

# **The Private Sector And Child Health Care**

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## **Acknowledgments**

I am highly thankful to the Technical Advisory Group, comprising Drs. Harry Cross, William McGreevey and Sagar Jain, for their critical review of my work and technical guidance. I am also grateful to Ms Varuni Dayaratna for providing useful comments for the improvement of the paper. I would also like to acknowledge support of April Harding and Sarbani Chakraborty. I received full support of Mark Hampton and Mariela Ohnemus among the library staff in the BASICS Library. I greatly appreciate Jen Meranberg's editorial support.

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## Executive Summary

**M**any families in developing countries seek child health care service from the private sector. Policy makers in the public sector, focusing on their own service delivery management, have largely ignored private providers. Without effective government stewardship, the quality of private child health care services leans too much toward curative care and gives too little attention to prevention.

There is a growing consensus that a function of government is to create an environment of promotion and regulation in which private services can flourish. Applied specifically to child health, this function combines harnessing and stewardship. Where public health promotion is limited, parents seek health services only for sick children. Private providers may have little incentive to focus on preventive care in such an environment. A vigorous public policy to promote healthy behavior, and cost-effective preventive interventions, could strike a responsive chord among private providers and yield better child health outcomes.

This paper summarizes findings from over 130 studies of private services provided to improve child health. These studies demonstrate that public-private interactions in favor of better child health have been moderately successful in some cases. Much better results are possible. The key to success is more effective public guidance, or what the latest *World Health Report 2000* refers to as stewardship. This paper distils lessons of experience with private sector child health services and links them to a framework of public-private relations that can form a strengthened basis for child health improvements in developing countries.

This paper supports the work of an inter-agency working group directed at improving child health. It forms part of a larger toolkit to be made available to health practitioners and policy makers seeking to apply lessons of experience to challenges in the many different country settings in which these specialists are working. The toolkit

will answer this key question: “What approaches can induce private sector providers of child health services to do a better, more cost-effective job of improving child health?” The positive answer will focus on a framework of public stewardship that harmonizes private actions to yield better health outcomes than currently prevail.

The paper concludes that to succeed with limited resources, governments must limit and focus their own activities and spending on making the private sector as effective as possible. On a continuing basis, public health managers need to reassess emerging issues, redefine the public sector role in stewardship of the private sector, and adjust its strategies to promote child health care. A key step for effective public action has been to recognize that public health requires actions by both public and private providers.

The providers of private health care services can be induced to do a better job of providing essential, basic, and preventive health care services. Government behavior may be changed, and changed government behavior may in turn cause changes in private sector behavior.

First, governments need to recognize their budget limitations. With limited resources, they must focus on providing critical public goods to the poorest as well as useful guidance to private providers and service users. The challenge, that governments face is how to harness the energies of the private sector in achieving health sector objectives while offsetting the failures of private markets.

Second, governments must manage incentives and promote regulations that will induce the private sector to place greater emphasis on basic, essential, and preventive care over responsive, curative, and unessential care. Incentives may be preferable to regulations because they are easier to manage and enforce. A regulatory regime is an essential feature of public management of the health sector as a whole. Where appropriate, governments should also consider how to put into

place social health insurance that is consistent with local cultures and norms.

This paper discusses some negative lessons. In countries such as Mexico, private providers are less effective than public sector providers in addressing child health needs. A Malaysian study found that private providers neglect preventive measures. Moreover, in some instances, supplier-induced demand may lead to more costs than benefits in private provision of child health care services.

Positive lessons, however, outweigh the negative. Contracting or outsourcing publicly subsidized child health services, an approach disdained in the past, was effective in Cambodia, El Salvador, Guatemala, Haiti, Madagascar, Malawi, Senegal, and Zimbabwe.

Moreover, the private sector can focus on the needs of poor children by working with NGOs that are not motivated by profit and that guard their independence from government. This approach has worked well in several LAC countries, Malawi, and Ghana.

In several cases documented by analysts, certain private sector efforts effectively address basic and essential care for clients and patients. In the Dominican Republic, India (Bihar State), Indonesia, Kenya, and Nepal, sound advocacy and information campaigns and provision of training for private sector providers yielded positive results in terms of basic and preventive care.

Finally, analyses show that regulations and incentives do matter and are complementary in nature. Since the private sector comprises a wide range of players, governments need to specify carefully what their policies will promote and what they will restrict. When regulations are too constrictive, they inhibit effective private action. Loosening the regulatory environment by providing a more favorable tax treatment for imported essential drugs, for example, can have a beneficial impact on child health.

Increasing public-private interactions in favor of child health constitutes an important challenge to improving welfare in low-income countries.

