familiar facts that demonstrate that most developing country health systems include much more than government-run

Figure 2 **Core steps in developing a roadmap for mixed health system stewardship**




services. It also discusses the challenges of private markets for healthcare, as well as the opportunities. The second section discusses possible government stewardship mechanisms for mixed health systems, describing mechanisms that developed country governments use to better manage and harness their health markets, while acknowledging the challenges of implementing such mechanisms in the developing world. The third section offers ideas for accelerating progress toward improved stewardship of mixed health systems.

## 1. The context: Country health systems include much more than government-run services



The private sector in health is large in many low income countries, with an active marketplace for healthcare provision and financing. A number of studies have demonstrated that many patients in various countries rely on formal and informal private providers for key services, such as treatment of malaria, diarrhea, and acute respiratory infections.[12,13] In addition, many countries have more private providers than public providers. While detailed statistical information and landscaping on the mix of public-private providers are not systematically collected in most developing countries, some data and much experience suggest that private providers are more numerous and accessible in many locales.

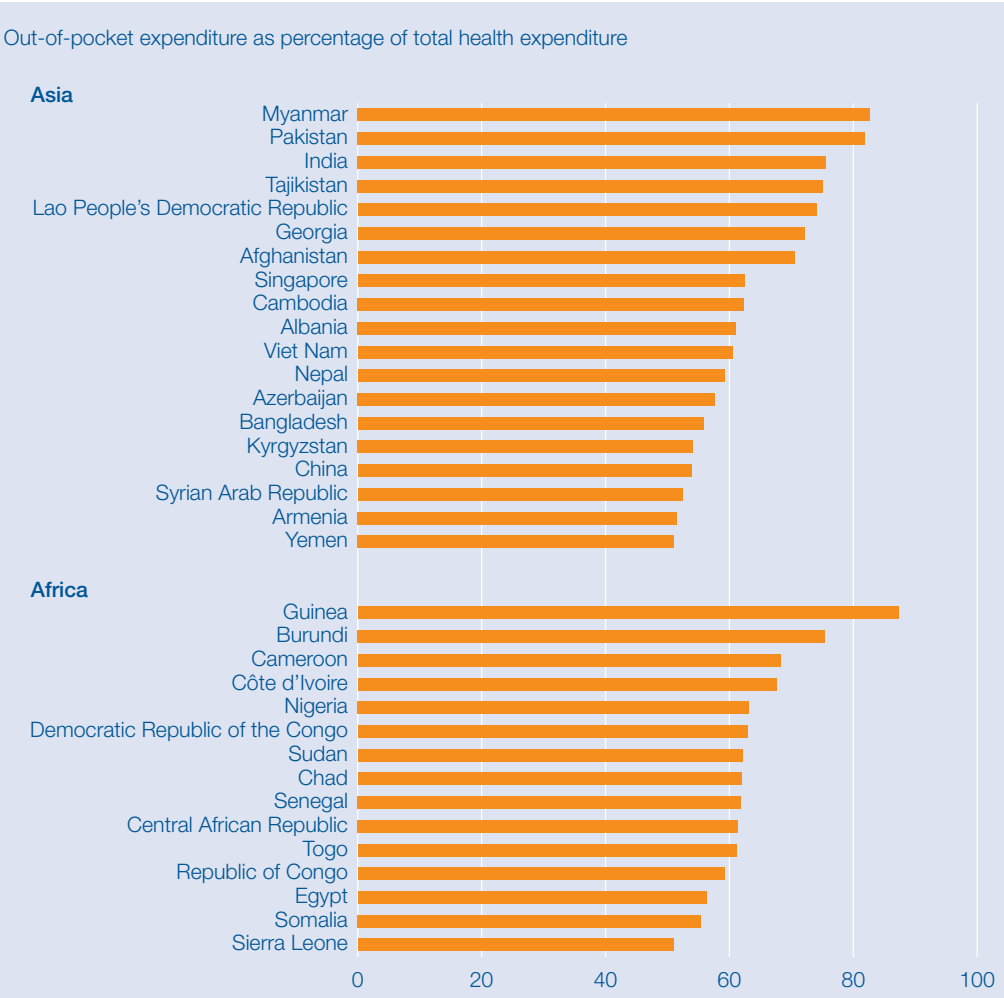
The evidence is most striking in parts of South Asia and Sub-Saharan Africa. For example, in Madhya Pradesh, India (67 million people), a statewide data collection and provider mapping initiative shows that private delivery outlets, with 76% of all physicians and 72% of qualified paramedics, far outnumber the public providers. In addition to these large percentages of formal providers working in the private sector, 30% of providers were in the informal sector. All told, the study suggests that more than 75% of all providers statewide operate in the private sector.[14]

In addition, it is well established that financing for health services comes largely from private sources in many low income countries. Although the public-private mix greatly varies by country, and data to accurately quantify this mix is scarce, in at least 19 countries in Asia and 15 countries in Africa—including many of the most populous nations (Bangladesh, China, India, Nigeria, Pakistan)—more than half of total health expenditures are private out-of pocket transactions (figure 1.1). Upward of 75% of India's spending on health is through out-of-pocket payments, as is 63% of Nigeria's.[15]

**Financing for health services comes largely from private sources in many low income countries**

The proportion of private out-of-pocket payments is not equivalent to the proportion of private provision, because these payments can be paid to public providers (as formal user fees or informal payments) or to private providers. But high out-of-pocket spending may signal a high degree of market activity and private provision within the health sector. Out-of-pocket spending is the most inequitable and inefficient form of financing for healthcare, leaving patients—particularly the poor—vulnerable to further impoverishment and lack of access to key services.

Figure 1.1 **Out-of-pocket spending makes up more than half of total health expenditure in a number of countries in Africa and Asia**




**Source:** WHO National Health Accounts data for 2006.

Note that despite large private sectors and active markets for healthcare in many countries, many people still do not receive key health services. Data from 44 middle and low income countries suggest that the higher the private participation in primary healthcare, the higher the exclusion from treatment and care.[16] Data from 26 Sub-Saharan countries showed that more than half of the poorest children receive no healthcare at all when sick.[17] This is a complex problem partly related to a lack of demand and lack of supply, but inequitable out-of-pocket financing likely contributes much to this problem.

## A varied mix of service providers

In countries with active healthcare markets, the private sector in health comprises a variety of individuals and organizations, with the mix depending on the country and type of service. Individual practitioners and organizations in the private health sector can be not-for-profit or for-profit and informal (untrained or unlicensed) or formal (some training or licensed; table 1.1).[18] The type and extent of participation of the private health sectors differ considerably by country and by service—there is no one model or mix.

New analysis of Demographic and Health Survey (DHS) data, completed for this project by Supon Limwattananon of the Thai Ministry of Public Health's International Health Policy Program, underscores this variety. The study distinguishes the use of informal private providers, formal private providers, and public providers for four maternal and child health services (family planning, delivery, child fever or cough, and child diarrhea) in 25 low income countries in Sub-Saharan Africa and South and South-East Asia.[19] Since formal sector care (public or private) may be viewed as more desirable than informal sector care (because of increased, if insufficient, oversight of formal providers), Limwattananon's study differentiated formal from informal private care.

Table 1.1 **Examples of private health providers**

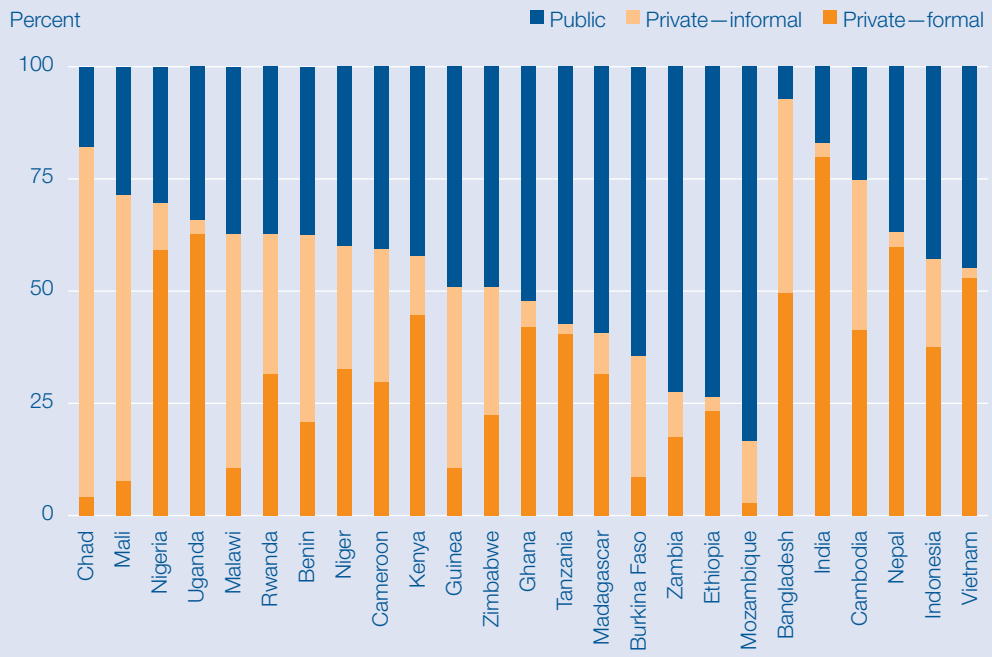
| Provider | Informal provider | Formal provider |
|---|---|---|
| Not-for-profit | • Local, unpaid midwife<br>• Volunteer village health worker | • Faith-based organization clinics or hospitals<br>• Nongovernmental clinics or hospitals<br>• Volunteer doctors |
| For-profit | • Individual drug sellers<br>• Traditional healers<br>• Untrained/unlicensed private practitioners of allopathic medicine | • Private hospital<br>• Chain of drug stores<br>• Licensed private physician |

Although DHS data are imperfect, the analysis demonstrates that each country, and each type of service within a country, has a somewhat different mix of public-private service use. This finding is important because it suggests that policies toward the private sector and programs for delivery of key interventions would benefit from additional information about where patients seek care. For example, the analysis found that public sector participation in delivery of services for child fever or cough is low in Chad, Mali, Nigeria, Bangladesh, India, and Cambodia—and high in Mozambique, Ethiopia, and Zambia (figure 1.2).[20] Among countries with large private sectors the informal private sector predominates in some countries (Chad, Mali, and Malawi) and the formal private sector in others (India, Uganda, and Nigeria). Shares of public, formal private, and informal private care also vary by country for the three other services measured in the DHS—child diarrhea, family planning, and deliveries.[21]

There are also geographic and economic differences in the composition of service provision. Conventional wisdom has it that the formal private sector is typically used by urban or wealthier populations, while informal private and public providers are more heavily used among rural or poorer populations. The DHS data confirm this.[22]

**Each country, and each type of service within a country, has a somewhat different mix of public-private service use**

Figure 1.2 **The percentage of children receiving care for fever or cough in public and private health facilities varies by country**




**Source:** Limwattananon 2008, technical partner paper 1.

## Is the private sector growing or shrinking?

The short answer is that data are inadequate in nearly every developing country to know whether the private sector, on the whole, is growing or shrinking. But some evidence suggests that the public-private mix can change over time, with private informal and formal care following differing patterns of growing or shrinking in some countries.

In most developing countries health sectors were predominately private until governments established national health ministries in the 20th century. This likely increased the public share of total services. Limwattananon's study attempted to identify more recent shifts in the public-private mix between two DHS waves about 5–6 years apart for 25 countries.

In some countries and for some services the private sector appears to be growing. In Nigeria there was a 22 percentage point increase in the share of family planning services delivered by the private sector between 1999 and 2003. Benin, Guinea, Mali, Mozambique, Niger, Bangladesh, Indonesia, and Cambodia also experienced increases of more than 10 percentage points in the private share of family planning services.[23] Similarly, increases in the share of private child diarrhea services were greater than 10 percentage points in Bangladesh, Cameroon, Guinea, and Zimbabwe.[24]

For some services the share of private sector participation has declined. In Ethiopia, Mozambique, Niger, and Vietnam the private share of diarrhea services fell—as did the private share of deliveries in Vietnam, Cambodia, and Nepal.

Limwattananon's study identifies countries by which source of care (public, formal private, and informal private) increased in share and which decreased in share over the period of time between the two DHS waves (table 1.2).

Based on these data, available for only a handful of services, it is difficult to determine

Table 1.2 **Countries experiencing greater than 10 percentage point shifts in the share of public, private formal, and private informal care**

| | Reproductive health | | Childhood illness | |
|---|---|---|---|---|
| **Area** | **Family planning** | **Deliveries** | **Diarrhea** | **Fever or cough** |
| **Countries where public services increased** | | | | |
| Informal private declined | | Vietnam<br>Cambodia<br>Nepal | Ethiopia<br>Mozambique | Rwanda<br>Burkina Faso |
| Formal private declined | | | Vietnam<br>Ethiopia | |
| **Countries where formal private services increased** | | | | |
| Informal private declined | Indonesia<br>Uganda | Indonesia | Rwanda<br>Niger | Nigeria<br>Rwanda |
| Public declined | Indonesia | Mali | | Niger |
| **Countries where informal private services increased** | | | | |
| Formal private declined | Malawi<br>Cameroon<br>Cambodia | | Chad<br>Zimbabwe | Chad |
| Public declined | | | Chad<br>Bangladesh<br>Zimbabwe<br>Cameroon | Chad<br>Ghana |

*Source:* Limwattananon 2008, technical partner paper 1.

whether the private health sector overall is growing or shrinking. But the data do suggest that sector shares may be dynamic over time and that private informal and private formal care are following different patterns of growing or shrinking in some countries.

## Complexity of mixed public-private systems

The structure of health markets is complex, with the lines between public and private often unclear, making strict public-private distinctions difficult and overly simplistic.

In mixed health systems the line between public and private is frequently blurred.[25] Distinguishing public from private is difficult for three reasons. First, government-employed physicians often "moonlight" (engage in dual practice) as practitioners in the market system.[26] Second, several combinations of public and private financing and delivery can make categorization difficult. And third, given the various combinations of public-private financing and delivery, most individual providers likely have some mix of "social" and "personal" motivation, which is not always aligned with the commonly assumed motivation of their organizational structure. Moreover, survey data show little consensus among global health professionals about the definitions of "public" and "private."[27]

Distinguishing public and private is complicated by the combinations of public and private financing and provision.[28] For example, healthcare can be completely publicly financed and delivered—or completely privately financed and delivered. But when public financing is combined with private delivery or vice versa, strict classification as public or private becomes difficult (table 1.3).

Furthermore, most individuals who work in health systems face some mix of "social" and "personal" motivation (table 1.4). Social motivation—the desire to serve the common good—is frequently associated with providers in public or nonprofit and faith-based settings. These

**Table 1.3 Public-private financing and delivery in healthcare**

| Delivery | Public financing | Private financing |
|---|---|---|
| Public delivery | • General taxation funding of public providers (such as NHS model)<br>• Social health insurance funding of public providers | • Required user fees, copayments paid to public providers<br>• Informal payments paid to public providers |
| Private delivery | • Social health insurance funding with private delivery network<br>• Pool of general tax funding used to fund private delivery network<br>• Government contracting-out of specific services | • Out-of-pocket payments to private providers<br>• Private health insurance reimbursement of private providers |

**Table 1.4 Organizational structure and incentive structure**

| Incentive | Public organization | Private organization |
|---|---|---|
| Positive "social" motivation | Public employees motivated to serve the public good<br>• Public clinics<br>• Public hospitals | Private employees motivated to serve the public good through nonpublic organizations<br>• Nongovernmental organizations<br>• Faith-based organizations |
| Negative "personal" motivation | Profit maximization<br>• Illegal dual practice that leads to absenteeism<br>• Commodities diverted to private markets<br>• Under-the-table payments | Profit maximization<br>• For-profit hospital excluding poor patients to maximize profit<br>• Drug seller recommending additional, unnecessary treatments to increase revenues |

*Note:* There may also be personal motivations that have positive benefits, but this chart focuses on the possible negative consequences of purely negative personal motivations.

motives are typically assumed to be positive. Meanwhile, personal motivation—the desire to enhance one's own well-being—is commonly associated with private providers. These motives are sometimes assumed to be negative, especially when present in the health sector.

But an individual's affiliation with a particular organizational structure does not predetermine motivation. In fact, most health professionals experience a mix of social and personal motivations. Many government-employed physicians are undoubtedly motivated to provide high-quality care to the poor, given their status as public servants. But many of these same physicians may be tempted to enhance their income by soliciting "informal" payments or engaging in illegal dual practice, leading to absenteeism from public facilities, perhaps because of low public sector salaries. Similarly, private practice physicians may be motivated to provide unnecessary care or to overcharge patients to maximize personal revenues. Yet, some private physicians may provide high-quality, honest services, even at times offering free or discounted care to the poorest members of their community out of a sense of altruism.

Although table 1.4 focuses on the possible negative effects of personal motivation, it is also important to note that personal motivation is not intrinsically negative. Strong personal motivations can be leveraged, through proper incentives, to achieve positive social outcomes. In fact, some would argue that the proper leveraging of personal motivation is one of the most effective mechanisms for achieving a desired outcome.[29] This is demonstrated by the proliferation of performance incentive programs in the health sectors of both the developed and the developing world.

In a recent study to assess the attitudes of global and national stakeholders toward the private sector in health in low and lower middle income countries, one of the primary findings was that there is no consensus about what is meant by the "private sector" or a "public-private partnership."[30] There is no agreement among global and national respondents about who should be included in the definition of "private sector."[31] While the majority of

respondents understood the term to include nongovernmental organizations, faith-based organizations, and for-profit providers, a handful of respondents included other nonstate actors, such as traditional healers, midwives, and multinational companies.[32] Attitudes toward the nonprofit sector tended to be more positive than attitudes toward the for-profit sector. Respondents also expressed confusion and frustration about how "public-private partnerships" are defined.

This difficulty differentiating public from private and the lack of consensus about the definitions of these terms calls into question the value of focusing on public/private distinctions as the key determinant of whether a provider is contributing to the key health system goals.

## Why do health markets persist?

Underresourced public systems face limitations in delivering healthcare to all, leading patients to turn to private sources of healthcare provision and financing. Health markets, which in most countries existed before government health services, may have persisted because of the lack of accessibility to government services. In most countries these public systems have never been properly resourced, structured, or incentivized to cover all populations and health needs. This often results in public services that may not reach the poorest, who need the services most. And in some cases, patients may prefer private services, despite the availability of public services.

Even when public care exists in theory, public hospitals often have high absenteeism.[33] Low salaries in the public sector lead to income supplementation strategies, such as dual-practice or moonlighting in the private sector. As a result, private providers may be more accessible to patients, at least in part because private payments can provide the incentives for private providers to remain at their clinics, because providers receive payments only after serving a patient. In contrast, public salaries may be forthcoming even if a provider is absent.

General problems of accessibility are even worse for the poor. Studies of African health spending have shown that public health funds disproportionately benefit wealthier populations.[34]

Another reason private services can be more attractive is the relative cost of care. Once lost working time, travel, and unofficial user fees are taken into account, private services—which may require less travel and wait times—are often cheaper than public.[35] And some evidence suggests that private providers are viewed as more customer friendly by patients, which can increase their perceived quality.[36]

Recent pressure by international donors on ministries of health to focus on particular diseases (malaria, HIV, tuberculosis), interventions (vaccination), or populations (poor mothers and children) may contribute to the persistence of health markets and increase care-seeking in the private sector for other diseases, interventions, and populations. According to data on the global burden of disease collected by the World Health Organization, some of the leading causes of mortality, even in the poorest nations, are chronic disease, including coronary heart disease and stroke. As countries move along the epidemiological and demographic transitions (using national income as a proxy), the mortality attributable to chronic disease rises exponentially (table 1.5).[37] If public health agencies are encouraged to expand their focus on specific populations and interventions, at the expense of general primary and chronic care, the private sector may fill the void. Without adequate stewardship of private providers, complex chronic illnesses may be poorly managed.

**Without adequate stewardship of private providers, complex chronic illnesses may be poorly managed**

## Challenges for health markets

Large and complex health markets are associated with poor financial protection and uneven

**Table 1.5 Four of the top 10 killers in low income countries are chronic illnesses**

| | Deaths | |
|---|---|---|
| **Leading causes of death** | **Number (millions)** | **Percent** |
| **Lower respiratory infections** | **2.94** | **11.2** |
| **Coronary heart disease** | **2.47** | **9.4** |
| Diarrheal disease | 1.81 | 6.9 |
| Human immunodeficiency virus or acquired immune deficiency syndrome | 1.51 | 5.7 |
| **Stroke or other cerebrovascular diseases** | **1.48** | **5.6** |
| **Chronic obstructive pulmonary disease** | **0.94** | **3.6** |
| Tuberculosis | 0.91 | 3.5 |
| Neonatal infections | 0.90 | 3.4 |
| Malaria | 0.86 | 3.3 |
| Prematurity and low birth weight | 0.84 | 3.2 |

*Note:* Chronic illnesses are shown in bold type.
Source: WHO 2008.

quality—especially given the limitations of developing country capacity to regulate these markets. A large and complex private health sector in a health marketplace comes with advantages and disadvantages. The private sector may fill some of the gaps in public sector delivery, while offering greater convenience and accessibility. But without the proper incentives for quality, equity, and affordability, and without adequate monitoring, health markets can produce poor outcomes.

It is well established that health markets everywhere are susceptible to three main market failures.[38] First, asymmetries of information arise when patients do not have complete information about the type and quality of services they require. Such asymmetries leave health consumers susceptible to price-gouging, poor quality care, and improper clinical treatment and prescribing. Second, a health consumer's personal decisions can create positive or negative externalities. That is, a patient's decisions might affect others, but the patient does not consider such effects in making those decisions. These external effects can be positive (herd immunity achieved when patients receive immunizations). Or they can be negative, as with drug-resistant strains of malaria arising from poor compliance to prescribed drugs or improper prescribing (table 1.6). Third, monopolies or oligopolies can take control of health service delivery or financing in a region, precluding competition that would otherwise promote higher quality, greater efficiency, and lower prices.

Health markets also face the challenge of equitable distribution of care. Health markets favor wealthier segments of the population (see figure 1.3). When the wealthier have more access to preventive and curative care, the health needs among income segments begin to vary considerably.[39] Wealthier segments tend to suffer predominantly chronic ailments while poorer segments tend to suffer more from communicable disease. Without a mechanism to intervene and control health markets, this distribution of wealth and disease perpetuates the inequitable delivery and financing of care.

Health service delivery is plagued by uneven quality in both public and private sectors. While functioning markets can provide incentives for high quality care, poorly regulated markets may perpetuate low quality. Patients might receive unnecessary or even harmful

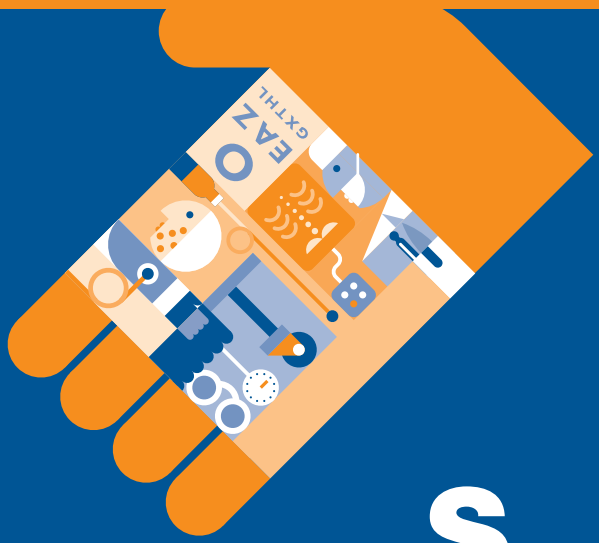
Table 1.6 **Potential negative outcomes in health markets**

| Category | Negative outcome | Example |
|---|---|---|
| Delivery | Uneven quality | • Unlicensed drug sellers<br>• Untrained providers<br>• Unhygienic conditions<br>• Understaffed facilities |
| | Inappropriate diagnosis | • IV drip for common viruses<br>• Diarrhea diagnosed as Malaria without blood test<br>• Improper prescribing of antibiotics |
| Financing | Price-gouging | • Overcharging for services<br>• Overcharging for drugs |
| | Catastrophic expenses | • Out-of-pocket payment for long-term hospitalization<br>• Out-of-pocket payment for surgery<br>• Out-of-pocket payment for chronic illness over time |
| | Inequitable expenditures | • Poor pay disproportionately more of their income for health care than the rich<br>• Poor more likely to pay out-of-pocket |
| | Lack of financial access | • Financially prohibitive to seek care at perceived high quality outlets |

care when providers seek to maximize profits and there are few controls for monitoring and enforcing quality. In addition, given information asymmetries and poorly trained providers, clinical diagnosis and therapies in poor settings can be outdated and not the most cost-effective. Anecdotal reviews tell of profit-seeking doctors prescribing intravenous drips for common viruses and pharmaceutical outlets dispensing counterfeit drugs to unsuspecting patients. Lower income and rural populations are most affected by the failings of private healthcare.[40]

Health financing issues also abound for the poor. Those unable to pay out-of-pocket for care are often turned away from high quality care in private hospitals and clinics. Price-gouging is another impediment. The poor often seek curative care for ailments when they are already very ill (rather than seek preventive care or care earlier in their illness), leaving them vulnerable to the high costs of clinical diagnosis, medication, and hospitalization. Unmonitored providers may overcharge and deliver unnecessary or inappropriate care. A recent study found that unqualified providers in and around New Delhi, India often buy cheap and outdated antibiotics and sell them to unsuspecting poor.[41] Inadequate pooling of risk and lack of subsidies for the poor leads to high (often crippling) out-of-pocket payments, the most inequitable form of health financing.[42]

The poorest suffer most from catastrophic expenditures on health since they spend a greater percentage of their incomes on healthcare than the wealthier. Many country studies have found that the underprivileged are more likely to pay out-of-pocket for health problems, and spend disproportionately more of their income on health than more privileged groups.[43] And even the small costs for common illnesses, when added up, can be financially disastrous for poor households.[44]



Stewardship, in the standard sense of "the careful and responsible management of something entrusted to one's care"[45] is quintessentially a government function. According to the WHO, health system stewardship is "the ability to formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide the necessary intelligence on health system performance in order to ensure accountability and transparency."[46] Policy mechanisms for stewardship of government-provided health services are somewhat different from those needed to steward the private part of the health system, since these services are not under the direct management of government and can receive funds from private sources.[47] In addition, information about private service providers and their quality of service, costs, and results is typically less readily available.[48]

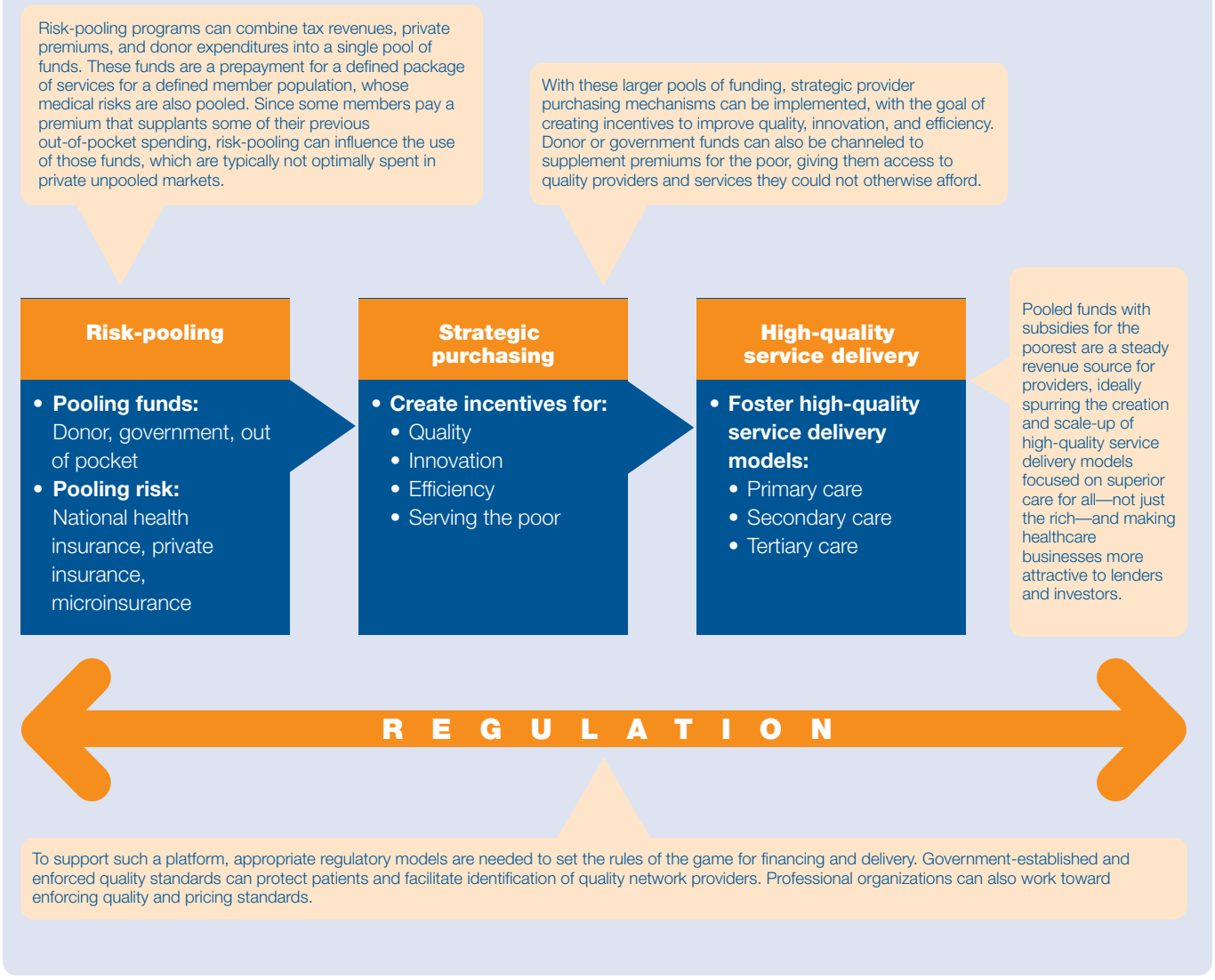
Most high income countries, and a growing number of middle income countries, have policy mechanisms to steward both public and private actors. They have private markets for healthcare, but they have avoided many of the potential negative outcomes because their governments engage in stewardship of the whole health system, including the part not under direct government control. These stewardship policies for mixed health systems attempt, with some success, to harness the private market to achieve the key health system outcomes of improved health status, financial protection, and responsiveness to the expectations of the population—as well as the intermediate goals of access, quality, efficiency, and equity.[49]

Mixed health system stewardship mechanisms include:

- Regulatory policies that monitor quality effectively and mitigate the worst health market failures.
- Financing policies that minimize out-of-pocket payments and increase access by pooling risks across populations with subsidies for the poor.
- Purchasing policies that create incentives for quality and for delivering high-impact interventions and services to the poor.[50]

In many health system models, these three mechanisms are viewed separately from the overall stewardship function—which is focused on policy, planning, and governance. But when it comes to exercising control over the private part of the health sector, these are the primary mechanisms at the state's disposal. So the conceptual model here considers them mechanisms for stewardship (figure 2.1). These mechanisms often complement direct provision of key services by government to certain populations, with different countries choosing different

**Figure 2.1 Conceptual model for mixed health system stewardship**



mixes of direct government provision and stewarded private markets.

The conceptual model shows how mixed health system stewardship mechanisms—regulation, risk-pooling, and purchasing—can build reinforcing incentives for private health actors to focus on the major health system goals (see figure 2.1). Combined, these mechanisms can promote better health outcomes and financial protection, as well as higher quality and more equitable private health service delivery. Variations on this model have produced good outcomes in most high income countries (such as France, Germany, Japan, Korea, the Netherlands, and Switzerland) and in an increasing number of middle income countries (such as Chile, Colombia, Thailand).

**Regulation, risk-pooling, and purchasing can build reinforcing incentives for private health actors**

A substantial literature is relevant to these mechanisms, particularly the financing and purchasing mechanisms, with regulation having been less studied.[51] There is also a large literature on the variations and impacts of these components.

What follows are brief summaries of how each of these mechanisms can contribute to the stewardship of health markets to achieve health system goals. It is not an exhaustive discussion of all versions of each mechanism and the evidence about their effectiveness.

## The regulatory mechanism

Monitoring and enforcing physician, hospital, and drug standards to promote high quality care, whether established by the government or self-imposed by provider groups, is necessary to promote health system goals. Success requires regulatory bodies to have basic technical capacity to perform regulatory functions—setting standards, informing regulated entities about standards, monitoring and enforcing standards, and undertaking legislative review. This type of regulation has been well developed in most high income countries (though is still imperfect) but remains difficult to implement and enforce in many low income countries.[52]

In general, regulation of healthcare markets aims at controlling the distribution or market entry, price, and quality of products and services (table 2.1).[53] For example, regulating for price (such as price-setting for healthcare providers or pharmaceuticals) is common in many developed countries. Regulating for quantity and quality is also common.

Government regulation is just one type of regulatory mechanism. Private providers can organize themselves into networks, establishing quality standards and developing monitoring and evaluation mechanisms to ensure those standards are met.[54] Providers may be motivated to join a network and meet its standards because it can drive demand for their services. And membership in an exclusive network can give access to valuable cross-referrals, as well as opportunities for knowledge sharing with a trusted group of other providers. These types of networks can be self-imposed by doctors through professional associations, created by integrated delivery organizations, or created through franchises where the franchisor establishes certain standards and takes responsibility for monitoring franchisees.[55]

## The financing mechanism

Most high income countries that have substantial private participation in the delivery of care have public financing systems that provide social health protection, address equity issues, and influence quality, within the context of private markets for health. France, Germany, Japan, the Netherlands, Switzerland, Austria, Belgium, Luxembourg, and several countries in Central and Eastern Europe have such systems, which generally provide physical and financial access to quality health services to nearly all segments of the population.[56]

A large literature describes and evaluates various pooled health financing mechanisms.[57] Public revenues can be raised in several ways, primarily through taxes on employees' earnings (social health insurance), but also through

**Table 2.1 High income country regulatory activities**

| Regulation | Typical high income country regulations |
|---|---|
| Establish basic conditions for market exchange | • Define and protect property rights and patents<br>• Govern solvency and bankruptcy of health services institutions<br>• Protect patients' rights |
| Promote equitable access | • Assign new medical graduates to service in underserved areas<br>• Assure patients' rights to emergency services |
| Correct market failures | • Deal with external effects through direct government provision of free and highly subsidized programs (health education, immunization)<br>• Educate consumers to make informed choices by:<br>  • Labeling<br>  • Regulating truth-in-advertising<br>  • Restricting physicians' advertising<br>• Protect buyers unable to judge quality by:<br>  • Regulating inputs through:<br>  • Standards for food hygiene/purity of drugs<br>  • Licensing of physicians, nurses, and pharmacists<br>  • Accreditation of labs and hospitals<br>  • Regulating processes by implementing practice guidelines and patient reporting<br>  • Regulating outputs through:<br>  • Standard quality report cards<br>  • Liability<br>  • Disciplinary standards<br>  • Medical malpractice<br>  • Clinical audit |
| Control supplier-induced demand | • Regulate human resources by:<br>  • Limiting training slots and billing numbers<br>  • Restricting foreign medical school graduates<br>  • Disclosing conflicts of interest<br>• Regulate capital investment by:<br>  • Limiting new technology and new facility construction<br>  • Restricting imports of equipment |
| Counteract monopoly | • Restrict monopolies by:<br>  • Enacting antitrust laws and restricting predatory conduct<br>• Regulate monopolistic prices by:<br>  • Establishing price schedules<br>  • Establishing reference prices for drugs |
| Correct unacceptable market results | • Prohibit the sale of tobacco to minors<br>• Prohibit assisted suicide |

*Source:* Adapted from Roberts, Hsiao, Berman, and Reich 2004.

general taxation revenues, frequently used to provide subsidies for the poorest in society. Funds can then be pooled and used to reimburse providers (private and sometimes public) for care that falls into defined benefit packages. Typically these systems are "demand-side," since patients can choose from among a large network of providers and the insurance pool reimburses that provider a negotiated or government-determined rate for the services provided. Through public insurance programs, the government gains control over resources that would otherwise fund private out-of-pocket market transactions. In this way the government can be a steward of those resources, even if it is not the direct provider of care. Publicly

managed pooled financing systems have helped mitigate the most egregious problems of unregulated private healthcare markets, including catastrophic expenditures, price-gouging, low quality, and inequitable access.

## Reduced catastrophic expenditures

Public pooled financing arrangements help to avoid catastrophic expenditures, which can lead to impoverishment, because the risk of illness is spread over a large population, so no one person—regardless of individual costs—bears an unmanageable personal expense.[58] When benefits packages are broad, most key services are covered under the insurance program. Problems of financial access for the poor are mitigated because the poorest in society are allowed to join larger pools, with their premium costs subsidized. In this way, there is risk-sharing and cross-subsidy not only between healthy and unhealthy people but also between poor and rich.[59]

**Pooled financing models can influence the quality of private care in several ways**

## Better quality

Pooled financing models can influence the quality of private care in several ways. By organizing funds at a group level (rather than relying on individual out-of-pocket transactions), well implemented public health insurance programs create a platform for pooled strategic purchasing that can protect patients from low quality care.[60] The demand side of health insurance means that funds follow patients to the provider of their choice. An insurer can engage in strategic purchasing by developing a network of preferred providers for insured patients to choose from. Private providers may be included in a network (and thus be eligible for insurance reimbursements) only if they meet basic quality standards. In addition, some insurance programs have pay-for-performance models that monitor specific quality standards and foster additional quality improvements through payment mechanisms.[61] An insurer's status as payer gives it the power to collect key information and monitor the quality of providers in the network. The insurer can provide clinical protocols, training, and quality-assured products and then measure the provider's results. If quality is not up to standard, it can withhold payments or remove the provider from the network. (See the next section on the purchasing mechanism.)