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## Contents

1	Introduction .....	1
1.1	Background .....	1
1.2	Objectives .....	1
1.3	Analytical Framework .....	1
1.4	Application of the framework to child health .....	2
1.5	Organization of the Paper .....	4
2	Need to Mobilize the Private Sector .....	5
2.1	Inability of the Public Sector to Meet Child Health Care Needs .....	5
2.2	The Private Sector Role in the Delivery and Financing of Child Health Care .....	5
2.3	The Changing Perspective on the “Role of State” .....	7
3	Harnessing the Private Sector: Strategies and Instruments .....	8
3.1	Financial Incentives .....	8
3.2	Regulation of Producers and Providers .....	12
3.3	Information Dissemination .....	16
4	Expanding the Role of the Private Sector in Child Health Care: Strategies and Instruments .....	20
4.1	Strategic use of resources—division of labor between the government and private sector .....	20
4.2	Strategies to grow the private sector .....	22
5	Proposed Actions for Effective and Sustainable Private Sector Participation .....	25
5.1	Formulation of conducive policy for private sector participation .....	25
5.2	Role of partners, donors and technical agencies in facilitating and guiding the government in private sector participation and development .....	25
5.3	Capacity strengthening of public sector on stewardship function .....	25
6	Key Policy and Implementation Issues .....	27
6.1	Competition from Subsidized Products Can Crowd out the Private Sector .....	27
6.2	People Seek Health Care from a Broad Range of Sources .....	27
6.3	The Public and Private Sectors Could Be Competitors Too .....	27
6.4	The Quality of Services Provided by Private Health Practitioners Varies .....	27
6.5	The Public and Private Sectors’ Priorities May Differ .....	28
6.6	Mobilizing the Commercial Sector Is Different from Mobilizing the Non-Profit Sector .....	28
6.7	Non-Economic Benefits Also Motivate the Private Sector .....	28
7	Information Gaps and Future Study Needs .....	30
8	Proposed Structure for the Toolkit .....	31
	Bibliography .....	32

### **List Of Figures**

- 1.1: Public private roles in promoting child health
- 1.2: Role of the state and private health care market: a strategic assessment
- 2.1: Who Uses Public versus Private Health Facilities for ARI
- 2.2: Private Share of Total Health Spending, 108 Countries
- 4.1: Use of Immunization Services in India, Malawi, and Peru
- 4.2: Percent of Primary Care Received by the Poorest and Richest Segments of Society
- 4.3: ORS Sales in Pakistan

### **List Of Boxes**

- 2.1: Use of Private Sector Services by Low-Income Groups
- 2.2: A Call for Greater Private Sector Participation
- 3.1: Contracting out of District-Level Services in Cambodia
- 3.2: Incentives to Increase Private Sector Participation
- 3.3: Subsidizing Recurrent Costs of Mission Facilities
- 3.4: Free Vaccines as an Incentive to Deliver Immunization Services
- 3.5: NGOs Participating in Setting Protocols and Quality Standards
- 3.6: Consumer Protection Act for Malpractice and Negligence of the Private Sector
- 3.7: Delivering Basic Health Care Services in an Alternative System in Bolivia
- 3.8: NGOs Can Play an Important Role in Generating Demand
- 3.9: Empowering Community to Participate Actively in Health Care
- 3.10: Promoting Health Behaviors
- 4.1: Appropriate Roles of Public and Private Sectors
- 4.2: Improving Image and Getting More Business
- 4.3: Social Marketing of Insecticide-Treated Mosquito Nets (ITNs) in Tanzania
- 4.4: Contraceptive and ORS Marketing in UP Using Commercial Channels
- 4.5: NGOs Complementing Government Services
- 6.1: Improving Image and Status of Private Providers

### **List Of Tables**

- 3.1: Strategies and instruments for harnessing the private sector
- 3.2: Contracting out Preventive Health Care
- 4.1: Strategies and instruments for expanding the private sector

### **Annex Tables**

- A1: Lessons learned
- A2: Involving NGOs in improving child health care services

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# The Private Sector And Child Health Care

## 1 Introduction

A large number of households in developing countries seeks child health care services from the private sector. Despite this, policy makers have largely ignored it while developing health policies. Without an effective stewardship of government, the technical quality of child healthcare services provided by the private sector has generally remained poor. In this context, there is a growing consensus that a better match between the role of public and private sectors and their respective capabilities needs to be established. In such a redefined role, the public sector would largely perform a stewardship function and create an environment in which the private sector can help the state achieve its goals in the health sector.

This raises a number of policy issues: how governments can fulfill their stewardship function in the context of child health, how they can work with the existing private sector to improve the effectiveness of child health services, and how they can encourage further private sector participation in the delivery of child health care services. Policy makers and analysts usually possess little knowledge or understanding of the private sector. In addition, the strategies and instruments to “harness” and “grow” the private sector for the achievement of child health objectives are not widely studied, or understood. This paper provides an overview of reform strategies and instruments being utilized in developing countries to enhance the contribution of the private sector to child health care.