## Less price-gouging

Public insurance models typically minimize price-gouging because insurers and providers negotiate reasonable reimbursement rates, and providers typically are not allowed to "balance-bill," or to charge patients more than the agreed-to rate.[62] Patients receive care "free" at the point of service, or pay a predetermined copayment.

## Wider availability and use of services

Public health insurance can also increase the availability of quality services for the poor.[63] It provides a steady stream of revenues to providers, a major incentive for the entry and scale-up of organizations that can meet network standards. Steady revenue streams make healthcare businesses more attractive to lenders and investors, allowing them to attract capital for growth and investments that may yield greater quality and efficiency (information systems, facility upgrades, medical equipment).[64] Health insurance also provides a mechanism to funnel demand-side subsidies (from general tax revenues or cross-subsidies from the contributions of wealthier populations) to the poor, giving providers an incentive to make services available to poor populations and allowing for more comprehensive benefits packages. Targeted benefits packages can encourage wider use of effective preventive and curative services. Several insurance programs have demonstrated increased use of services by the poor.[65]

Most countries that achieve their health system goals do not rely exclusively on private health insurance. Although private health

insurance can promote some objectives, such as reducing catastrophic expenses and improving quality for some populations, it frequently fails to achieve key access and equity objectives.[66] In purely private insurance models, pooling is made difficult by the tendency of higher risk people to purchase insurance, while lower risk people choose not to (adverse selection). And purely private models leave out poorer populations who cannot pay or relegate them to very narrow packages of benefits. But several countries (such as Switzerland and the Netherlands) do rely on private insurers to conduct some risk-pooling and purchasing functions in the context of strongly regulated public health insurance markets, which require universal participation, subsidize the poor, and heavily regulate price and benefits packages. In this way, these systems may be viewed as public financing models, even though they rely on private companies to carry out some functions. Less regulated private insurance markets, such as the United States, are not as successful in achieving key access and equity objectives.

## The purchasing mechanism

Purchasing is the interface between institutional purchasers and healthcare providers to align incentives and payment mechanisms with desired outcomes and to establish and monitor targets to ensure high-quality care. Similar to financing, there is a large literature on purchasing and contracting for health services.[67] Two types of purchasing are contracting out and strategic purchasing.

### Contracting out

In contracting out models the government usually conducts a competitive process to select one or several providers to deliver specific health services to a specific population. Contracts sometimes replace what previously were government-provided services (such as a contract to a private provider to operate a public health clinic or hospital). Competition among providers generally occurs at the point of the tender, rather than after the contract is awarded, since contracts tend to be awarded to small numbers of providers and are often "winner take all" for a particular geographic area. Accordingly, payments are usually on the "supply side," with the government directly purchasing a set quantity of services.

### Strategic purchasing

In contrast, strategic purchasing models are usually designed to purchase from a large number of existing market providers. These models can exercise greater control over a myriad of private health providers than is possible when individual patients seek care in private transactions. Thus, strategic purchasing can enable greater stewardship of health markets. High income countries relying on health insurance to finance the majority of health service delivery use purchasing to influence the behavior of various health sector actors to support better health outcomes.[68] In addition to setting consistent payment levels across providers, institutional purchasers can select networks based on their performance on quality indicators and accreditation. They can also design payment mechanisms that create incentives for quality and appropriate use. And they can create measurement and evaluation systems to support these mechanisms, while also providing potentially valuable information to patients and policymakers.

**Strategic purchasing can enable greater control over private health providers**

While contracting out is one way for governments to harness the private sector, this paper focuses on strategic purchasing, which is more relevant for stewardship of complex health markets. While most strategic purchasing models are imperfect, with impact highly dependent on the quality of design and implementation, they are a major lever used by high income country health systems to influence the behavior of providers, particularly private providers.

## Limited stewardship of health markets in the developing world

Stewardship mechanisms that have been successful for mixed health systems in the developed world—including regulation, risk-pooling, and purchasing—have not been fully adopted in most of the developing world, especially in the lowest income countries. Experimentation with the models is still limited, evidence on best practices is weak, resources to build capacity are scarce, and thus the ability to scale up is minimal. Many contextual causes of the lack of stewardship can be attributed to systemwide (not just health sector) deficiencies, such as administrative capacity constraints, poor incentives, and corruption. In addition, in many developing countries collaboration between public and private sectors is rare. A web-based survey of global health professionals found several barriers that might explain this lack of collaboration (figure 2.2).

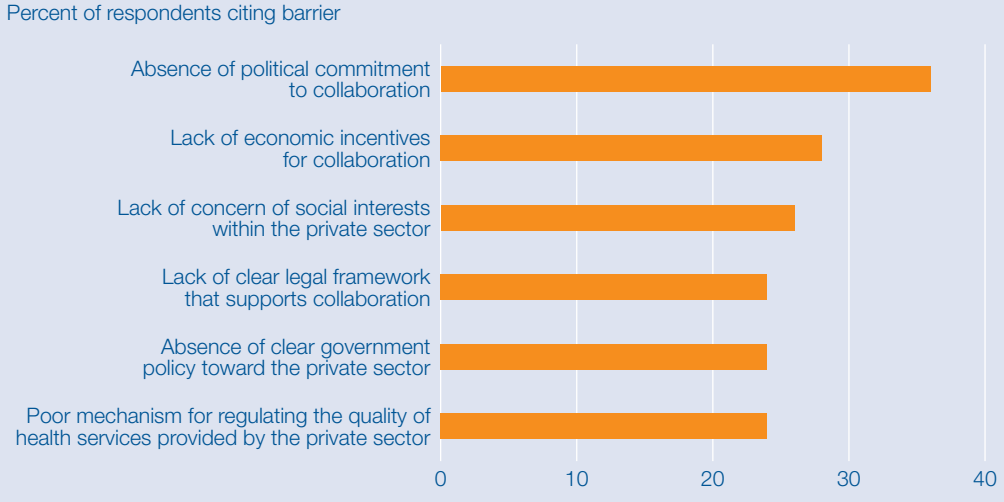
**Many developing countries do not have the regulatory structures to enforce quality standards**

### Limited regulation

Unlike high income countries most developing countries do not have the regulatory structures to appropriately monitor medical care and enforce quality standards.[69] Some governments have legal frameworks but inadequate enforcement, while others have neither.[70] A review of regulatory systems found a negative relationship between private health spending and government capacity to regulate, noting that in practice, even when legislative measures do exist, enforcement is weak.[71] In addition, a landscape analysis of attitudes toward the private sector found that the majority of respondents feel that governments do not do an effective job of regulating providers, especially for-profit providers (figure 2.3).[72]

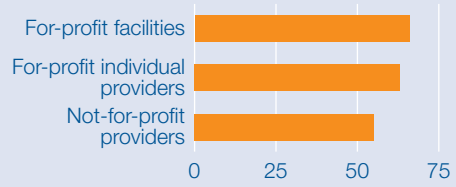
It is clear that regulations and the associated enforcement designed to protect consumers have significantly lagged behind the development of private markets for health services and products. The many reasons include limited information about private health actors, administrative capacity constraints, and policy capture and corruption. A survey completed for this project by the Thai Ministry of Public Health's International Health Policy Program found that significant percentages of respondent countries self-reported high levels of these

**Figure 2.2** Commonly cited barriers to public-private collaboration




**Source:** Hozumi and others 2008, technical partner paper 2.

**Figure 2.3 Many respondents think the government does not do a good job in regulating providers**




**Source:** Hozumi and others 2008, technical partner paper 2.

constraints for key regulatory agencies, such as government regulatory agencies, hospital accreditation bodies, and professional councils (figure 2.4).[74]

*Limited information about private actors in the health sector.* When government agencies lack comprehensive information about which providers are providing what services to what types of patients, it is very difficult to regulate them. When information is nonexistent, the magnitude of problems may not even be known or acknowledged. Collecting information about the private sector has not been given enough attention or resources. And this is exacerbated by incentives for private providers to operate informally to avoid taxation, costly compliance, or even time-consuming administrative licensure processes that may be on the books, even if not enforced well. The sector's fragmentation also makes collecting information difficult. Effective regulation will be possible only if there is adequate information about who uses the private sector (rich or poor, young or old, urban or rural), what services they seek, why they go to the private sector, results obtained, and the implications of private sector use for equity, financial protection, and public health.[75]

*Administrative capacity constraints.* Inadequate skills and insufficient funding for enforcement are partly related to the general capacity limitations common in low income countries.[76] But the capacity to regulate may be even less developed than administrative capacity for other typical ministerial functions, such as procuring drugs or implementing immunization programs. This may be because many stretched health systems (and the donors and technical agencies that support them) have not considered funding regulatory activities a priority. Many ministries of health have been structured to focus primarily on their own government-managed service delivery systems, rather than on regulating competing or complementary private delivery systems.[77] The skills and resources to manage the direct delivery of care are quite different from those to regulate. Another

**Regulation is difficult without comprehensive information about providers**

**Figure 2.4 Many respondent countries report high levels of regulatory constraints, 2008**


**Source:** Thai International Health Policy Program Global Survey of Regulatory Capacities in Low and Lower Middle Income Countries 2008.

barrier is that the fragmented private health sectors of most developing countries make enforcement difficult and costly.[78]

*Policy capture and corruption*. Even more insidious and difficult to change are the incentives that lead to policy capture and corruption. Harmful incentives exist in many government delivery systems, often manifested in informal payments to providers, absenteeism, leakage of supplies, or kickbacks from suppliers to government officials.[79] Similar incentives can also make regulation difficult. Regulatory regimes are susceptible to capture—when legislation and regulations are drafted to benefit particular interest groups, when inspectors extort the providers they are charged with inspecting, or when regulated entities pay bribes to government officials to ignore lack of compliance.[80]

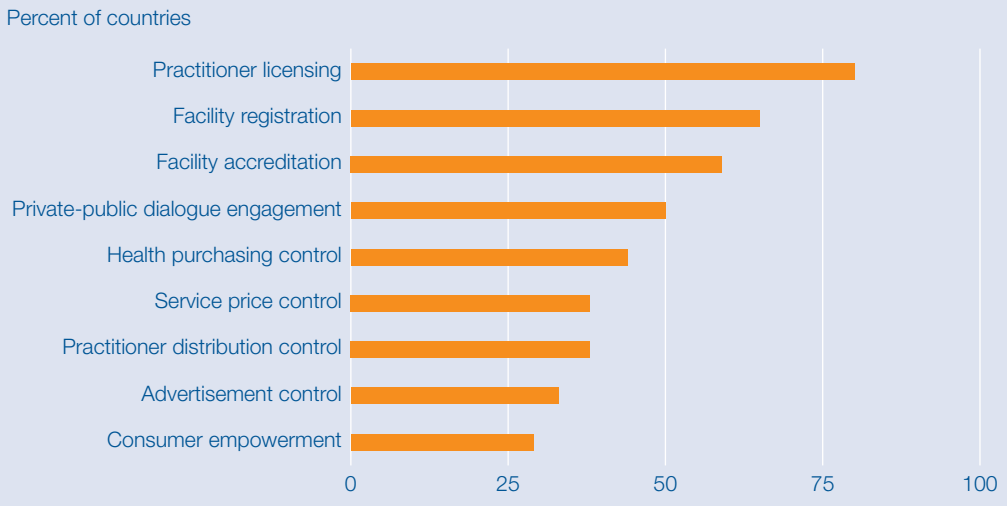
**Even legal providers are usually unmonitored by the state for quality or pricing**

Lack of capacity to implement and monitor health system regulations leads to problems in the quality, access, and pricing of health services. Without a sound regulatory framework and the associated capacity to monitor and enforce it, health market actors and transactions operate outside any kind of legal framework (informal service providers and drug peddlers). Even providers that may legally exist by law are usually unmonitored by the state for quality or pricing.

Regulation is an inherently complex and challenging task. The survey of countries about regulatory constraints found that the majority of countries surveyed self-report high concern about their own ability to apply regulatory measures for practitioner licensing, facility regulation, and facility accreditation (figure 2.5). Significant minorities of countries stated a high degree of concern about other regulatory functions.

While comprehensive regulatory regimes are absent in most low income countries, a few narrow regulatory programs have been somewhat successful. There have been some attempts to regulate pharmaceuticals in Lao PDR, Nigeria, Pakistan, Thailand, and Vietnam—and medical practice in India and Malawi.[81] In addition, the ADDO program to regulate drug-sellers has met some success in Tanzania and is being replicated in Uganda (box 2.1; also

**Figure 2.5 Many countries report high concern about the application of regulatory measures for practitioner licensing, facility regulation, and facility accreditation, 2008**




**Source:** Thai International Health Policy Program Global Survey of Regulatory Capacities in Low and Lower Middle Income Countries for 2008.

see program description in the companion document *Innovative pro-poor health care financing and delivery models)*. But aside from this handful of narrowly targeted programs, there appear to be few successful large-scale attempts, if any, to control the quality of private health providers in low income countries.

## Limited pooled financing

Some middle income countries (Chile, Colombia, the Philippines, Thailand, and some countries in Eastern Europe) and a handful of poorer countries (Rwanda and Ghana) have implemented risk-pooling at a national level with some success (see box 2.2 for a description of Ghana's national health insurance program).[82] They have reduced reliance on the most inequitable and inefficient form of financing—out-of-pocket spending at the point of service—and replaced it with public spending or social health insurance contributions. They have also gained some control over previously private out-of-pocket expenditures, increasing their ability to steward these resources. In Colombia, as a result of national risk-pooling, social security expenditures have been growing since 1993 to become the largest financing source for health, and private financing has decreased, with out-of-pocket spending dropping from 44% of total health spending in 1993 to 7.5% in 2003.[83]

For most low and middle income countries, implementing risk-pooling and health insurance remains a challenge due to the high informality of the workforce and limited government capacity.[84] A few poor countries have attempted reforms to implement national health insurance, but most start (and stop) with government and formal sector employees. For example, Nigeria and Tanzania have attempted health financing reforms, with little success so far in expanding beyond government employees. National health accounts data make it clear that even in countries where private health spending is highest, very few have adequate methods for pooling private expenditures and risk (figure 2.6).

*Key constraints to risk-pooling reforms.* The challenge of reliably generating funds may be the largest barrier to risk-pooling programs in low income countries.[85] The payroll-tax-based revenue-generation systems common in high and some middle income countries are very difficult to implement when large segments of the population are informally employed. In addition, the lack of a robust tax base to generate funds through general taxation limits general-taxation-based revenues.

**Risk-pooling remains a challenge due to high informality of the workforce and limited capacity**

Other common implementation challenges include:[86]

- Developing mechanisms for targeting subsidies to the poor.
- Ensuring fiscal sustainability by adopting realistic benefits packages that can be supported by the available resources, and then accurately calculating the cost of benefits and expected revenues.
- Overcoming major administrative hurdles in enrollment and claims-processing.
- Implementing appropriate purchasing mechanisms to create incentives for better quality care.
- Ensuring that funding pools are safely and appropriately governed.

*Examples of risk-pooling reforms.* Despite these challenges there have been a handful of widespread government-led insurance reforms in developing countries. Successful programs tailor approaches to insurance reform to the needs and context. Rwanda and Ghana have a modified version of social health insurance that relies on elements of community-based health insurance, which are then scaled up to the national level. Both countries combine government tax-generated funding with private premiums for some segments of the informal sector population, collected in the

**Box 2.1 Accreditation of drug shops in Tanzania**

In 2001 a Tanzania Ministry of Health study found severe problems with the country's 4,600-plus government authorized private sector drug stores, including frequent stock-outs, unlicensed and untrained staff, substandard equipment, and poor referral systems. As a response in 2002 the Tanzania Food and Drug Authority, in collaboration with Management Sciences for Health/Strategies for Enhancing Access to Medicines, and Tanzanian regional and local government authorities embarked on building a regulated system of accredited retail drug dispensing outlets (ADDOs) that would provide a range of affordable, quality drugs and services in rural and periurban areas where there were few or no registered pharmacies. Funding was provided by the Government of Tanzania, U.S. Agency for International Development and the Danish International Development Agency.

The program, initially piloted in the one region, is being expanded to include three additional regions, with plans to achieve nationwide coverage by 2012. It aims to address the challenges of uneven medicine distribution, poor dispensing practices, fragmented knowledge and competence, substandard medicines, and an inadequate regulatory framework. With support from public and private sector stakeholders, it employs a holistic approach that combines changing the behavior and expectations of individuals who use, own, regulate or work in retail drug shops. It does this by building on existing infrastructures and introducing a combination of training, appropriate incentives, consumer pressure, and regulatory coercion to affect client demand.

The ADDO program introduced accreditation for community-based drug shops based on Ministry of Health's standards and regulations and in accordance with the goals of the National Health Policy and Health Sector Reforms Program. ADDO inspectors conduct mapping and preliminary pre-accreditation inspections of the community-based drug shops to assess individual needs.

ADDO also provides training in business skills, documentation and record-keeping to drug dispensers and owners, as well as such commercial incentives as loans to ADDO shops. In addition, ADDO promotes customer awareness of the quality of medicines and services through public education.

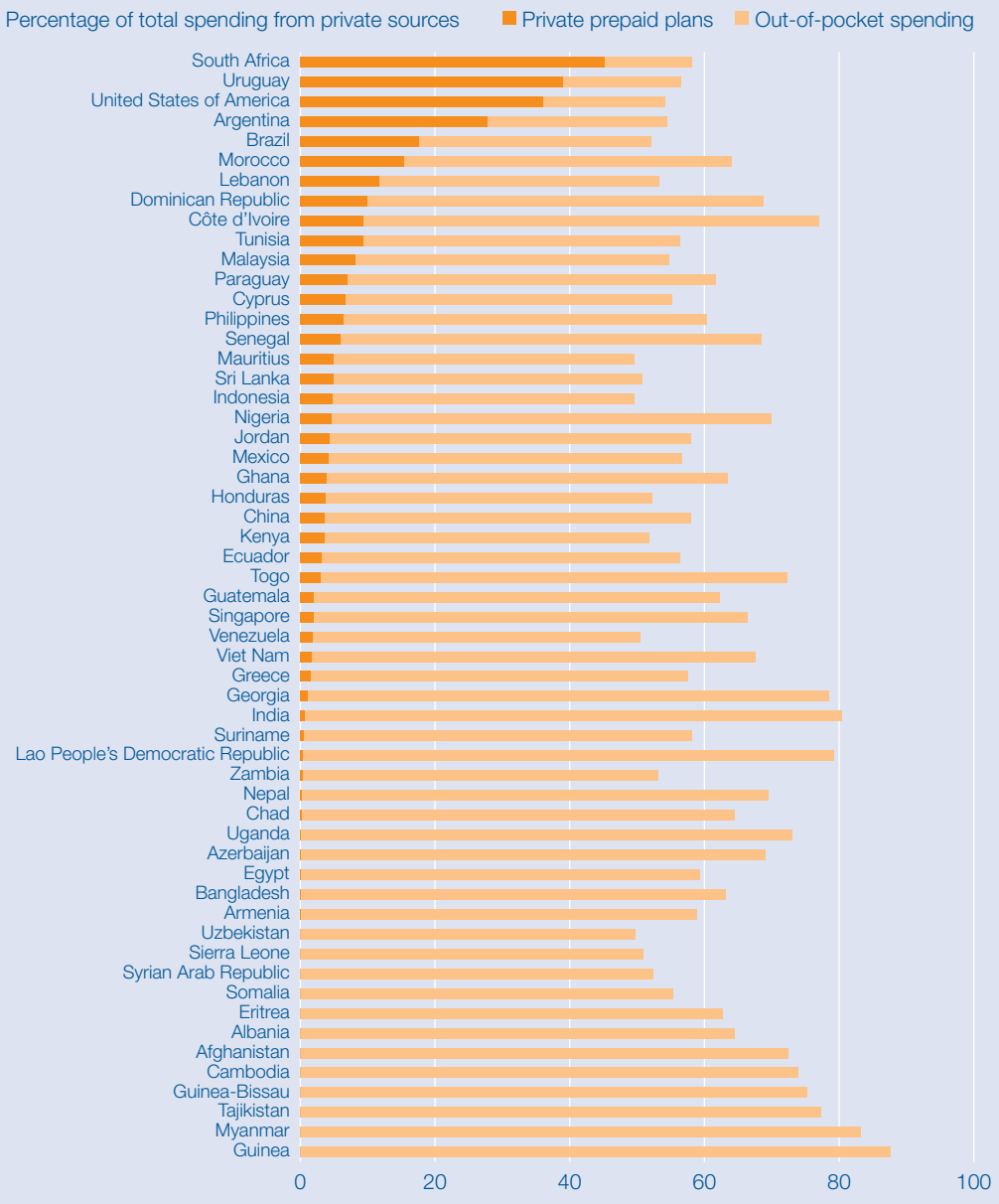
ADDO runs monitoring and evaluation inspections by ward and district inspectors and is working to strengthen local regulatory capacity. Evidence suggests that ADDO has contributed to improving rural and periurban communities' access to quality, safe, effective, and affordable medicines. Compared with baseline information obtained in a survey in 2001, ADDO has increased community access to quality, safe and effective drugs. There was less than 2% unregistered drugs in the market at the endline evaluation, compared with 26% at baseline in the pilot region. In addition, there has been an improvement in rational drug use through adherence to requirements for dispensing prescription drugs. This was evidenced by the finding that only 14% could dispense antibiotics for treating upper respiratory tract infection, compared to 39% at baseline. ADDO has also created reliable employment and income-generating opportunities for ADDO dispensers and created a skilled pool of trainers, dispensers, and inspectors.

**Source:** Tanzania Food and Drug Authority (www.tfda.or.tz/Addopage1.html) and Keith Johnson, Management Sciences for Health.

community.[87] This has enabled the reduction of "point of service" user fees. The two countries rely on existing private community-based health insurance programs and other strong community structures (such as rural cooperatives) to collect premiums from informal sector workers where traditional social health insurance mechanisms are ineffective. Some criticize these programs because the total amount collected through premiums is a relatively small percentage of overall resources and administratively costly to collect.

Middle income success stories like Colombia, the Philippines, and Thailand have relied on high rates of economic growth to expand total health spending, funneled into insurance.

Figure 2.6 **Among countries with high private health spending, private pooled expenditures remain a very small portion**




**Source:** WHO National Health Accounts data from 2006.

The programs have generated revenues from different sources, but all seek to gradually cover larger percentages of their population (with goals of universal coverage), while subsidizing the poorest. All these programs finance the demand-side, allowing patients to choose their provider, with reimbursements following the patient to that provider. In most circumstances, qualifying private providers are allowed to participate in the program and receive reimbursements.

None of the constraints to financing reform will be easily overcome. Even the handful of countries that are far down the road of

**Box 2.2 National health insurance in Ghana**

In 2003 the Government of Ghana passed a Health Insurance Act that aims to reduce out-of-pocket expenditures and ultimately achieve widespread financial and physical access to quality health services. The reform was tailored to the Ghanaian context, institutionalizing what were existing informal forms of pooling and financing in the system.

The reform leveraged a network of community-based health insurance schemes that were reaching some of the most difficult-to-reach rural informal sectors. The Act endorsed and further mandated the establishment of mutual health organizations (MHOs) in every district in Ghana. The scheme is executed through these MHOs, currently present in 145 districts across the country. The MHOs manage most insurance administration, from enrollment and premium collection (if necessary) to claims processing and reimbursement.

The scheme pools multiple sources of financing, including tax-generated funding (a new consumption tax), payroll contributions from formal sector populations, and private premiums paid directly to the MHOs by some informal sector populations. Insurance is fully subsidized for pregnant women, children, the elderly, and those deemed too poor to contribute. All beneficiaries are entitled to a generous range of services and commodities. Services are provided through a network of public and private providers.

While the insurance system faces significant challenges, including ensuring efficiency in insurance administration and fiscal stability, Ghana has made noteworthy strides in just a few years. It is one of the only low income nations that has been able to achieve significant levels of coverage through public health insurance. As of March 2009, roughly 55% of the population, were enrolled in the scheme. Anecdotal health service evidence suggests that since the scheme's introduction, use has increased, especially among target populations such as pregnant women, and financial protection has improved.

**Source:** Personal communication with Ghana National Health Insurance Authority during March 2009.

implementation face major challenges. But it may be important for governments and their development partners to press on. Patients in most low income countries continue to pay a significant portion of healthcare costs out-of-pocket, and governments have little ability to exercise any stewardship over this large portion of total health spending. In the near term public health spending is unlikely to increase enough to displace private spending. Most African countries have not met their Abuja targets,[88,89] and even if they did, few would have enough government revenues to cover a comprehensive package of services.[90] This suggests that governments may need to implement mechanisms, such as risk-pooling, that better harness private expenditures in pursuit of national health goals, while minimizing the negative effects of out-of-pocket spending.

## Limited purchasing

In developing countries strategic purchasing mechanisms can potentially be used with private providers to improve quality of care, promote effective health interventions, and increase incentives for serving the poor.[91] Purchasing can also complement command and control regulatory activities by offering incentives for providers to support national health system goals.[92]

The more common purchasing approach in the developing world has been contracting out key services, such as primary care in rural districts, to a small number of designated providers—frequently international NGOs (as in Cambodia, Afghanistan, and Guatemala, and now planned for Liberia).[93] Some studies have found that this type of contracting increases access to services in remote areas and improves quality, especially in weak states.[94]

Other studies have questioned the efficiency of these arrangements, as well as their possible negative impact on government capacity.[95]

*Key constraints to purchasing reforms.* This report does not emphasize the contracting out model because it is not primarily designed to help governments exercise better stewardship over large existing private markets for care. Instead, the report raises the question: Can strategic purchasing be a successful vehicle to engage with the many small and individual private providers who make up the bulk of the private sector in developing countries and to improve the relevance and quality of their services?[96]

While the answer may be yes in theory, strategic purchasing remains relatively underused. Governments tend to focus on service delivery by public providers, where financial and administrative resources have historically been concentrated. Pools of funding that could be used for purchasing are rare (as discussed under risk-pooling). To engage in purchasing from nonstate providers, most governments would have to shift resources away from direct state provision of services. This is politically challenging and may not be in line with health sector strategic plans.

In addition, donor aid has traditionally focused largely on government infrastructure, though more recently some donor efforts have supported purchasing from the private sector for specific disease interventions (TB-DOTs, bednets, anti-malarials). Some of these programs have successfully delivered key interventions, but are not conceived as broad purchasing mechanisms to influence quality, cost, and access for a wide range of preventive and curative care.

Another barrier may be the fact that in many countries there is very little existing collaboration between the two sectors to lay the groundwork for a purchasing relationship.

All three of the constraints discussed under regulation apply to purchasing, as well. The absence of information about private providers—who they are, what patients they serve, and what services they provide—limits the ability to engage in purchasing from them. Administrative capacity constraints also pose a challenge. The design of monitoring mechanisms, network arrangements, and payment policies is quite complex—even for developed countries. And implementing even well designed policies can be difficult. In addition, governance and political issues are also a concern in purchasing models, which can be subject to bribery and siphoning of funds.

**The absence of information about private providers limits the ability to engage in purchasing from them**

*Examples of purchasing reforms.* Despite the challenges, some low and middle income countries have begun to implement strategic purchasing mechanisms. Two innovative models have been launched in different states in India. Andhra Pradesh has implemented Aarogyasri, a state-funded health coverage scheme that contracts with numerous private and public hospitals to provide 942 specified inpatient surgical procedures to below-the-poverty-line citizens, who receive this coverage for free. Those who qualify for the program can choose from hundreds of hospitals, and Aarogyasri reimburses the facilities at negotiated rates (box 2.3; see also Mallipeddi, Pernefeldt, and Bergkvist 2008, technical partner paper 7).[97]

In another type of purchasing reform, the state of Gujarat now provides vouchers for deliveries for poor women, which can be redeemed from a large network of private providers (box 2.4).[98]

These programs have implemented initial building blocks of strategic purchasing, including subsidies for the poor, quality standards, and competition among providers. Going forward, there may be an opportunity to build even more sophisticated strategic purchasing mechanisms, including increased quality monitoring and pay-for-performance, onto these platforms. For example, Rwanda is a leader in performance-incentive programs that

**Box 2.3 Health coverage for inpatient services in Andhra Pradesh, India**

The Aarogyasri community health insurance scheme has been formulated by the government of Andhra Pradesh to bring quality medical care within the reach of the poor. Through Aarogyasri, the state provides insurance for the treatment of serious ailments that require hospitalization and surgical intervention, such as cancer, kidney failure, heart and neurosurgical diseases. Care is provided through a network of public and private providers. The cost of insurance for the below-the-poverty line population is fully subsidized by the state through federal funds.

The Aarogyasri Health Care Trust administers the program through several key partners: networks of providers, communities of the insured, commercial insurers, and Aarogyasri Trust.

*Network of providers.* Aarogyasri leverages public and private healthcare providers to offer a broad range of high-quality services to its beneficiaries. Most of the hospitals in the network are private (267 of 365 hospitals). There are strict protocols on treatment, involving around 942 medical and surgical packages, with costs fixed by the Trust's panel of doctors. Network eligibility requirements are somewhat stringent, but additional patient volumes (and thus additional revenues) are an attractive proposition for public and private hospitals to improve operating procedures in line with the eligibility requirements for Aarogyasri. In-network providers are also required to undertake a specified number of village health camps (at least four in a week at places identified by the Trust) to maintain their network status.

At the 24-hour health helpline, 100 doctors and 1,600 paramedics handle 53,000 calls a day.

*Communities of the insured.* Aarogyasri hires Aarogya Mitras as intermediaries to oversee each in-network hospital and serve as representatives of the insured to help them navigate the system, receive quality care, prevent fraud, and conduct reviews and evaluations of service provision. To ensure performance efficiency and acceptability among local communities, Aarogya Mithras are selected by the stakeholders of the state government's rural poverty program or the Self Help Group movement from the local area of each hospital.

*Commercial insurer.* Aarogyasri competitively bid out the back office insurance administration of its scheme, with Star Health and Allied Insurance Company winning the contract for the first round of roll-outs. Star Health and Allied conducts all claims processing, reimbursements, network building and maintenance, and pricing.

*Aarogyasri Trust.* Comprising representatives from various government agencies, the Trust serves as the governing body for the program and oversees the insurance company's management of network providers and the claims processing mechanism.

With the help of these various partners, Aarogyasri has implemented several information management and fraud prevention mechanisms rarely seen in low and middle income countries. It has a proprietary information system that monitors real-time case information flows, with each case preauthorized with the help of identified indicators and diagnostic test results. The claims are also processed online by the insurer and double-checked by Trust doctors. All provider reimbursements are made online. Aarogyasri also has a sophisticated retinal laser scan mechanism for validating the identity of members. This provides safeguards against free-riders who attempt to pass themselves off as subscribers or family members of a subscriber, say by presenting the membership card of a subscriber. The membership card together with the retinal laser scan provide subscribers with direct access to Aarogyasri assistance counters at the network hospital for examinations and treatment.

So far, network hospitals under the scheme have conducted more than 8,300 health camps in rural areas, providing checkups to more than 1.6 million people and free surgeries or treatment to more than 200,000 people.

**Source:** Babu, A. Indian Administrative Service, Chief Executive Officer, Aarogyasri Health Care Trust, Government of Andhra Pradesh; http://www.aarogyasri.org/ASRI/index.jsp; and http://www.aponline.gov.in/apportal/HomePageLinks/aarogyasri.html.

**Box 2.4 Vouchers for deliveries in Gujarat, India**

The government of the state of Gujarat, in India, introduced a voucher scheme for institutional deliveries, Chiranjeevi Yojana, in 2005. The objective is to improve institutional delivery rates by filling gaps in public maternity services by tapping into a vast network of private providers. The vouchers encourage expectant low income mothers in remote areas (where absenteeism in the public sector is high and accessing private providers often financially prohibitive) to seek maternal care by offering them free delivery at any in-network private provider. The vouchers also provide an incentive for private medical practitioners to provide maternity services to the poorest.

Chiranjeevi Yojana was rolled out as a pilot in four districts and had 170 private obstetricians (of 200) enroll in the scheme. Eligible doctors display a board outside their hospital stating: "This hospital is supported by the district reproductive and child health society, for providing free delivery and emergency obstetric care to Below Poverty Line families." These doctors provide free obstetric services for below-poverty-line women, following protocols developed by the government in consultation with the Federation of Obstetrics and Gynecological Societies of India.

Doctors are reimbursed by the government for every 100 deliveries (rather than per delivery) and the amount of reimbursement is fixed, with normal and complicated cases reimbursed at the same rate. The measures counter any incentive to perform unnecessary or higher cost procedures.

Given the success of the scheme in the four pilot districts, it was scaled statewide and now covers all districts, including nearly 850 private obstetricians. The institutional delivery rate rose from about 55% before the voucher scheme was initiated to 76% today.

**Source:** Bhat and others 2006.

target provider behavior,[99] where hospitals with incentives achieved higher-quality scores than hospitals without incentives.[100] The Rwanda program could serve as a model for the types of incentives that could be implemented in other purchasing models.[101]

## Systemic barriers to stewardship in mixed health systems

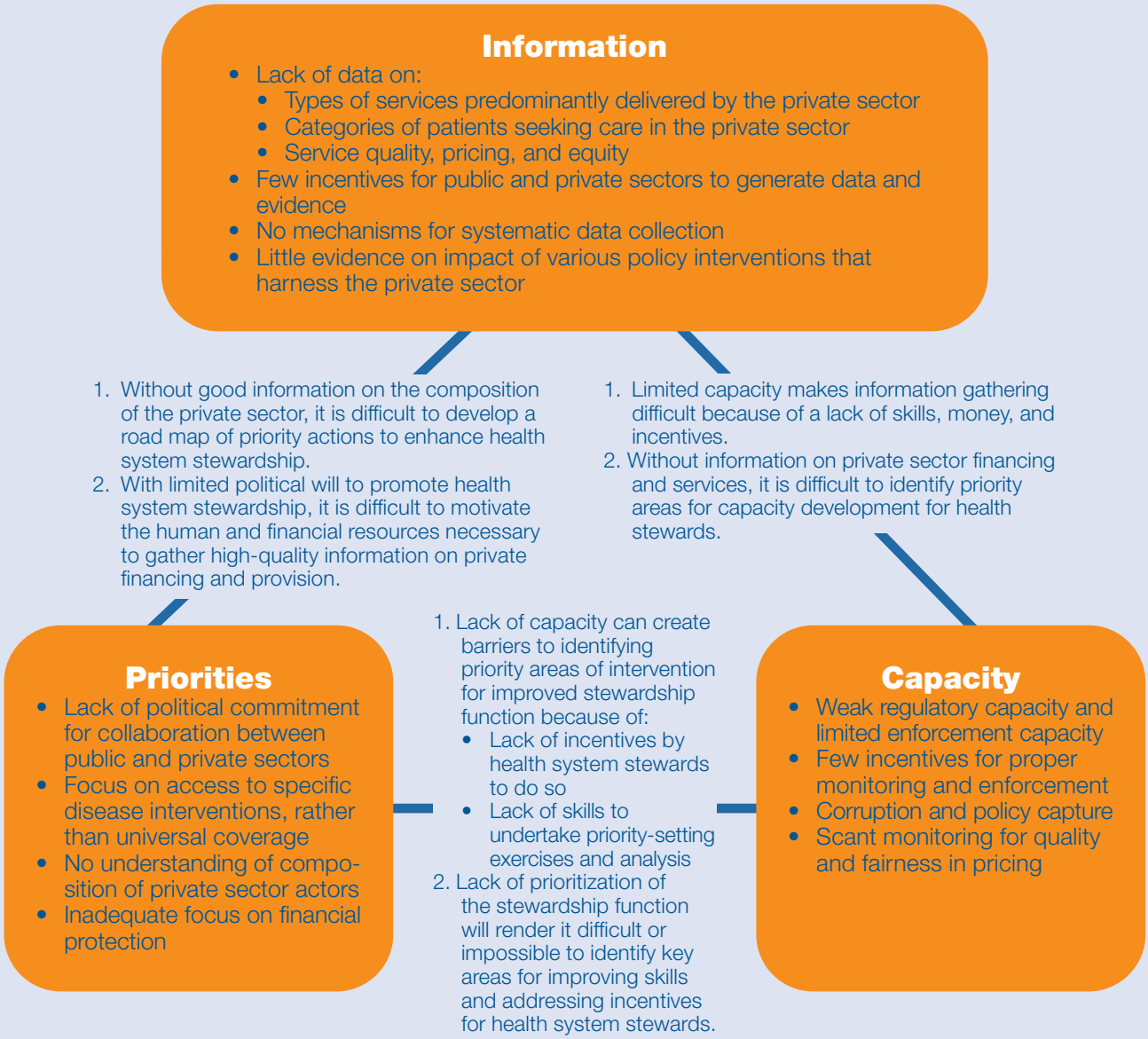
All countries with health markets face some barriers to implementing financing, purchasing, and regulatory mechanisms. But the issues are most pronounced in low income countries, with weak institutional capacity to manage market health systems. While there are several possible reasons that effective mixed health system stewardship models have not developed, three key explanations are a dearth of necessary information, a lack of government capacity for stewardship functions, and a failure to set a high priority for the stewardship of whole health systems.

The three barriers are interrelated, so that attempts to address one barrier can help to address the others. For example, without good information on the composition of the private sector, it is difficult to develop a commitment to priority actions that enhance health system stewardship. And limited capacity makes systematic information gathering difficult because of lack of skills, money, and incentives to gather basic data on private sector financing and services (figure 2.7).