### 1.1 Objectives

The purpose of the paper is to help the Inter-agency Working Group<sup>1</sup> prepare a toolkit to marshal the resources of private sector to improve child health care in developing countries. The toolkit would help policy makers collect information, formulate strategies and implement

them to encourage private sector participation in child health care. This paper will also determine the structure of the toolkit.

The paper uses an analytical framework to gather and analyze information about public-private partnership programs, the effectiveness of these programs, and to identify the areas for future work on public-private issues in child health care. The paper is based on a review of 130 published and unpublished relevant studies.

### 1.2 Analytical Framework

In this context, the paper uses an analytical framework to help health policy makers and planners identify policies to:

- Work with the private sector to ensure that the services it provides meet health sector goals (harnessing the private sector);
- Create an environment that supports private sector growth consistent with child health goals (growing the private sector).

Certain principles of public finance and institutional economics guide the public-private division of labor. These principles also set out the stewardship role of the public sector in guiding (the often much larger) private sector in financing and provision of child health services.

These principles help clarify the rationale for effective mix of public and private sectors in health care goods and services and marking out their specific domains. According to these principles, a desirable division of labor between public and private sectors in health depends on whether markets can work properly (contestability), so that the private sector will produce positive results, and whether information is sufficiently available (measurability) to permit

assessment of the effectiveness of services. When markets and information fail, governments must play a corrective role. When markets and information succeed, government can open space to private response to consumer demand. As these conditions differ from time to time and place to place, the relative roles and relations of private and public sectors must evolve as well (For detailed description of the framework and the associated principles see, Chakraborty and Harding 2001 pp.5-8).

Both theory (level of contestability and measurability) and available empirical evidence suggest that a majority of goods and services can be adequately produced and delivered through the private sector, provided the public sector performs its function of creating enabling conditions for private sector participation and appropriate regulatory roles.

Governments can use a variety of instruments including financing, regulation, provision of information and mandates to correct the market failure (Musgrove 1996). These instruments fall within the domain of the stewardship function of the public sector. Stewardship is the key function of the public sector and has been defined as a “function of a Government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry (WHO 2000)”. Effective stewardship creates supportive environment for the involvement of health sector stakeholders such as purchasers, providers and consumers. It also influences the behavior of these key stakeholders to ensure their greater contribution towards the achievement of desirable outcomes.

Governments perform their stewardship functions to harness private sector by using three instruments namely application of financial incentives, regulations and information dissemination. They provide financial incentives through contracting, indirect public finance and insurance regulation in order to influence the private sector behavior. Regulation involves government actions and policies to influence the activities and priorities of the private sector and prevent market failures. Information

dissemination entails the use of both education and persuasion to change the behavior of providers as well as patients in ways that improve child health care services.

Stewardship functions also include expanding the private sector in certain areas or sub sectors either through “growing” the private sector or “transferring” some activities currently in public sector to private sector. Through this, they encompass and exploit the existence, capabilities and potential of both the public and private sector – especially in service delivery. It involves identifying easy win sectors in which the private sector can perform more productively and creating an enabling environment for its growth. It facilitates the use of scarce government resources on priority interventions and objectives.