### Lack of data and information on health markets

Few governments systemically collect information on private providers, services delivered, pricing, or quality, and huge gaps remain in understanding the landscape of national health markets. Nor is there much evidence on some potentially successful models of private healthcare delivery and financing around the developing world, cropping up in even the poorest settings. While the models seem promising, data

Figure 2.7 **Barriers to health system stewardship and their interrelationships**




on their sustainability and impact are seldom available. If the value of these models for engaging the private sector is not demonstrated, it is possible that ineffective programs will proliferate or effective programs will fail to scale up.

The question remains: Why are the data not being collected? First, there are few incentives or mechanisms to collect data on the private sector in health. The public sector, focused on its own services, has little reason to collect information on nonstate actors. In some countries, governments do not even have the legal framework to mandate data submission from private providers. And private providers, focused on running a business or organization, have few incentives to provide information or conduct impact evaluations unless requested by government or donors. As a result, information

systems are not sufficiently developed—nor are processes that capture private sector data (numbers of providers, locations, service offerings, types of patients served, volumes of services, pricing, training, quality).[102]

This lack of data on the private sector encourages stakeholders to fall back on existing attitudes about the roles of the public and private sectors in health systems—attitudes that, in the absence of additional evidence, are difficult to change. Without a method to assess the level, type, pricing, and quality of private activity, governments cannot know how to steward health systems, structure reforms, and manage pricing and quality.

## Lack of government capacity for stewardship functions

The stewardship functions of risk-pooling, purchasing, and regulation are challenging to implement. Even in high income countries, where these functions are fairly well managed, policymakers and government administrators constantly seek to improve them.

Stewardship of the nonstate sector involves activities that may be outside the traditional scope of ministries of health, which tend to focus on the direct service activities of government hospitals and health centers (such as hiring and paying practitioners, procuring drugs, and maintaining infrastructure) and on delivering such public health interventions as immunization. The financial and analytical skills required to run an insurance program and develop sophisticated purchasing are typically not robust in health ministries. And while the skills required for regulating private providers may be more similar to direct delivery of services, they still require quite different mindsets and work processes. Meanwhile, in tight government health budgets, clinical salaries and supplies crowd out funding for the regulation of private providers.

A lack of transparency also presents challenges for implementing risk-pooling, purchasing, and regulatory models. Harmful incentives exist in many government delivery systems, often manifest in informal payments to providers, absenteeism, leakages of supplies, and kickbacks from suppliers to government officials. Similar incentives can make risk-pooling, purchasing, and regulation difficult. Large pools of insurance funding can be raided. Purchasing programs intended to improve quality can instead enrich government officials with kickbacks. And regulatory regimes are susceptible to extortion and bribery.[103]

Given these challenging capacity constraints, why should developing countries focus at all on stewardship of the nonstate sector? Given the large size of health markets in some countries and the potential for both medical and financial harm to patients, as well as the possible opportunity to harness private providers to achieve health system goals, it may be imperative to develop the capacity to implement these functions.

**Stewardship involves activities that may be outside the traditional scope of ministries of health**

## Failure to set a high priority for the stewardship of whole health systems

At a most basic level, stewardship of whole health systems (both public and private) may not be viewed as a priority either by national governments or by the donors and technical institutions that influence their priorities. The most commonly cited barrier to public-private collaboration was "absence of political commitment to collaboration" (36% of respondents). But why has this been the case? Lack of evidence on the existence and impact of the private sector and the complexity of private sector activity and transactions, among other systematic problems, make it challenging for governments to set a high priority for private sector-related issues in public policy and financing.

In addition, ministries of health often focus (for very good reasons of cost-effectiveness) on delivering proven health interventions for priority diseases and populations. And donor and national policy priorities and funding line

up within these priorities in disease silos. This limits both the focus on and funding of stewarding complex health markets, which provide a vast array of services (above and beyond prevention and treatment for priority diseases) to all populations (not just priority populations). Attempts to focus resources may have the unintended consequence of de-emphasizing the government's role as steward of the whole system.

In addition, many ministries of health pursue the goal of health status over other health system goals—financial protection or patient satisfaction.[104] This leads them to focus, understandably, on how to deliver a limited number of the most cost-effective health interventions to specific populations. They may be less focused on health interventions that do not make this short list but that many individuals may seek, often in the private market, especially if they are less available in the public sector. Although vertical disease-specific approaches remain crucial to achieving the Millennium Development Goals, global and national health policymakers have recently begun to refocus on horizontal health system issues. The recent attention to system issues could provide an opportunity to sharpen the focus on stewardship of whole health systems, especially the nonstate providers in those systems.

# 3. Ideas for accelerating progress toward better stewardship of mixed health systems

Mixed health systems are a reality, with large health markets in many countries. These health markets are complex, and they present significant challenges in quality and financial protection, as well as opportunities to leverage private providers to support national health goals. Stewardship mechanisms—such as regulation, risk-pooling, and purchasing—can help governments mitigate these challenges and harness opportunities. These mechanisms have been successfully used by many high income countries and a growing number of middle income countries. But governments in low income countries face significant constraints, which impede implementing such mechanisms. The constraints include lack of information, weak capacity, and failing to set a high priority for the stewardship of whole health systems.

Recognizing that there are no easy or obvious answers and that there is a legitimate debate about the role of the private sector within health systems, the following ideas—offered with much humility—attempt to address the three major barriers of lack of information, lack of capacity, and lack of priority (table 3.1). It is hoped that these three sets of ideas, ordered from least difficult to implement to most difficult, will be considered by developing country policymakers, donors, technical agencies, and other stakeholders. But just as desirable would be for these initial ideas to spur additional rigorous and creative research by many other global health thinkers and implementers—and to lead to more ideas for addressing the challenges and capitalizing on the opportunities.

## Invest in information about health markets

The lack of key information about health markets is one major barrier to improving the stewardship of mixed health systems. More systematic information about health markets is a key first step in any reform. Collecting and disseminating useful information, while certainly not trivial or inexpensive, may be the easiest way to start addressing the challenges laid out in this report. It does not require significant political will or major expansions of capacity. For better or worse, it can also be driven by international stakeholders, though the leadership and support of country governments is desirable.

**Collecting and disseminating useful information may be the easiest way to start addressing the challenges**

Data about private markets are crucial for national health stewards who seek to regulate key aspects of care such as quality and price, to promote effective health interventions across the entire system, and to ensure access for all populations. For example, the following information would be useful:

- Who is providing care (public providers, private providers, formal providers, informal providers)?
- What type of care (family planning, HIV/AIDS care, basic primary and chronic conditions care, drug dispensing) is being provided to what type of patients (rich or poor; urban or rural)?
- Why do patients use the private sector or the public sector?
- For what services do patients use the private sector?
- How do patients get information on their potential service options?
- How much do patients pay for various services?
- What is the geographic distribution of services by public and private sector?
- How large is the informal sector? What kinds of providers make up the informal sector (traditional healers, untrained providers of allopathic medicine, trained providers of allopathic medicine without official licenses)?
- What is the quality of services delivered in the public and private sectors, both technically and as perceived by patients?

Table 3.1 **Ideas for accelerating progress toward better stewardship of mixed health systems**

| Challenge | Idea |
|---|---|
| Lack of data | Invest in information about health markets |
| Lack of government capacity | Support innovative models that can serve as "stepping stones" to broader reforms |
| Lack of stewardship as a priority | Develop a "roadmap" for mixed health system stewardship |

Countries (and their development partners) should build mechanisms and incentives for the ongoing collection of health market data to develop sound stewardship policies. Unfortunately, few incentives compel the collection of this type of data at the country level. Ideally, the data collected should be useful for policymaking and practical implementation at the country level—not primarily for the use of international development partners interested in assessing the results of their efforts. But given the global focus on measurement and results, it would be ideal to attempt to harmonize the data elements collected, as well as indicators of success, so that they can also be used for monitoring and comparison across countries.

### Suggestions for moving forward

Collecting health market information is an area where donors and technical agencies could make a difference in the short to medium term. Donors could provide resources for collecting basic data on health markets. And technical agencies such as the WHO could encourage countries to make collecting and using this information a priority. Ideally, countries would exercise leadership in collecting it (or at least welcome and use data collected by third parties). While information collection can

be expensive and time-intensive, it does not require major political fights or expansions in government capacity. So, it may be the easiest of the three recommendations to implement.

Researchers and analysts could develop, with country officials, a set of priority health market indicators that should be collected on an ongoing basis by every country and be comparable across countries. Collection methods could include:

- *Provider mapping*—to develop a complete picture on who is providing care, where they are located, what services they offer, and what levels of training they have.
- *Household surveys*—to determine the use of key services and where those services are obtained.
- *Patient exit surveys*—to determine the socioeconomic status of users of various types of services, the price of services, and the perceived quality.
- *Qualitative interviews or focus groups*—to identify the big challenges faced by both providers and patients and better understand reasons for patient use of particular providers.
- *Direct submission of operational data by providers*—to track volumes and types of services provided, disease surveillance data, quality data, and the like.

While it would be prohibitively expensive to collect comprehensive data in every location, helpful information could be obtained at a lower cost by identifying "sentinel sites" in some countries, where data would be collected periodically (such as every two years) and then compared over time and across geographies to identify trends and issues.

Activities in progress include developing a set of indicators on the private health sector across all African countries (World Bank Group) and detailed mapping of the private health sectors in several African countries (World Bank Group, French Development Agency, and USAID). These activities can serve as a valuable starting point, but they do not yet encompass the full set of ongoing information that policymakers will need to feed country-level stewardship activities.

## Support innovative models that can serve as "stepping stones" to broader reforms

In the absence of near-term government capacity for broad stewardship of health markets, governments and private entities can foster models that harness private markets and address their failures by reducing provider fragmentation, creating incentives for quality, providing subsidies for targeted populations and high impact interventions, and using technologies that expand access and improve quality. These models—such as professional associations, provider networks, franchises, vouchers, community-based health insurance, social marketing, and telemedicine—are not necessarily systemic solutions. However, in situations of limited government capacity, they may achieve some of the benefits of government-led regulation, risk-pooling, and purchasing, while producing faster near-term outcomes even if for narrower populations. They may also serve as stepping stones and stimulants for comprehensive government-led reform, as well as long-term components of a comprehensive health system.

**Governments and private entities can foster models that harness private markets and address their failures**

Many of these models have been described by previous efforts.[105] And as a part of the work of the broader Rockefeller study several technical partners described additional models.[106] Their goal was to identify specific private sector programs that have the potential to influence the performance of broader health systems (rather than just targeting a particular disease). A companion report, *Innovative Pro-Poor Healthcare Financing and Delivery Models* (Dimovska and others 2008), outlines 33 specific innovative private sector programs.

Many of the models, implemented by private organizations with assistance from donor

agencies, build on existing structures, attempting to improve them rather than replace them. They may be feasible where there is weak government capacity,[107] little transparency, and low priority on existing private markets—or where government reforms are still in progress and longer term. But ideally, they should be driven by or strongly supported by governments.

Such models could make health markets more effective and equitable in five ways:

**Many models build on existing structures, attempting to improve them rather than replace them**

- *Reduce fragmentation.* Interventions that reduce provider fragmentation include franchising, professional associations, provider networks, and integrated models (such as chains of drug stores or health clinics). These models can make it easier to monitor quality, provide oversight, support greater coordination and continuity across providers (improving quality and efficiency), and facilitate government regulation. Consolidated groups of providers are easier and less costly to monitor than highly fragmented providers.
- *Change provider incentives and increase monitoring.* Interventions that change the incentives of private providers or monitor their quality include: network (HMO) models, accreditation or licensing through professional associations or other independent entities, franchises, and any public or private demand-side financing payment mechanisms (insurance, vouchers) when coupled with purchasing mechanisms to improve quality. When successfully implemented, these models can give providers incentive to focus on higher impact services and higher quality care—and not on providing large quantities of low quality products and services.

  Providers may be motivated to join a quality-monitored network and meet its standards because it can drive demand for their services. In addition, membership in an exclusive network can give them access to valuable cross-referrals, as well as opportunities for knowledge sharing with a trusted group of other providers. These types of networks can be self-imposed by doctors through professional associations or created through franchises where the franchisor establishes certain standards and takes responsibility for monitoring franchisees, or developed through wholly owned integrated delivery models.[108]
- *Provide subsidies for targeted populations and high-impact interventions.* Models that provide subsidies for specific interventions or populations, such as subsidized public and private insurance and vouchers, can increase both demand and supply for effective interventions. Such subsidies can encourage high quality providers to serve lower income markets that they might not be able to serve in the absence of subsidies. This has the potential to improve access to important interventions for key services, while improving equity by giving the poor access to providers who may previously have been accessible only to the rich.
- *Educate and incentivize patients to demand the most beneficial services.* Models that increase patient demand for effective care include social marketing, conditional cash transfer programs, leveraging rural cooperatives and other existing communities, and trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations). These models may increase the supply of high quality services by private providers and reduce inappropriate provider behavior.[109]
- *Use technologies that expand access and improve quality.* Technological innovations such as medical advice call

centers, telemedicine, mobile diagnostic devices, and healthcare kiosks, many pioneered by private social entrepreneurs, can provide higher quality and more consistent care to hard-to-reach populations, while increasing efficiency. Electronic health records and databases can improve the quality of treatment and reporting, and create improved means to systematically measure provider performance.

If each of these models were more widespread, health markets would be more effective and equitable (table 3.2). Some of these models can also be viewed as initial steps in a sequence of intermediate moves toward more comprehensive government-led reform, as well as long-term components of a comprehensive health system.

Note that low income countries, given their capacity constraints and other characteristics, may follow somewhat different paths toward health system stewardship than the advanced market economies. In fact, they may be able to develop effective new models or institutional innovations when barriers preclude the use of traditional high income country stewardship mechanisms, such as government-led regulation.[110] It is possible that these models may be more effective in some settings than the traditional government-led stewardship mechanisms, especially in the near term.

**Low income countries may follow different paths to stewardship than advanced market economies**

## Examples of innovative models

Most of these models are already being piloted in many countries, with support from key donors, such as USAID, DFID, and KFW. In a handful of cases programs have been scaled

**Table 3.2 Innovative models to make health markets more effective and equitable**

| Goal | Potential benefits | Examples of models |
|---|---|---|
| Reduce fragmentation of providers | • Increase transparency, reduce informality, and create visibility and legality<br>• Make it easier and less costly to regulate (reduce both cost and potential principal-agent problems)<br>• Reduce transaction costs/information costs<br>• Increase oversight | • Franchises<br>• Provider networks<br>• Integrated models (pharmacy or clinic chains)<br>• Professional associations |
| Change provider incentives and increase monitoring | • Align provider incentives with patient need for quality, affordability, and access<br>• Sharpen the focus on quality by making patient volumes and payments contingent on meeting standards<br>• Strengthen the ethics and self-accountability of the private sector (foster ethical behavior, create standards) | • Network (HMO) models<br>• Accreditation or licensing through professional association or other independent entities<br>• Franchises<br>• Pay-for-performance mechanisms<br>• Any public or private demand-side financing mechanism (insurance, vouchers), when coupled with purchasing mechanisms designed to improve quality |
| Provide subsidies for target populations and high-impact interventions | • Increase access to higher quality care for the poor, create incentives for private providers to serve the poor<br>• Increase use of high-impact effective interventions | • Insurance<br>• Vouchers |
| Educate patients to demand the most beneficial services and reduce asymmetries of information | • Increase demand for effective interventions, which may in turn increase supply<br>• Reduce asymmetries of information | • Social marketing<br>• Rural cooperatives<br>• Conditional cash transfer programs<br>• Trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations) |
| Use technologies that provide access and improve quality | • Increase efficiency<br>• Improve quality and consistency | • Telemedicine<br>• Call centers<br>• Kiosks<br>• Electronic medical records |

to broader populations. Although it is hard to know how widespread any of the interventions is, because there is no global tracking mechanism, social marketing and social franchises are probably the most common. Both techniques rely on tapping into large networks of healthcare providers to expand coverage and leverage economies of scale. Social marketing uses marketing techniques to achieve widespread behavior change and increase demand and supply for healthcare services and products. Social franchising applies the lessons of commercial franchising[111] to socially beneficial causes, allowing organizations to offer individuals or small businesses the opportunity to join a franchise network and benefit from a set of incentives offered only to franchise members. In exchange, the franchisee must comply with a range of requirements, often including adhering to quality and pricing standards for the provision of a set of services and paying fixed or profit-sharing franchise fees.[112]

**Left on its own, the private sector does not provide an easy solution to improving broad health systems**

For example, Population Services International franchised over 14,000 existing clinics in Pakistan to ensure high quality family planning services, which it monitors with mystery clients and facilitates through ongoing standardized training.[113] Clinics that meet standards receive the PSI-sponsored Greenstar logo, and this branding assures consumers of the clinic's quality. Greenstar has been successful in expanding access and is currently distributing an estimated 30% of all contraceptives in Pakistan. And a recent study showed that Greenstar provider quality was higher than those of nonfranchised providers.[114]

Franchising and social marketing techniques frequently support the delivery of a fairly narrow set of interventions, such as family planning and bednet distribution. But they could be leveraged much more broadly to influence the quality of and demand for a wide range of interventions in health markets. Consider a social franchise that has relationships with thousands of independent medical practitioners to provide them with high quality products, training, and service quality assurance for family planning. It could build on this platform and expand the scope of services more broadly to maternal and child health. But many funding sources are tied to specific disease programs, limiting expansions in scope.

Private financing models such as community-based health insurance and voucher programs have also been implemented in many countries. Such programs are typically plagued by inadequate scale and inadequate subsidies, which do not allow for substantial benefits packages or adequate access for the poor. So, many of these programs remain fairly small pilots, due to a lack of funding. But with more funding and government support, these fledgling programs might serve as models or stepping stones for more comprehensive reform, as in the case of Ghana's National Health Insurance (see box 2.2) and the Gujarat maternity voucher scheme (see box 2.4).

Some models, such as strengthening self-regulation through the support of professional associations, have not been piloted significantly, so their possible impact is unknown. And many models that use technologies—such as call centers, telemedicine, and kiosks—are fairly new and yet to be fully evaluated and scaled.

## Private models fall short of broad health system stewardship

While many of the above privately implemented models can improve the functioning of health markets within their service areas, they fall short of broad stewardship because they are usually not geographically widespread and they frequently target more narrow interventions. University of Toronto researchers note that most privately implemented innovative programs are "vertical" (for specific diseases or conditions). They conclude that the private sector, left on its own, does not provide an easy solution to improving broad horizontal health systems.[115]

The finding suggests that it would be unwise to assume that the private sector alone can solve the challenges of complex health markets. Government will ultimately need to play a strong stewardship role. But it is important to acknowledge that many innovative private models have likely achieved social benefits for the poor (if not fully scaled or evaluated). A goal of the health system stewardship model described in this report—including integrated regulation, risk-pooling, and purchasing—is to promote the rational expansion of private sector models, such as those described above, which are designed to achieve positive social impacts, while discouraging models that ignore the poor in favor of the rich.

## Suggestions for moving forward

Governments should make it a point to know what private market innovations are occurring in their countries and consider how these programs can complement existing government services. Ideally, governments should view high impact models that harness and improve the performance of health markets as a part of the health system in the regions where they complement government services. They should consider direct contracts with innovative programs. Implementers of innovative private programs should be invited to participate in health policy discussions. Meanwhile, implementers of innovative models that harness and manage the private sector should be aware of national health strategies and determine how their model will contribute. They should work to form relationships with government and integrate with existing public services.

In the absence of direct government funding, donors should create additional, long-term, sustainable financing mechanisms for privately implemented programs that improve health market functioning. They should revisit the definition of "sustainable" and recognize the need for ongoing subsidies, whether provided by donors or ultimately by governments through purchasing mechanisms. Meanwhile, funding for these models should be more flexible and more focused on strengthening broader health systems and health markets, rather than just on delivering specific interventions. For example, the global health community should consider whether some of the current supply-side subsidies should be converted to demand-side subsidies, through third-party premium supplements for health insurance. Under this type of financing mechanism, funds would follow patients to the providers they choose (within a designated network) rather than be provided directly to providers, such as public hospitals or designated international NGOs. Donors should also consider converting some disease-specific donor funding to supplement health insurance premiums. Financing disease-specific services through a broader pooled financing platform could be a mechanism for vertical programs to facilitate broader health system financing mechanisms that could be leveraged for other diseases and health services, while continuing to finance treatments for priority diseases.

**Governments should consider how market innovations can complement government services**

Meanwhile, program implementers should consider how to better link demand-side financing models (such as insurance and vouchers) with innovative delivery models (such as franchising), to improve incentives and control over performance. Program implementers and policymakers should consider how mechanisms that improve the functioning of health markets can also be used to monitor and incentivize informal as well as formal sector providers.

Donors should consider supporting the systematic cataloguing, documentation, and evaluation of initiatives that incorporate the mechanisms identified here, with the goal of creating a publicly accessible central database with key information (program model, location, numbers served, types of services). This would be useful to policymakers seeking to understand their alternatives, to program implementers looking for on-the-ground partners, to researchers looking to evaluate the

effects of various programs, and to donors and investors looking for programs to support. Such a database, if populated on an ongoing basis through a network of informants around the world, could monitor the growth (or shrinkage) of various models.[116] Once programs are identified, a subset could be chosen for documentation (through detailed case studies that describe the program and rationale for key choices) and impact evaluation along such dimensions as quality, equity, and coverage. Ideally, researchers would agree on consistent methodologies, so that results could be compared across programs.

**Improved stewardship is a long-term aspiration rather than a short-term goal**

Donors should also consider supporting networks of implementers of similar programs, so that common challenges and best practices could be identified and jointly addressed. Networks could jointly undertake operations research on how to make certain programmatic models most successful and then share findings across programs and countries.

## Develop a roadmap for mixed health system stewardship

Improved stewardship of mixed health systems—especially the nonstate sector—is a long-term aspiration rather than a short-term goal. Any reforms are likely to be gradual, stepwise, and subject to political pressures. Given the complexity of reform processes, it is important for ministries of health in countries with large private healthcare markets to develop a clear roadmap for building a strong stewardship model.

Ministries already engage in numerous planning processes, some driven internally and some by donors or donor groups. More attention should be paid, as a part of these planning efforts and policy design processes, to how the health system will ultimately address the challenges and opportunities of health markets. These challenges include how to achieve financial protection given high out-of-pocket payments for numerous services (including those not deemed priority interventions from a public health standpoint) and how to ensure quality when many patients seek care from unmonitored providers on a fee-for-service basis.

Three primary stewardship mechanisms can improve the functioning of health markets by increasing quality, availability, and affordability of healthcare for poor people in developing countries. Regulatory models can improve quality by setting and enforcing standards. Risk-pooling and health insurance have been shown to protect individuals from catastrophic health expenses, increase use of beneficial services, and ultimately improve health status. Provider purchasing and contracting can improve quality and availability of private providers by aligning payment incentives with desired outcomes, while establishing and monitoring quality and efficiency targets. Meanwhile, the privately implemented "stepping stone" interventions—such as professional associations, provider networks, franchises, vouchers, community-based health insurance, social marketing, and telemedicine—can be fostered and integrated into the health system using these stewardship mechanisms.

Some key policy considerations for countries moving toward the stewardship of mixed health systems include the following.

### Regulation

Very few lower income countries have well developed and enforced regulatory structures for health systems, and many experts question whether these countries have the resources to quickly and successfully develop them. Governments need to understand what kind of capacity already exists for building and enforcing regulatory standards and assess what new capacity must be developed. Ideally, they would set priorities for the various regulatory functions and processes and develop a multiyear

plan for funding and implementation that recognizes that not all functions can be built simultaneously.

As governments attempt to move toward better systems, the private sector can also address regulatory challenges through various forms of self-regulation (which governments and donors can encourage). Private providers can organize themselves into networks, establishing quality standards and developing monitoring and evaluation mechanisms to ensure that standards are met. Ministries of health can assist these networks by recognizing and endorsing their standards. For example, in Nigeria the government has endorsed the Total Health Trust network of private doctors and included it in the country's national health insurance plan based on the network's operation against a set of transparent, enforced standards.

Regulation, whether through government or private means, will be a challenge in the short term, especially given the size of the informal sector in many developing countries. Global and local researchers can support government stewardship by conducting practical studies on how to make regulation more successful in various contexts.

## Risk-pooling

While progress in reducing out-of-pocket spending will likely be gradual in most places, developing countries should evaluate alternative roadmaps for achieving universal coverage. Will they embark on government-led social health insurance reforms similar to Colombia, Thailand, or more recently Ghana, perhaps combining community-based health insurance approaches with traditional social health insurance approaches to generate more revenues and pool risk of informal populations? Or will they instead attempt to create a regulatory infrastructure that fosters rational private voluntary insurance (offered by commercial enterprises or more grass-roots micro-insurance organizations) that could ultimately become the platform for universal coverage? Or will they focus primarily on expansion and improvement of public sector delivery, with associated increases in general taxes, as a means to wider coverage?

In the process, ministries of health will have to grapple with the extent to which participation in health coverage programs should be voluntary or mandatory and how to address informal sectors. Ministries must determine whether to generate funds through one of several funding streams (general taxation, employment taxes, community pools) and how donor and private revenues will be incorporated. They will need to consider how to create appropriate cross-subsidy mechanisms across income and risk groups. And the scope of covered benefits will need to reflect the available pooled resources. Politics will likely influence how funds can be raised, what is covered, and how care is organized.

**Developing countries should evaluate alternative roadmaps for achieving universal coverage**

Governments will also need to consider how to manage any complex administrative structures (enrollment and claims processes) and whether administrative capacity should be developed within governments or contracted to private organizations. It will also be important to ensure that any risk-pooling reforms address not only risk-protection but also quality improvements.

## Purchasing

Governments should consider how they can use purchasing strategies to incentivize quality and efficiency of private providers and provide access to traditionally underserved populations. If services are purchased, governments will need to also consider what kinds of providers (non-profit or for-profit) would be included in any purchasing and contracting agreements and what mechanisms they will use to make payments and to monitor quality. Any political implications of purchasing and contracting must also be considered.

## Innovative private models

Ministries of health will need to consider how innovative private models can fit within the broader health system to improve the functioning of health markets, and whether and how to promote these models. For example, can private franchising be leveraged to improve regulatory infrastructures? Should private networks of doctors and facilities function as primary providers of care within national health financing systems? As these new models are tested and replicated by social entrepreneurs and interested donors, governments in developing countries will need to develop policies that clarify their role within larger health systems.

Table 3.3 outlines key policy questions that governments may want to consider as they develop a roadmap for mixed health system stewardship.

## Suggestions for moving forward

Developing a roadmap implies that health system stewards focus as much on the *how* as on the *what*. In addition to identifying desirable policy options, efforts should be made to strengthen a process of reform in which initial success informs and strengthens coalitions, and enables further steps to deepen and broaden these efforts.

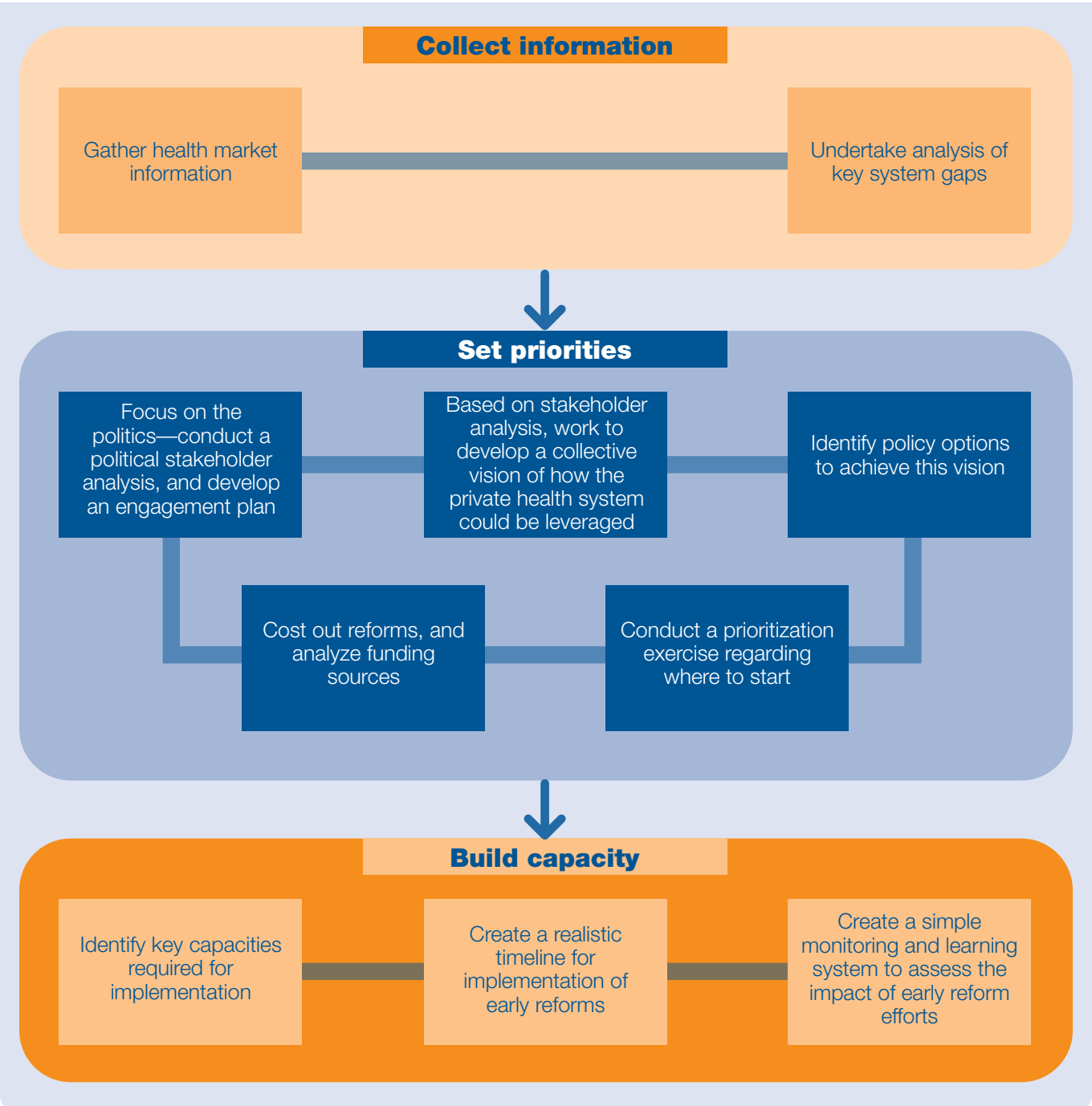
**Developing a roadmap implies that health system stewards focus as much on the *how* as on the *what***

Figure 3.1 outlines generic steps that governments and donors could consider before undertaking a reform process toward better stewardship of the private sector. It is important to view this process as evolutionary, and not revolutionary. Initial steps should focus on gathering the necessary information and completing the key analysis. A second set of steps involves developing a vision of a desired state for the overall health system and priorities for

**Table 3.3 Policy questions to consider in developing a roadmap for mixed health system stewardship**

| Mechanism | Key policy questions |
|---|---|
| Regulation | • What capacity exists for building and enforcing regulatory standards?<br>• What capacity is required for building and maintaining sound health regulations?<br>• To what extent can the private sector be engaged in self-regulation?<br>• What aspects of regulation could be tackled first (such as drug shops, counterfeit drugs)? Is there a vision for what kind of regulatory system to develop and a roadmap for how to get there over time? What is the cost?<br>• What incentive structures can encourage adherence to regulations (both government regulation and self-regulation)?<br>• How can regulation address informal providers?<br>• How can risk-pooling and purchasing mechanisms reinforce or strengthen regulation? |
| Risk-pooling | • What populations to target and in what sequence to introduce insurance to various populations (informal or formal, rural or urban)?<br>• How to introduce the concept of risk-pooling?<br>• What to include in benefits package?<br>• What providers to include in service delivery network?<br>• How to price and fund insurance?<br>• How to mitigate insurance risks?<br>• How to manage insurance administration? |
| Purchasing | • What types of services might be purchased or contracted?<br>• What kinds of providers should be included in purchasing agreements?<br>• What are the political implications of purchasing and contracting services? |
| Private models | • What innovative service delivery models already exist in the country? What is their impact? How could they better be harnessed and integrated into the broader health system?<br>• How do innovative service delivery models fit into the broader health system? What innovative service delivery models might the government want to emulate? What innovative service delivery models might the government want to purchase or contract out?<br>• How can new service delivery models be properly incentivized and monitored through regulation (fairness in pricing, quality, and the like)?<br>• How can innovative service delivery models be leveraged to reach the poorest?<br>• What role should the government play in testing new models of service delivery for impact, quality, and fair pricing? |

Figure 3.1 **Core steps in developing a roadmap for mixed health system stewardship**




desired reforms. Finally, the process includes capacity-building. A goal of this stepwise reform should be to avoid overwhelming the institutional and financial capacities of national governments and donors.

The exact policy choices and country reform processes will be determined by the existing context—financing and delivery arrangements, skills and capacities, and political economy (which will determine whether

the political space exists to plan and undertake reforms). There are no normatively correct policy choices or reform processes that every country should undertake. Instead, countries should match their specific endowments and needs to develop a roadmap appropriate for their purposes, with a focus on learning and feedback, and perhaps less stress on putting together a technically perfect set of policies. Decisions about initial entry points should be based on data and evidence, which should open possibilities for experimentation in a variety of areas. This experimentation should add to the evidence base. It should identify key capacity constraints and opportunities that need to be taken into account when promoting further reforms. And it should promote a more robust debate about ways to promote better functioning health systems.

**There is a need to focus pragmatically on how health markets can contribute to health system goals**

While governments must drive the development and implementation of roadmaps to stewardship, donors and technical partners can support them by:

- Recognizing the need to make progress in the stewardship of health markets that are used for many services beyond priority diseases and increasingly address chronic conditions.
- Developing the capacity to provide guidance for countries in how to manage their health markets.
- Strengthening planning processes in donor-driven health systems, considering the role of health markets by collecting and using data about where different populations seek care.
- Providing financial support for stewardship functions, such as collecting market information and building regulatory capacity.

Reform will evolve differently in each contextual setting. The menu of potential stewardship policy options outlined in table 3.3, combined with the generic "process" steps outlined in figure 3.1, offers national governments options to best achieve their objectives, while taking into account country-specific conditions. Viewed in this light, policy and practice reform is not an all-or-nothing proposition. Each country could consider building off of its specific endowments, while taking account of its particular challenges, to develop a stepwise reform process predicated on the idea that initial successes will improve conditions for future reforms.

## In conclusion

The debate around the ideal composition of health systems in the developing world, and the role of the public and private sectors in those systems, is legitimate and ongoing. Meanwhile, the negative effects of unregulated health markets persist and opportunities lie dormant. Given the size and scope of health markets in many countries, the unlikelihood that these markets will go away, and their potential for both harm and good, governments should consider how they can become better stewards of these markets—both addressing their limitations and attempting to harness them to support health system goals.

Above all, there is a need to focus pragmatically on how to ensure that health markets are contributing to the achievement of key health goals, such as the Millennium Development Goals, and financial protection goals such as universal coverage.[117] Aspects of health markets that contribute to key goals should be nurtured, and those that detract should be mitigated through regulation. Each context is different, with countries falling along a continuum of public and private participation in health systems. Those with large private healthcare markets are likely to need the most attention in addressing the complex problems of mixed health systems.

# Notes

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1. The term "mixed health system" was first described by Sania Nishtar in *Politics of health systems: WHO's new frontier* (Nishtar 2007a). Nishtar defines mixed health systems as a health system in which out-of-pocket payments and market provision of services predominates as a means of financing and providing services in an environment where publicly financed government health delivery coexists with privately financed market delivery.
2. *Private sector* and *nonstate sector* are used interchangeably to mean all nongovernment actors, including individuals and organizations engaging in non-profit or for-profit work.
3. Bennett, Kadama, and Hanson 2005; Harding and Preker 2003; Bloom and Standing 2002; Hanson and Berman 1998; ICF 2008; Mills and others 2002a,b; Nishtar 2007; Bustreo, Harding, and Axelsson 2003; Palmer and others 2003; Smith, Brugha, and Zwi 2001; DeCosta and Diwan 2007; Roberts and others 2008; Axelsson, Bustreo, and Harding 2003; Preker and Harding 2001; DFID Health Systems Resource Centre 2002.
4. Montagu 2002; Hanson 2004; Marek and others 2005; Berg 2000, 2005; Ruster, Yamamoto, and Rogo 2003; Brown and Chruchill 1999, 2000; Prata, Montagu, and Jefferys 2005; Huntington, Sulzbach, and O'Hanlon 2007; Brugha and Zwi 1998; Preker, Harding, and Travis 2000; Loevinsohn 2002; England 2004; Preker and Dror 2002; Bishai and others 2008; Bloom and Standing 2008; Batley 2006; Bennet and others 2005; Bustreo, Hardin, and Axelsson 2003; Mills and others 2002b; Patouillard and others 2007; USAID India 2006; WHO and USAID 2007; Marek and others 2005; Harding and Preker 2003; Berg 2005; Preker 2002; WHO 2006. See CGAP Working Group on Microinsurance (http://www.microfinancegateway.org/resource_centers/insurance/about), PSP-One (http://www.psp-one.com/section/psp_one_publications/), HLSP Institute (http://www.hlsp.org/hlspinstitute/), and Private Sector Program of the Karolinska Institute (http://www.psp.ki.se/).
5. Stephenson and others 2004; Armand and others 2007; Mongatu and others 2005; Brugha 2003; Thiede, Palmer, and Mbatsha 2004; Loevinsohn 2006; Hanson 2004; Lönnroth and others 2007. And see PSP-One at http://www.psp-one.com/section/psp_one_publications/; The Global Fund at http://www.gbcimpact.org/about-gbc/global-fund-private-sector-delegation; and PEPFAR at http://www.pepfar.gov/ppp/index.htm.
6. Hanson and others 2008; Mills, Bennet, and McPake 1997.
7. IFC 2007.
8. Oxfam International 2009.
9. World Bank n.d.; Montague and others 2009; Hanson and others 2008; Harding 2009.
10. WHO 2000.
11. WHO 2000.
12. Harding and Preker 2003; Hanson and Berman 1998; IFC 2007; Axelsson, Bustreo,

and Harding 2003; DeCosta and Diwan 2007; and others.