### **1.3 Application of the framework to child health**

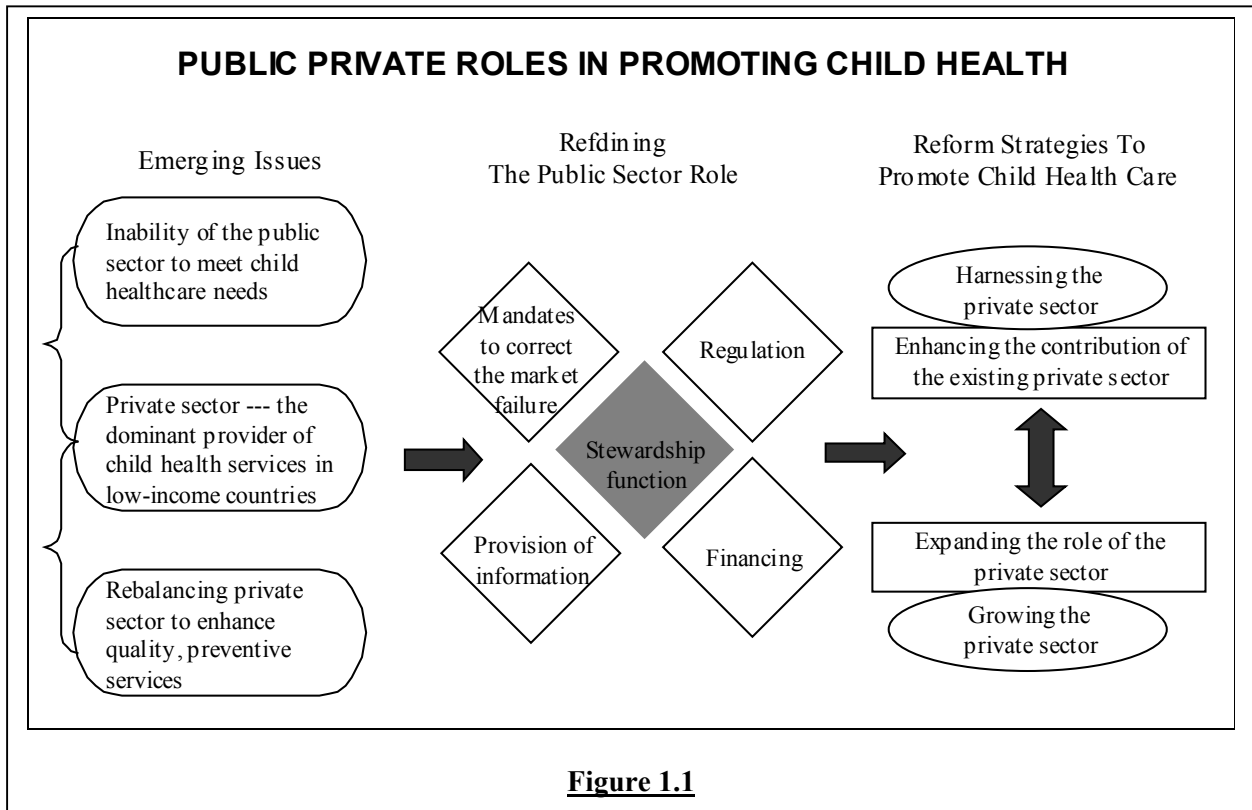
*Figure 1.1* summarizes the analytical framework in the context of child health care.

#### **1.3.1 Emerging issues**

Increasingly, policy makers and analysts in developing countries are taking notice of the role of private sector in delivering child health care services. This is because governments alone cannot meet the growing child health care demand, the private sector has already a major stake in child health care service provision, and because of changing perspective in favor of greater interaction between public and private sector for enhancing quality and preventive care services.

#### **1.3.2 Redefining the public sector role**

The role of governments in providing child health care remains extremely important despite the overwhelming presence of private sector. Governments’ effective stewardship role can ensure private sector’s positive contribution to child health. The degree of contestability, measurability and information asymmetry of child health care services and goods can be used to



determine the use of different instruments such as regulation, financing, information dissemination and mandates. For example, the delivery of child health care services has high contestability. Information dissemination function is particularly useful in promoting healthy behaviors among the community, improving case management practices of private practitioners through training, and implementing advertising campaigns through government media. Government mandates and regulations can be useful in guaranteeing the quality of child health care services. Regulatory reforms need to be implemented in combination with other regulatory instruments such as financial incentives, information dissemination. For example, self-regulation, periodic renewal of personnel licenses, accreditation of practitioners and facilities, enactment of consumer protection laws and awareness generation of consumer rights are appropriate regulatory measures in the context of child health care services. Public financing is a powerful instrument in affecting the behavior of the private sector. Direct and indirect financial incentives specific to child health services

include: extension of government's free insurance to cover immunization services provided by private providers; provision of free vaccines to the private sector as an incentive to deliver immunization services; easing of restrictions on advertising of child health products; mandated inclusion of child health care services in health insurance policies.