13. For example, in Sub-Saharan Africa, the majority of malaria episodes were initially treated by private providers (McCombie 1996). More than 50% of children who had diarrhea in Nepal and 90% in India (Kafle and others 1992) sought care outside the public sector. In Vietnam the private sector provided about 60% of all outpatient visits (Rohde 1997). A large proportion of children affected by diarrhea and acute respiratory tract infections in Egypt (Waters, Hatt, and Axelson 2002), Bolivia, Guatemala, and Paraguay (Ha, Berman, and Larsen 2002) received care from various types of private providers.
14. DeCosta and Diwan 2007.
15. WHO National Health Accounts.
16. Koivusalo and Mackintosh 2004.
17. Oxfam International 2009. Oxfam Data sourced from Marek and others 2005.
18. Oxfam International 2009; Bloom and Standing 2002; Hanson and Berman 1998; Mills and others 2002b; Roberts and others 2004.
19. Sector classifications are based on self-reported descriptions of the provider seen by the survey respondent. For child diarrhea and fever/cough, public sector includes government hospital, government health center/health post, government clinic, community health worker, and other public facility. Formal private sector includes private hospital/clinic, private pharmacy, private doctor, private mobile clinic, private health worker, and other private facility. And informal private sector includes shop, traditional healer, drug peddler/vendor, and others.

    The algorithm for determining health sector for each respondent was as follows. A patient who visited at least one public sector provider was defined as "public." A patient who never visited the public sector but at least one formal private provider was classified as "formal private." A patient who never visited the public sector or the formal private sector but who visited an informal provider was classified as "informal." This hierarchical typology biases the results in favor of the public sector share and against the informal sector and formal private sector share. As a consequence, the informal sector figure tends to be a lower bound (or underestimate) of the informal care choice as a fraction of total healthcare; whereas the public sector figure represents an upper bound of access to the public providers.
20. Demographic and Health Survey.
21. Limwattananon 2008, technical partner paper 1.
22. Limwattananon 2008, technical partner paper 1.
23. Limwattananon 2008, technical partner paper 1.
24. Limwattananon 2008, technical partner paper 1.
25. Nishtar 2007a.
26. Ferrinho and others 2004.
27. Hozumi and others 2008, technical partner paper 2.
28. Harding and Preker 2003.
29. Eichler and Levine 2008, technical partner paper 10; Eichler and others 2008.
30. Hozumi and others 2008, technical partner paper 2.
31. Hozumi and others 2008, technical partner paper 2.
32. This report broadly defines the private or nonstate sector to include all nongovernmental providers.
33. See the HRH Global Resource Center (http://www.hrhresourcecenter.org/taxonomy_menu/1/7) and the Capacity Project.
34. Preker and Carrin 2004.
35. Bourke and others 2004.
36. Forsberg 2009; Liu and others 2006.
37. WHO 2008.
38. Market failure is when a market "does not possess the requisite conditions for

reasonably effective competition" (Roberts and others 2004, p. 249).
39. Roberts and others 2008.
40. IFC 2007.
41. The Economist. "Quackdown: the high cost of medicines bought on the cheap." February 21, 2008.
42. Xu and others 2003.
43. Pannarunothai and Mills 1997.
44. Xu and others 2003.
45. Merriam-Webster website.
46. See http://www.euro.who.int/healthsystems/Stewardship/20061004_1.
47. See http://www.who.int/healthsystems/topics/stewardship/en/index.html.
48. Balabanova, Oliveria-Cruz, and Hanson 2008, technical partner paper 8.
49. See http://www.who.int/healthsystems/topics/stewardship/en/index.html.
50. Behavior change, another important mechanism for effective stewardship, is beyond the scope of this paper.
51. Roberts, Hsiao, Berman, and Reich (2004) define health system "control knobs," or health system levers "that can be adjusted by government action" and include financing, payment, organization, regulation, and behavior.
52. Kumaranayake 1998a,b; Kumaranayake and others 2000; Mathauer 2002.
53. Roberts and others 2004.
54. Balabanova, Oliveria-Cruz, and Hanson 2008, technical partner paper 9.
55. Bishai and others 2008.
56. Gottrett and Schieber 2006.
57. Gottrett and Schieber 2006; Dror and Preker 2002; Preker, Scheffler, and Bassett 2007; Preker and Carrin 2004; Gottret, Schieber, and Waters 2008; ILO 2008; Bennett and Gilson 2001; Brown and Churchill 1999.
58. Gottret, Schieber, and Waters 2008.
59. Xu and others 2005.
60. Lagomarsino and Kundra 2009.
61. Gottrett and Schieber 2006.
62. Park and others 2005.
63. Franco and others 2008.
64. Lagomarsino and Kundra 2008, technical partner paper 6.
65. Franco 2008; Ranson 2001; Card and others 2006; Gottret, Schieber, and Waters 2008.
66. Rannan-Eliya 2008.
67. Bennett and Mills 1998; Preker, Harding, and Travis 2000; Loevinsohn and Harding 2005; Pearson 2001; Eichler and De 2008; Eichler and Levine 2008, technical partner paper 10.
68. Eichler and Levine 2008, technical partner paper 10.
69. Asiimwe and Lule 1993; Mujinja, Urassa, and Mnyika 1993; Yesudian 1994; Ensor and Cooper 2003; Matsebula, Goudge, and Gilson 2005.
70. Bennett and others 2005.
71. Tangcharoensathien and others 2008, technical partner paper 8.
72. Hozumi and others 2008, technical partner paper 2.
73. Tangcharoensathien and others 2008, technical partner paper 8.
74. Questionnaires were sent to 64 low income countries and 41 lower middle income countries, with an overall response rate of 30% (15 low income countries and 17 lower middle income countries), including several respondents in each region of the developing world. Researchers identified key informants in each country to complete a self-administered email questionnaire, with iterative loops between researcher and key informants to clean and complete the questionnaire.
75. Hozumi and others 2008, technical partner paper 2.
76. Bennett and others 2005.
77. Bennett and others 2005; Bennett and others 1994; Hongoro and Kumaranayake 2000; Kumaranayake and others 2000.
78. Kumaranayake 1997; Hsiao 1995.
79. Savedoff 2006; Ngalande-Banda and Walt 1995; Soderlund and Tangcharoensathien 2000.

80. Savedoff 2006; Ngalande-Banda and Walt 1995; Soderlund and Tangcharoensathien 2000.
81. Tangcharoensathien and others 2008, technical partner paper 8.
82. Gottret, Schieber, and Waters 2008.
83. Pinto and Hsiao 2007; Baron 2005.
84. Lagomarsino and Kundra 2008, technical partner paper 6.
85. Preker, Scheffler, and Bassett 2007; Dror and Preker 2002; Preker and Carrin 2004.
86. Lagomarsino and Kundra 2008, technical partner paper 6.
87. Premiums are typically collected from working populations. For example, Ghana exempts from premiums all children under age 18, all pregnant women, all those over age 70, and those found unable to pay the premium. These premiums have eliminated user fees at the point of service for enrollees.
88. At a meeting in Abuja in 2001 African countries committed to allocating 15% of their government budgets to the health sector. In 2006 about 7% of government resources in Africa were going to health overall. Only Botswana, Burkina Faso, Liberia, Malawi, and Rwanda have crossed the 15% threshold (Hatt and Flesiher 2009).
89. Hatt and Fleisher 2009.
90. McIntyre, Loewenson, and Govender 2008.
91. England and the HLSP Institute 2008, technical partner paper 11.
92. England and the HLSP Institute 2008, technical partner paper 11.
93. England 2004.
94. Loevinsohn and Harding 2005.
95. Bennett and Mills 1998.
96. England and the HLSP Institute 2008, technical partner paper 11.
97. Bergkvist and Pernefeldt 2008.
98. Note that social health insurance is not a prerequisite for purchasing models, though it can be a key enabler by providing a new pool of funding. A number of programs, including the two Indian programs described in this section, engage in purchasing from private providers with funds generated through general taxation rather than through insurance mechanisms.
99. Eichler and Levine 2008, technical partner paper 10.
100. Schneidman and Rusa 2008.
101. Bhat and others 2006.
102. Balabanova, Oliveira-Cruz, and Hanson 2008, technical partner paper 9.
103. Tangcharoensathien and others 2008, technical partner paper 8.
104. Roberts and others 2004.
105. For example, USAID-funded PSP-One, DKT, World Bank, Karolinska Institut, Harvard School of Public Health, McKinsey & Company, London School of Hygiene and Tropical Medicine, and PATH, among others.
106. University of Toronto, Haseltine Foundation, Institute for Development Studies, Dalberg/MIT-Zaragoza.
107. Capacity-building is a well covered topic, even if no panaceas have yet been identified. A number of categories of interventions are frequently discussed to address root capacity challenges, such as leadership development, technical assistance, civil service reform, anti-corruption/good governance/transparency programs, and many more. While wholeheartedly encouraging interventions to build capacity, summarizing the general literature on these topics is beyond the report's scope. Progress in addressing the underlying constraints, though crucial, is likely to be slow, with a long time horizon.
108. Bishai and others 2008.
109. Bloom and others 2008, technical partner paper 4.
110. Bloom and others 2008, technical partner paper 4.
111. Traditional franchising is characterized by locally-owned outlets which deliver services according to a standardized model (Montagu 2002).

112. Private Healthcare in Developing Countries website: http://www.ps4h.org/social_franchising.html.
113. Dimovska and others 2008.
114. Bishai and others 2008.
115. Bhattacharyya and others 2008, technical partner paper 5.
116. For example, researchers at the University of California, San Francisco have begun to monitor the growth of social health franchises and have found that the model has been adopted quite rapidly in a number of countries over the past decade. This type of cross-country data collection and analysis would be useful for other types of program models, including public regulatory and insurance models.
117. Van der Gaag, Jacques, and Stimac's (2008, technical partner paper 3) findings from analysis of health spending across countries underscore these points. They investigated whether a larger share of government spending "buys" better health or has other measurable beneficial outcomes. While there is some evidence that public spending on healthcare can better target child health, they could not find any evidence that public financing produces different health outcomes from private financing. Neither general health, nor equity in health outcomes change when the public share in financing increases.

# Partner papers and references

## Technical partner papers


1. Limwattananon, Supon. 2008. "Private-public mix in woman and child health in low-income countries: An analysis of demographic and health surveys." International Health Policy Program, Thailand.
2. Hozumi, Dai, Laura Frost, Chutima Suraratdecha, Beth Anne Pratt, Yuksel Sezgin, Laura Reichenbach, and Michael Reich. 2008. "The role of the private sector in health: A landscape analysis of global players' attitudes toward the private sector in health systems and policy levers that influence these attitudes." *PATH* and researchers from the Harvard School of Public Health.
3. van der Gaag, Jacques, and Vid Štimac. 2008. "Toward a new paradigm for health sector development." The Brookings Institution and Amsterdam Institute for International Development.
4. Bloom, Gerald, Claire Champion, Henry Lucas, David Peters, and Hilary Standing. 2008. "Making health markets work for the poor: Improving provider performance." Institute of Development Studies and Future Health Systems Consortium.
5. Bhattacharyya, Onil, Anita McGahan, David Dunne, Peter A. Singer, and Abdallah Daar. 2008. "Innovative health service delivery models for low and middle income countries." University of Toronto.
6. Lagomarsino, Gina, and Sapna Singh Kundra. 2008. "Overcoming the challenges of scaling voluntary risk pools in low-income settings." Results for Development Institute.
7. Mallipeddi, Ravi, Hanna Pernefeldt, and Sofi Bergkvist. 2008. "Andhra Pradesh health sector reform—a narrative case study." ACCESS Health Initiative, Haseltine Foundation for Medical Sciences and Arts.
8. Tangcharoensathien, V., S. Limwattananon, W. Patcharanarumol, C. Vasavid, P. Prakongsai, and S. Pongutta. 2008. "Regulation of health service delivery in private sector: Challenges and opportunities." International Health Policy Program, Thailand.
9. Balabanova, Dina, Valeria Oliveira-Cruz, and Kara Hanson. 2008. "Health sector governance and implications for the private sector." London School of Hygiene and Tropical Medicine, Thai Ministry of Public Health, International Health Policy Program.
10. Eichler, Rena, and Ruth Levine, with contributions from Paul Gertler and Kristiana Raube. 2008. "Performance incentives in provider purchasing and contracting arrangements: Rationale and experiences." Center for Global Development, and the University of California, Berkeley.
11. England, R., and the HLSP Institute. 2008. "Provider purchasing and contracting mechanisms." HLSP Institute.
12. Mudenda, Dale, Christopher Mapoma, Bona Chita, Abson Chompolola, and Webby Wake. 2008. "Provider purchasing and contracting for health services: The case of Zambia." University of Zambia, Brookings Institution, and Results for Development.
13. Dalberg Global Development Advisors and the MIT-Zaragoza International Logistics Program. 2008. "Private sector role in health supply chains: Review of the

role and potential for private sector engagement in developing country health supply chains." MIT-Zaragoza and Dalberg.

## Companion report: Innovative service delivery and financing models

14. Dimovska, Donika, Stephanie Sealy, Sofi Bergkvist, and Hanna Pernefeldt. 2008. *Innovative pro-poor healthcare financing and delivery models. Examples from mixed health systems.* Results for Development Institute.

## References


Armand, Francoise, Barbara O'Hanlon, Mark McEuen, Lena Kolyada, and Leah Levin. 2007. *Maximizing private sector contribution to family planning in the Europe and Eurasia Region: Context analysis and review of strategies.* Bethesda, MD: Private Sector Partnership-One Project, Abt. Associates Inc.

Asiimwe, D., and J. C. Lule. 1993. "The public/private mix in financing and provision of health services in Uganda." In *Proceedings from the workshop on the public/private mix for health care in developing countries*, ed. S. Bennett and A. Mills. London: London School of Hygiene and Tropical Medicine.

Axelsson, H., F. Bustreo, and A. Harding. 2003. *Private sector participation in child health: A review of World Bank projects, 1993–2002.* HNP Discussion Paper. Washington, DC: World Bank.

Baron, G. 2005. "Cuentas de salud de Colombia: Aspectos conceptuales y análisis de reultados 1993–2002." Working paper. Health System Reform Support Program (Programa de Apoyo a la Reforma de Salud), Ministry of Social Protection and Social Development Division of the National Department of Planning, Bogota.

Bennett, S., G. Dakpallah, P. Garner, L. Gilson, S. Nittayaramphong, B. Zurita, and A. Zwi. 1994. "Carrot and stick: State mechanisms to influence private provider behavior." *Health Policy and Planning* 9 (1): 1–13.

Bennett, S., and L. Gilson. 2001. *Health financing: Designing and implementing pro-poor policies.* London: DFID Health Systems Resource Centre.

Bennett, S., K. Hanson, P. Kadama, and D. Montagu. 2005. "Working with the non-state sector to achieve public health goals." Working paper 2. World Health Organization, Geneva.

Bennett, S., P. Kadama, and K. Hanson. 2005. "Working with the private sector to achieve public health goals at the country level." WHO Background paper for The Montreaux Challenge: Making Health Systems Work, April 4–6, Glion Sur Montreaux, Switzerland.

Bennett, Sara, and Anne Mills. 1998. "Government capacity to contract: health sector experience and lessons." *Public Administration and Development* 18 (4): 307–26.

Berg, R. 2000. "Initiating public/private partnerships to finance reproductive health: The role of market segmentation analysis." Working Paper Series 7. Futures Group, Washington, DC.

Berg, R., and D. Meeker. 2005. "Monitoring reproductive health social marketing programs in developing countries: Toward a more strategic approach." In *Global public health communication: Challenges, perspectives, and strategies*, ed. M. Hiader. Boston, MA: Jones and Bartlett.

Bergkvist, Sofi, and Hanna Pernefeldt. 2008. "Innovative service delivery models in India." Haseltine Foundation, India.

Bhat, R., A. Singh, S. Maheshwari, and S. Saha. 2006. "Maternal health financing—issues and options: A study of Chiranjeevi Yojana in Gujarat." IIMA Working Paper 2006-08-03. Indian Institute of Management Ahmedabad. http://www.iimahd.ernet.in/publications/data/2006-08-03rbhat_Revised_Mar07.pdf (accessed April 12, 2009).

Bishai, David M., Nirali M. Shah, Damian G. Walker, William R. Brieger, and David H. Peters. 2008. "Social franchising to improve quality and access in private health care in developing countries." *Harvard Health Policy Review* 9 (1, spring): 184–97.

Bloom, G., and H. Standing. 2002. *Beyond public and private? Unorganised markets in health care delivery*. Washington, DC: World Bank.

Bloom, G., and H. Standing, ed. 2008. "Future health systems: Why future? Why now? Introduction to special issue of *Social Science and Medicine*." *Social Science and Medicine* 66 (10).

Bourke, Lisa, Collette Sheridan, Ursula Russell, Graeme Jones, Dawn DeWitt, and Siaw-Teng Liaw. 2004. "Developing a conceptual understanding of rural health practice." *Australian Journal of Rural Health* 12 (5): 181–86.

Brown, W., and C. Churchill. 1999. *Providing insurance to low-income households. part 1: A primer on insurance principles and products*. Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives Inc.

———. 2000. *Insurance provision in low-income communities. Part 2:* Initial lessons from micro-insurance experiments for the poor. Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives Inc.

Brugha, R. 2003. "Antiretroviral treatment in developing countries: The peril of neglecting private providers." *British Medical Journal* 326 (7403): 1382–84.

Brugha, Ruairi, and Anthony Zwi. 1998. "Improving the quality of private health sector delivery of public health services: Challenges and strategies." *Health Policy and Planning* 13 (2): 107–20.

Bustreo, F., A. Hardin, and H. Axelsson. 2003. "Can developing countries achieve adequate improvements in child health outcomes without engaging the private sector?" *Bulletin of the World Heath Organization* 81 (12): 886–94.

DeCosta, A., and V. Diwan. 2007. "Where is the public health sector? Public and private sector healthcare provision in Madhya Pradesh, India." *Health Policy* 84 (2–3, December): 269–76. doi: 10.1016/j.healthpiol.2007.04.004.