### 1.3.3 Reform strategies to promote child health care

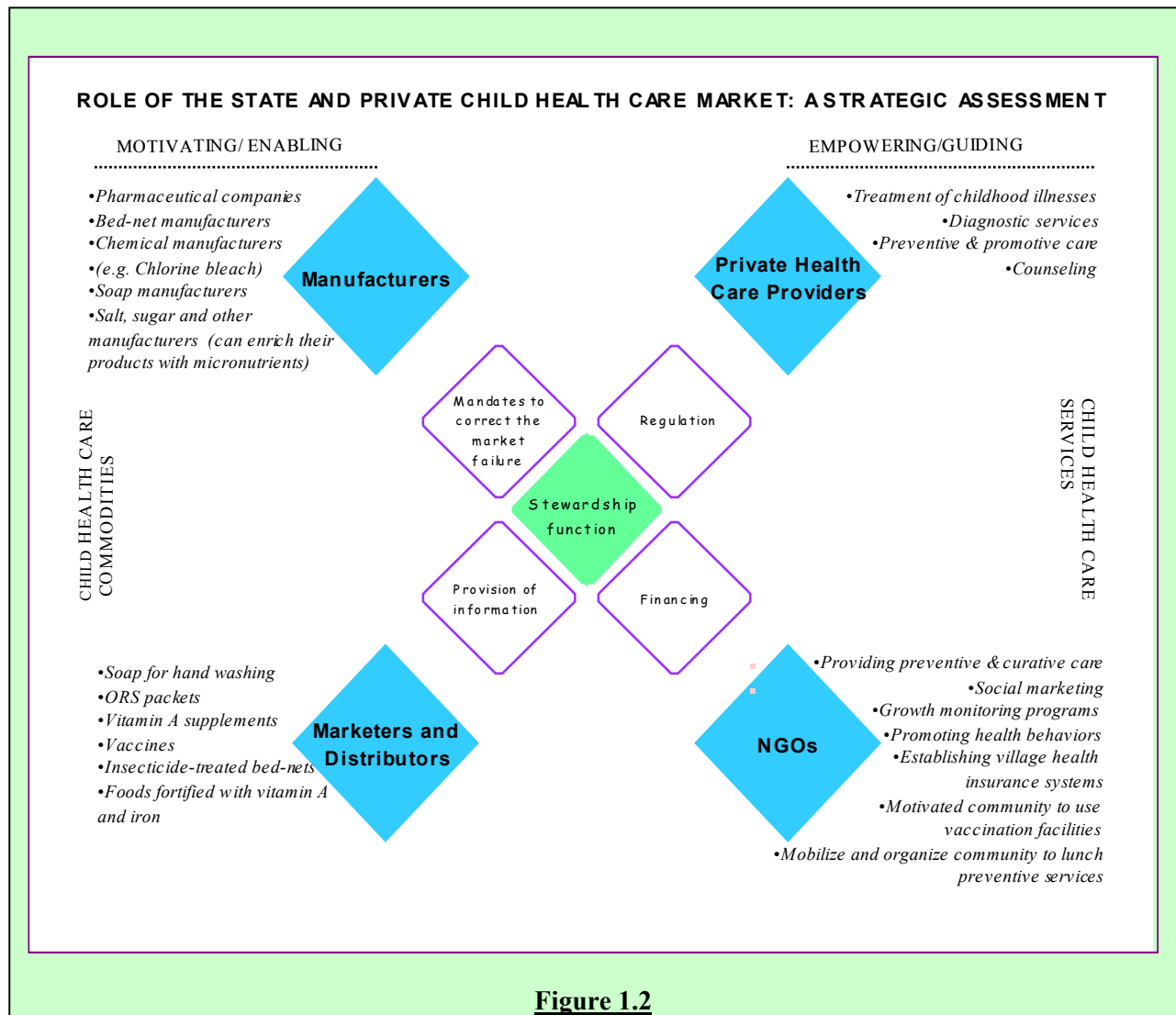
A review of the reform strategies reveals two alternatives: governments opt to focus on enhancing the contribution of the existing private sector and/or they opt to expand the private sector in certain areas. As the private sector is already the dominant provider of child health care services, the "harnessing" or guiding of existing private providers is more important than growing private sector/privatization. As the private child health care market<sup>ii</sup> comprises of non-governmental organizations, for-profit and not for-profit health care providers, and commercial sector, government use various instruments to

guide, enable, motivate, and influence the private sector (See **Figure 1.2**). The analytical framework suggests focused and strategic use of scarce government resources.

### 1.4 Organization of the Paper

Following this introduction, Section 2 assesses the need to mobilize private sector for child health care. Section 3 reviews successful strategies to

harness the private sector, and the instruments used for their implementation. Section 4 discusses different mechanisms and instruments used to expand the private sector in child health. Section 5 presents potential actions for effective and sustainable private sector participation. Section 6 presents key policy and implementation issues. Section 7 discusses information gaps and future research needs. Section 8 presents a proposed structure for the toolkit.



## 2 Need to Mobilize the Private Sector

Increasingly, policy makers and analysts in developing countries are taking notice of the role of the private sector in delivering child health care services. This is because governments alone cannot meet the growing child health care demand (Sec. 2.1); the private sector has already a major stake in child health care service provision (Sec. 2.2); and because of changing perspective of the international community in favor of greater private sector participation (Sec. 2.3).

### 2.1 Inability of the Public Sector to Meet Child Health Care Needs

Low-income countries are increasingly recognizing that the available resources are not sufficient to meet the growing health care needs of children. A large number of children still die from preventable and treatable diseases.

- According to the World Development Report 1993, about 49 percent of disability-adjusted life-years (DALYs) lost in India are attributable to morbidity and mortality among children 0–4 year-olds (World Bank 1993).
- In developing countries, about 12 million children under five years of age die each year. Seventy percent of these early deaths occur because of five preventable conditions: diarrhea, acute respiratory infection, malaria, measles, and malnutrition (BASICS 1999).
- Nearly three million children die each year from vaccine preventable diseases. About 30 million children (23% of the total) do not receive any kind of vaccination (WHO 2000).

### 2.2 The Private Sector Role in the Delivery and Financing of Child Health Care

#### 2.2.1 *The private sector is used extensively for child health care*

In developing countries, the private sector plays a major role in the treatment of childhood diseases such as diarrhea, respiratory infections, malaria, and others by producing, distributing, and marketing public health commodities. For example, about 80 percent of registered doctors in India work in the private sector (Bhat 1997).

- In developing countries such as Bolivia, Guatemala, Indonesia, and Paraguay, more than 50 percent of acute respiratory infections and diarrhea cases are treated in the private sector (Berman et al. 1994).
- In urban and rural India, more than 80 percent of households go to private health care practitioners for childhood illnesses (Chakraborty 1998). Ninety-three percent of diarrhea cases are treated in the private sector (Northrup 1997), and only 30 to 35 percent of patients receive ORS from the public sector; the remaining 65 to 70 percent go to the private sector, of which between 3 and 13 percent receive ORS from largely unlicensed private practitioners in rural areas (Rohde 1997).

Clients spend relatively large amounts of money for curative services in the private sector, demonstrating a willingness to pay for easy access, high-quality services, and the confidentiality that the private sectors offers.

**2.2.2 Even the poor use private sector services substantially**

Many recent surveys indicate that low-income women and children in developing countries use private providers (see **Box 2.1**). They also spend a greater proportion of their income on health care than do high-income women and children.

**Use of private sector services by low-income groups**

In Ghana, 50 percent of surveyed private clinic patients were from the low-income group. (Sclafani 1997)

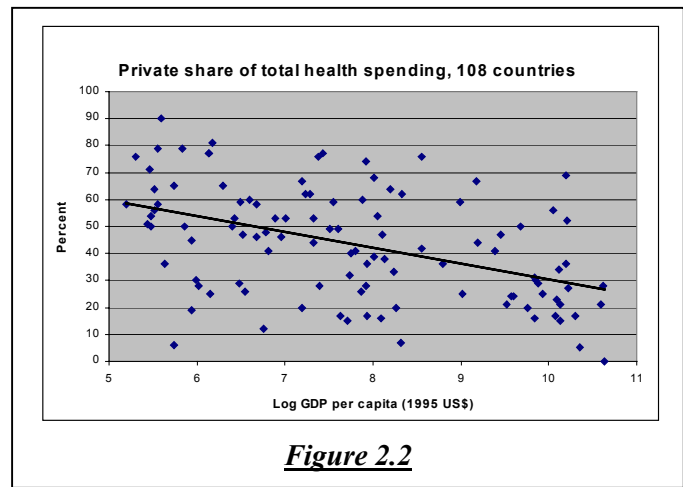
A recent household survey in Rajasthan reports that about 80 percent of private sector child health care clients and 75 percent of public sector clients belong to the lower one-half of the income distribution. (Winfrey et al. 2000)

**Box 2.1**

➤ In Zambia, 52 percent of the poorest quintile obtained treatment for ARI from public facilities (see **Figure 2.1**), compared with 18 percent of the richest quintile (Gwatkin et al. 2000).

**2.2.3 High out-of-pocket expenditure on child health care**

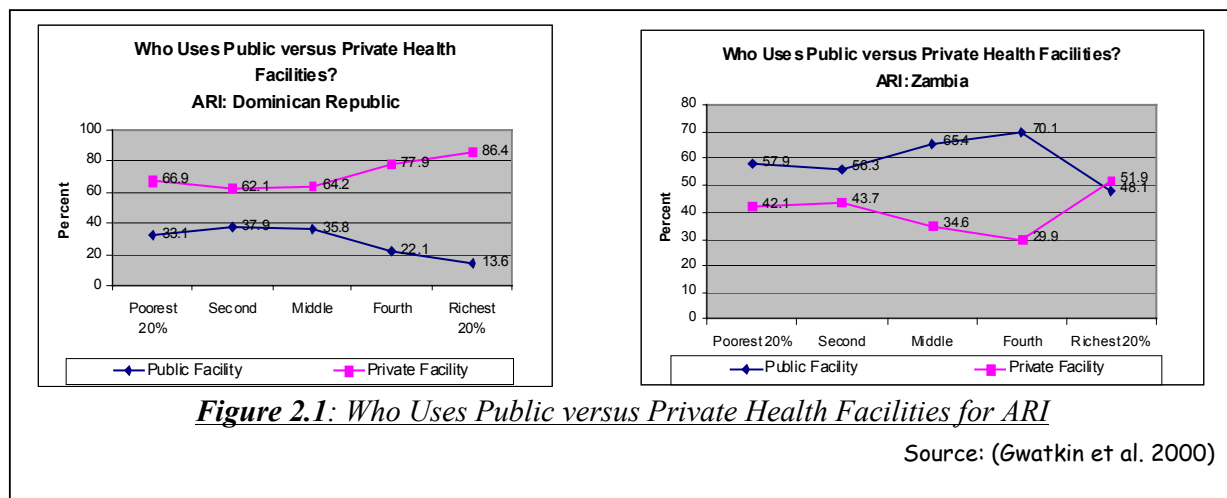
People in developing countries already spend a considerable sum on private child health care (see **Figure 2.2**).