DFID (Department for International Development) Health Systems Resource Centre. 2002. "Making the most of the private sector. Workshop report. Case studies." Department for International Development, London.

Dimovska, Donika, Stephanie Sealy, Sofi Bergkvist, and Hanna Pernefeldt. 2008. "Innovative pro-poor healthcare financing and delivery models. Examples from mixed health systems." Results for Development Institute.

Dror, D. M., and A. S. Preker, ed. 2002. *Social ReInsurance: A New Approach to Sustainable Community Health Financing.* Washington, DC: World Bank and International Labour Office.

Eichler, Rena, and Susna De. 2008. *Paying for performance in health: Guide to developing the blueprint.* Washington, DC: United States Agency for International Development.

Eichler, R., R. Levine, P. Gertler, and K. Raube. 2008. "Performance incentives in provider purchasing and contracting arrangements." Rockefeller Foundation.

England, R. 2004. *Experience of contracting with the private sector: A selective review*. London: DFID Health Systems Resource Centre.

Ensor, T., and S. Cooper. 2003. "Resource allocation and purchasing: Influencing the demand side." University of York, Centre for Health Economics for the World Bank RAP.

Escobar, M.-L., and C. Griffin. 2008. "Health insurance: An old approach but an innovative health financing mechanism for global health. The Health Insurance Challenge

Fund." Global Health Financing Initiative, The Brookings Insitution, Washington, DC.

Ferrinho, P., W. Van Lerberghe, I. Fronteira, F. Hipólito, and A. Biscaia. 2004. "Dual practice in the health sector: Review of the evidence." *Human Resources for Health* 2 (October): 14. doi:10.1186/1478-4491-2-14.

Forsberg, Birger. 2009. "Private sector programme in health." Presentation at Asia Health Policy Program, Walter H. Shorenstein Asia-Pacific Research Center, Stanford University, January 27. http://www.psp.ki.se/ (accessed May 12, 2009).

Franco, Lynne Miller, François Pathé Diop, Clara R. Burgert, Allison Gamble Kelley, Marty Makinen, and Cheick Hamed Tidiane Simpara. 2008. "Effects of mutual health organizations on use of priority health-care services in urban and rural Mali: A case-control study." *Bulletin of the World Health Organization* 86 (11): 817–908.

Gottrett, P., and G. J. Schieber. 2006. *Health financing revisited: A practitioners guide*. Washington, DC: World Bank.

Gottret, R., G. J. Schieber, and H. Waters, ed. 2008. *Good practices in health financing: Lessons from reforms in low- and middle-income countries*. Washington DC: World Bank.

Ha, N. T., P. Berman, and U. Larsen. 2002. "Household utilization and expenditure on private and public health services in Vietnam." *Health Policy and Planning* 17: 61–70.

Hanson, Kara. 2004. "Public and private roles in malaria control: The contributions of economic analysis." *American Journal of Tropical Medicine and Hygiene* 71: 168–73.

Hanson, K., and P. Berman. 1998. "Private health care provision in developing countries: A preliminary analysis of levels and composition." *Health Policy and Planning* 13 (3): 195–211.

Hanson, Kara, Lucy Gilson, Catherine Goodman, Anne Mills, Richard Smith, Richard Feachem, Neelam Sekhri Feachem, Tracey Perez Koehlmoos, and Heather Kinlaw. 2008. "Is private health care the answer to the health problems of the world's poor?" *PLOS Medicine* 5 (11): e233.

Hanson, K., C. Goodman, J. Lines, S. Meek, D. Bradley, and A. Mills. 2004. *The economics of malaria control intervention*. Geneva: Global Forum for Health Research, World Health Organization.

Harding, A. 2009. "Oxfam—this is not how to help the poor." Global Health Policy Blog. Center for Global Development, Washington, DC. http://blogs.cgdev.org/globalhealth/2009/02/oxfam-this-is-not-how-to-help.php.

Harding, A., and A. Preker. 2003. *Private participation in health services*. Health, Nutrition and Population Series. Washington, DC: World Bank.

Hatt, Laurel E., and Lisa K. Fleisher. 2009. "Toward solving health financing challenges in Africa—a way forward." Health Systems 20/20 Brief. United States Agency, for International Development, Washington, DC. http://www.healthsystems2020.org/content/resource/detail/2187/ (accessed May 12, 2009).

Hsiao, W. C. 1995. "Abnormal economics in the health sector." In *Health sector reform in developing countries: Making health development sustainable*, ed. P. Berman. Boston, MA: Harvard University Press.

Huntington, Dale, Sara Sulzbach, and Barbara O'Hanlon. 2007. *Public policy and franchising reproductive health: current evidence and future directions. Guidance from a technical consultation meeting.* Geneva: World Health Organization. http://who.int/reproductive-health/publications/publicpolicy_franchising/index.html (accessed May 12, 2009).

Hygeia Community Health Plan. 2008. *Hygeia Community Health Plan's 1st year*

*implementation report: The Shonga model—presenting an innovative approach to health care delivery*. Lagos: Hygeia.

IFC (International Finance Corporation). 2008. *The business of health in Africa*. Washington DC.

ILO (International Labour Office). 2008. *Social health protection: An ILO strategy towards universal access to health care.* Global Campaign on Social Security and Coverage for All. London.

Kafle, K. K., R. P. Gartoulla, Y. M. Pradhan, A. D. Shrestha, S. B. Karkee, and Jonathan D. Quick. 1992. "Drug retailer training: experiences from Nepal." *Social Science and Medicine* 35 (8): 1015–25.

Kumaranayake, Lilani. 1997. "The role of regulation: Influencing private sector activity within health sector reform." *Journal of International Development* 9 (4): 641–49.

———. 1998a. "Effective regulation of private sector health service providers." Draft paper prepared for the World Bank Mediterranean Development Forum II in Morocco, September. London School of Hygiene and Tropical Medicine.

———. 1998b. "Economic aspects of health sector regulation: strategic choices for low and middle income countries." PHP Departmental Publication 29. London School of Hygiene and Tropical Medicine, London.

Kumaranayake, L., P. Mujinja, C. Hongoro, and R. Mpembeni. 2000. "How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe." *Health Policy and Planning* 15 (4): 357–67.

Lagomarsino, G., and S. S. Kundra. 2009. "Making health markets work for the poor: The benefits of health insurance." Id21 insight 76. Id21, Brighton, UK.

Liu, Y., P. Berman, W. Yip, H. Liang, Q. Meng, J. Qu, and Z. Li. 2006. "Health care in China: the role of non-government providers." *Health Policy* 77 (2, July): 212–20.

Loevinsohn, B. 2002. *Practical issues in contracting for primary health care delivery: Lessons from two large projects in Bangladesh*. Washington, DC: World Bank.

———. 2006. "Contracting for health services with the private sector: The Evidence and experience from developing countries." Presentation to the Global Health Council Annual Conference, May–June, Washington, DC. World Bank.

Loevinsohn, B., and A. Harding. 2005. "Buying results? Contracting for health service delivery in developing countries." *The Lancet* 366 (9486): 676–81.

Lönnroth, Knut, Tin Aung, Win Maung, Hans Kluge, and Mukund Uplekar. 2007. "Social franchising of TB care through private GPs in Myanmar: An assessment of treatment results, access, equity and financial protection." *Health Policy and Planning* 22 (3):156–66. doi:10.1093/heapol/czm007.

Marek, T., C. O'Farrell, C. Yamamoto, and I. Zable. 2005. *Trends and opportunities in public-private partnerships to improve health service delivery in Africa*. Washington, DC: World Bank.

Mathauer, I. 2002. "Institutionalized pathologies in Uganda: Why regulation of private health care providers fails?" Presentation for the World Bank HSD Thematic Group.

Matsebula, T., J. Goudge, and L. Gilson. 2005. "Regulating the pharmaceutical sector: Coping with low capacity while maintaining regulatory independence." HEFP Working Paper 01/05. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, London.

McCombie, S. C. 1996. "Treatment seeking for malaria: a review of recent research." *Social Science and Medicine* 43 (6): 933–45.

McIntyre, D., R. Loewenson, and V. Govender. 2008. *Meeting the promise: Progress on the Abuja commitment of 15% government funds to health*. Cape Town, SA: Equinet.

Mills, A., S. Bennett, and B. McPake, ed. 1997. *Private health providers in developing countries: Serving the public interest?* London: Zed Books.

Mills, A., R. Brugha, K. Hanson, and B. McPake. 2002a. "Approaches for improving service delivery in the non state sector: What is the evidence on what work, where and why?" Paper presented at the Making Services Work for Poor People World Development Report 2004 Workshop, November 4–5, Oxford, UK.

———. 2002b. "What can be done about the private health sector in low-income countries?" *Bulletin of the World Health Organization* 80 (4): 325–30.

Montagu, D. 2002. "Franchising of health services in developing economies." *Health Policy and Planning* 17 (2): 121–30.

Montagu, D., R. Feachem, N. S. Feachem, T. P. Koelmoos, H. Kinlaw, and R. Smith. 2009. "Oxfam must shed its ideological bias to be taken seriously." *British Medical Journal* 23 (338b): 1202.

Montagu, D., N. Prata, M. Campbell, J. Walsh, and S. Orero. 2005. "Kenya: Reaching the poor through the private sector—a network model for expanding access to reproductive health services." HNP Discussion Paper. World Bank, Washington, DC.

Mujinja, P., D. Urassa, and K. S. Mnyika. 1993. "The Tanzanian public/private mix in national health care." In *Proceedings from the Workshop on the Public/Private Mix for Health Care in Developing Countries*, ed. S. Bennett and A. Mills. London: London School of Hygiene and Tropical Medicine.

Ngalande-Banda, E., and G. Walt. 1995. "The private health sector in Malawi: Opening Pandora's box." *Journal of International Development* 7: 403–22.

Nishtar, Sania. 2007a. "Politics of health systems: WHO's new frontier." *Lancet* 370 (9591): 935–36.

———. 2007b. "The public private interface in health—a call to action." Gateway Paper III. Heartfile, Pakistan.

O'Sullivan, Gael, Cindi Cisek, Jeff Barnes, and Sara Netzer. 2007. *Moving toward sustainability: Transition strategies for social marketing programs.* Washington, DC: Private Sector Partnerships-One.

Oxfam International. 2009. "Blind optimism: Challenging the myths about private health care in poor countries." Oxfam briefing paper 125. Oxfam International, Oxford, UK. http://www.oxfam.org.uk/resources/policy/health/downloads/bp125_blind_optimism_private_health_care.pdf.

Palmer, N., A. Mills, H. Wadee, L. Gilson, and H. Schneider. 2003. "A new face for private providers in developing countries: What implications for public health?" *Bulletin of the World Health Organization* 81 (4): 292–97.

Pannarunothai, S., and A. Mills. 1997. "The poor pay more: Health-related inequality in Thailand." *Social Science and Medicine* 44 (2): 1781–90.

Park, M., T. Braun, G. Carrin, and D. B. Evans. 2005. *Provider payments and cost-containment: Lessons from OECD countries.* Technical brief for policymakers, No. 2/2007. Geneva: World Health Organization. http://www.who.int/health_financing/documents/cov-pb_e_07_2-providerpay_oecd/en/index.html (accessed May 12, 2009).

Patouillard, E., C. Goodman, K. Hanson, and A. Mills. 2007. "Can working with the for profit sector improve utilization of quality health services by the poor? A systematic review of the literature." *International Journal for Equity in Health* 6 (17). http://www.equityhealthj.com/content/6/1/17 (accessed May 12, 2009).

Pearson, M. 2001. "Demand side financing for healthcare." Unpublished manuscript. DFID Health Systems Resource Centre, London.

Pinto, Diana, and William C. Hsiao. 2007. "Colombia: Social health insurance with managed competition to improve health care delivery." In *Social health insurance for developing nations*, ed. William C. Hsiao, R. Paul Shaw, Paul R. Shaw, and Andrew Fraker. Washington, DC: World Bank. http://books.google.com/books?id=NTjPXKZ1MhgC&pg=PA108&lpg=PA108&dq=Colombia,+social+health+insurance+reforms,+out+of+pocket&source=bl&ots=cMtqAfiRAY&sig=dVaYamYuFySNGgHM5zHoLgo8GWQ&hl=en&ei=KkT_SaudGJTaMb3AwKwE&sa=X&oi=book_result&ct=result&resnum=9#PPA107,M1 (accessed May 12, 2009).

Prata, Ndola, Dominic Montagu, and Emma Jefferys. 2005. "Private sector, human resources and health franchising in Africa." *Bulletin of the World Health Organization* 83 (4): 241–320.

Preker, A. S, ed. 2002. *Health care financing for rural and low-income populations: The role of communities in resource mobilization and risk sharing*. Washington, DC: World Bank.

Preker, A. S., and G. Carrin, ed. 2004. *Health financing for poor people: Resource mobilization and risk sharing.* Washington, DC: World Bank.

Preker, A. S., and D. M. Dror. 2002. *Social reinsurance: A new approach to sustainable community health financing*. Washington, DC: World Bank, and Geneva: International Labour Organization.

Preker, A., and A. Harding. 2001. *The economics of public and private roles in health care: Insights from institutional economics and organizational theory*. Washington, DC: World Bank.

Preker, A., A. Harding, and P. Travis. 2000. "'Make or buy' decisions in the production of health care goods and services: New insights from institutional economics and organisational theory." *Bulletin of the World Health Organization* 78 (6): 779–90.

Preker, A. S., and J. C. Langenbrunner. 2005. *Spending wisely, buying health services for the poor*. Washington DC: World Bank.

Preker, A. S., R. M. Scheffler, and M. C. Bassett. 2007. *Private voluntary health insurance in development: Friend or foe?* Washington, DC: World Bank.

Rannan-Eliya, Ravi. 2008. "Addressing the funding gap: Strengthening health financing strategies in partner developing countries." Institute for Health Policy, Sri Lanka.

Ranson, K. M. 2001. *The impact of SEWA's medical insurance on hospital utilization and expenditure: A household survey*. Washington, DC: World Bank.

Roberts, M., W. Hsiao, P. Berman, and M. Reich. 2008. *Getting health reform right. A guide to improving performance and equity.* Oxford: Oxford University Press.

Rohde, J. 1997. "Harnessing the private sector to serve public health: The case of ORS in India. Child Survival Basics." *Basics Quarterly Technical Newsletter* 4: 1–3.

Ruster, J., C. Yamamoto, and K. Rogo. 2003. *Franchising in health*. Washington, DC: World Bank.

Savedoff, W. D. 2006. "The causes of corruption in the health sector: A focus on health care systems." In *Global Corruption Report 2006: Special focus on corruption and health*, ed. J. Kotalik and D. Rodriguez. London: Pluto Press.

Schneidman, M. Rusa, and L. Rwanda. 2006. "Performance based financing for health." Center for Global Development Working Group on Performance-based Incentives, Washington, DC.

Schultz, J., and B. Tadesse. 2006. "Impact of supplemental insurance on access, expenditures and health: Evidence from Europe & the U.S." Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of

the American Society of Health Economists, June 04, Madison, WI. http://www.allacademic.com/meta/p_mla_apa_research_citation/0/9/3/3/5/p93357_index.html#get_document (accessed May 12, 2009).

Smith, E., R. Brugha, and A. Zwi. 2001. *Working with private sector providers for better health care: An introductory guide*. London: Options Consultancy Services, and London School of Hygiene and Tropical Medicine.

Soderlund, N., and V. Tangcharoensathien. 2000. "Health sector regulation: Understanding the range of responses from government." *Health Policy and Planning* 15 (4): 347–48.

Stephenson, R., A. O. Ssui, S. Sulzbach, P. Bardsley, G. Bekele, T. Gidday, R. Ahmed, G. Gopalkrishnan, and B. Feyesitan. 2004. "Reproductive health in today's world. franchising reproductive health services." *Health Services Research* 39 (6 Pt 2, December): 2053–80. http://www.popline.org/docs/1768/320899.html (accessed May 12, 2009).

Thiede, Michael, Natasha Palmer, and Sandi Mbatsha. 2004. "South Africa: Who goes to the public sector for voluntary HIV/AIDS counseling and testing?" HNP Discussion Paper. World Bank, Washington, DC.

USAID (United States Agency for International Development), India. 2006. "International workshop on social franchising in the health sector, workshop proceedings." United States Agency for International Development, Washington, DC.

Waters, H., L. Hatt, and H. Axelsson. 2002. *Working with the private sector for child health*. Washington, DC: World Bank.

WHO (World Health Organization). 2000. *World Health Report 2000. Health systems: Improving performance*. Geneva.

———. 2006. "Working with the non-state sector to achieve public health goals." Background paper for Consultation on Priorities and Actions at Chateau de Penthes, Pregny, Geneva, February 20–21.

———. 2008. "Fact sheet: Top 10 causes of death." World Health Organization, Geneva. www.who.int/entity/mediacentre/factsheets/fs310_2008.pdf (accessed May 12, 2009).

WHO (World Health Organization) and USAID (United States Agency for International Development). 2007. *Public policy and franchising reproductive health: Current evidence and future directions. Guidance from a Technical Consultation Meeting.* Geneva: World Health Organization.

World Bank. n.d. "World Bank responds to new Oxfam health report." World Bank, Washington, DC. http://go.worldbank.org/FJVS7II3A0 (accessed May 12, 2009).

Xu, K., D. B. Evans, G. Carrin, and A. M. Aguilar-Rivera. 2005. *Designing health financing systems to reduce catastrophic health expenditure.* Technical brief for policymakers 2/2005. Geneva: World Health Organization. http://www.who.int/health_financing/documents/cov-pb_e_05_2-cata_sys/en/index.html (accessed 12, 2009).

Xu, K., D. B. Evans, K. Kawabata, R. Zeramdini, J. Klavus, and C. J. L. Murray. 2003. "Household catastrophic health expenditure: A multicountry analysis." *Lancet* 362 (9378): 111–17.

Yesudian, C. A. K. 1994. "Behaviour of the private health sector in the health market of Bombay." *Health Policy and Planning* 9 (1): 72–80.

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Drawing extensively on the findings of a 2008 review sponsored by the Rockefeller Foundation (resulting in 14 reports) and on the vast other literature on the private health sector and health systems, this report by the Results for Development Institute, with support from the Rockefeller Foundation, outlines the large and complex private markets for healthcare and emphasizes the importance of effective stewardship by governments of their country's health system, especially given the reality that the private (nonstate) part of the system is large and complex, with major challenges and significant opportunities.

The report suggests three types of policies for better stewardship of mixed health systems:

- Regulatory policies that monitor quality effectively and mitigate the worst health market failures.
- Financing policies that minimize out-of-pocket payments and increase access by pooling risks across populations with subsidies for the poor.
- Purchasing policies that create incentives for quality and for delivering high-impact interventions and services to the poor.

And it discusses three ideas for accelerating progress toward better stewardship of mixed health systems:

- Investing in information about health markets.
- Supporting innovative models that can serve as "stepping stones" to broader reforms.
- Developing  a roadmap for mixed health system stewardship.

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