An analysis of DHS data for 44 countries shows:

➤ Sixty-six percent of the poorest quintile of the population in the Dominican Republic obtained treatment for acute respiratory infections (ARI) from private facilities (see **Figure 2.1**)

➤ A recent survey conducted in the Udaipur district of Rajasthan, India, shows high out-of-pocket expenditure on child health care both in rural and urban areas.



- About 81 percent of respondents paid for child health care even in public sector health facilities.
  - Medicines constituted the majority of expenses (63%), followed by consultation (21%) and transport (14%) (Hotchkiss et al. 2000).
- For the developing world as a whole, private households account for roughly one-half of all health spending, ranging between 30 and 60 percent across countries (Rosen et al. 1999)
- Household out-of-pocket expenditure accounts for about 75 percent of the total health expenditure in India (World Bank 1997).
- In Vietnam, 68 percent of health financing comes from the private sector; the private

percent of its household income on health care compared with 5.2 percent spent by the richest quintile (Fabricant et al. 1999).

### 2.3 The Changing Perspective on the “Role of State”

Numerous international organizations including the World Bank, UNICEF, USAID, and WHO are acknowledging and championing greater interaction between the public and private sectors. The World Bank’s 1993 and 1997 reports advised governments to target efforts and resources to preventing market failures in health care by restricting the use of resources for goods and services with positive externalities, such as immunization, and by addressing information asymmetry. These international agencies are also recognizing, and advocating for, the need for greater public-private interaction and redefinition

#### A call for greater private sector participation

“A growing challenge is for governments to harness the energies of the private and voluntary sectors in achieving better levels of health systems performance, while offsetting the failures of private markets”.

“Health policies and strategies need to cover private provision of services and private financing, as well as state funding and activities. Only in this way can health systems as a whole be oriented toward achieving goals that are in the public interest”.

The World Health Report, 2000

#### **Box 2.2**

sector’s contribution in provisioning health care services is about 50 percent (Krasovec et al. 1999)

- A recent analysis of sources and uses of RCH finances indicates that household out-of-pocket expenditure accounts for about 78 percent of the total child health care expenditure in Rajasthan, India (Sharma et al. 2000).
- A review of five developing country studies shows that the poorest quintile spent 15.5

of public sector roles (see **Box 2.2**).

Experience in most countries supports increasing private sector participation in child health care. Moreover, the private sector’s role is well established and accepted both by society and government. Encouraging the private sector to play a greater role would allow governments to refocus their efforts to reach the poorest and most remote populations.

### 3 Harnessing the Private Sector: Strategies and Instruments

#### 3.1 Financial Incentives

This section reviews the first reform strategy, harnessing the private sector for child health care, and the instruments used for its implementation. It reviews the prevailing mechanisms and instruments through which governments exert influence over the private sector, classifying them under three categories: financial incentives, regulation, and information dissemination (See *Table 3.1*).

Proper incentives and adequate information are two powerful tools to improve system performance by involving the private sector. Governments often provide financial incentives through contracting, indirect public finance and insurance regulation in order to influence the private sector behavior. The most prevalent mechanism and the one that has the greatest impact is outsourcing health care services.

##### 3.1.1 Outsourcing child health care services

Developing countries are harnessing private sector resources by contracting out government health services. Outsourcing government health services

**Table 3.1: Strategies and instruments for harnessing the private sector**

STRATEGY	INSTRUMENTS	Strategies for POLICY MAKERS and PROVIDERS	Strategies for COMMUNITY
HARNESSING THE PRIVATE SECTOR to improve the effectiveness of child health care services	Financial Incentives	<ul style="list-style-type: none"> <li>- Contracting out preventive health care</li> <li>- Providing tax breaks and subsidies for increasing the coverage</li> <li>- Promoting Joint Investments as a means to increase capacity and reach</li> <li>- Subsidizing costs of operations to increase viability of private health care providers</li> <li>- Using government resources to increase coverage</li> </ul>	
	Regulation	<ul style="list-style-type: none"> <li>- Lowering legal and regulatory barriers</li> <li>- Facilitating self-regulations among competing entities</li> <li>- Enforcing regulatory controls to ensure safe and affordable private services</li> </ul>	<ul style="list-style-type: none"> <li>- Enacting consumer protection laws and raising awareness of consumer rights</li> <li>- Introducing fee exemption schemes for children</li> </ul>
	Information dissemination	<ul style="list-style-type: none"> <li>- Promoting information sharing and networking between government and private sector</li> <li>- Facilitating analysis-based discussions/dialogue of the respective roles of public, commercial and NGO sectors</li> <li>- Providing training support to private practitioners to conform to good practice norms</li> </ul>	<ul style="list-style-type: none"> <li>- Promoting healthy behaviors</li> <li>- Creating demand for preventive care</li> </ul>

enhances the “efficiency of both provider and purchaser via the incentive structure inherent in the contract” (Palmer 2000). Such an arrangement gives financial incentives to private sector providers by ensuring demand for their services. Involvement of the private sector also makes publicly funded services more accountable, transparent, and efficient.

### 3.1.1.1 *Benefits of Contracting*

Outsourcing has the potential to generate substantial efficiency gains by securing services of comparable or higher quality at lower costs and by harnessing contractors’ ability to fill temporary or permanent gaps in government capacity.

Contracting out clinical services to the for-profit private sector is a common practice in developing countries, but evidence of governments’ purchasing NGO-provided services is limited. NGOs might be more tightly supervised and supported through contractual agreements, which could tie government funding to conditions, such as the level of services to be provided. “Contracting out health services to NGO sector can be a means to guard against “government failure” by removing politics from the process of delivery, while ensuring that key decisions, such as determination of total funding levels, the overall service strategy, and the specification of service delivery, remain in the public sector” (Marek et al. 1999).

A recent study in Zimbabwe on government outsourcing of clinical health services to churches suggests that contracting out to church providers may even generate technical efficiency gains (Gilson et al. 1997).

### 3.1.1.2 *Key success factors for Contracting*

In most developing countries, contracts are promoted despite the weak capacity of markets and governments to manage them, thus negating the benefits of the outsourcing. Efficiency gains realized through contracting depend on numerous conditions, including, but not limited to

- Government’s ability to negotiate, implement, and monitor contracts;

- Adequacy of information on government production costs, as well as those of competitors; and
- The presence of actual or potential competition (Broomsberg et al. 1997)

### 3.1.1.3 *Child health care activities contracted out*

Some typical government-contracted services include

- Preventive services, such as well-baby clinics, provided by missionary health centers and hospitals;
- Immunization and other preventive services provided by some industrial and agricultural companies to workers and their families; and
- Community nutrition projects in Senegal and Madagascar for malnourished children. These projects using a contract management approach and provided preventive services through the private sector, outside the dominance of public health care professionals (Marek et al. 1999).

### 3.1.1.4 *Contracting strategies*

Few examples exist of the government contracting out preventive services. Two examples include well-baby clinics provided by missionary health centers and hospitals, and immunization and other preventive services provided by some industrial and agricultural companies to workers and their families (See **Box 3.1**).

### Contracting out district-level services in Cambodia

"The Ministry of Health developed a system for contracting health services to improve coverage and service quality of essential health care packages in five districts. This is a pilot project undertaken by the MOH, which acts as a purchaser. By the end of 1998, the MOH awarded five contracts to NGOs through competitive tenders (although some of the bidders were for-profit firms). Two contracts were for "Contracting-Out." Under this system, the provider is completely responsible for the management and delivery of health services to a district, through health centers and a district (referral) hospital. Three other contracts were for "Contracting-In," where the management of services is contracted out, but district health staff remains under MOH control. In all contracts, the MOH specified that the delivery of a defined package of health services and the service coverage were to be achieved within the four-year contract period.

Although the contracts have not yet been completed, evidence from MOH monitoring systems suggests that contracted-out districts performed significantly better in terms of service coverage, as compared with contracted-in districts, a result likely due to more effective managerial control over staff. However, the quality and efficiency gains of the contracting approach have yet to be established. As reported by contractors, obstacles to these contracts include lack of supply of vital diagnostic and health care equipment."

(Smith et al. 2000 draft paper)

#### Box 3.1

Community nutrition projects in Senegal and Madagascar reached a large number of malnourished children by implementing the contract management approach (See *Table 3.2*). Both projects successfully provided preventive services through the private sector, outside the dominance of government health sector (Marek et al. 1999).

	<b>Community Nutrition Project, Senegal</b>	<b>Secaline Project, Madagascar</b>
<b>Beneficiaries reached</b>	100,000 children up to 3 years of age and 131,000 women in 14 cities	241,000 children under 5 years of age and their mothers in 534 villages
<b>Overall management</b>	Agetip	Project's unit (Secaline)
<b>Services</b>	Monthly growth monitoring; weekly nutrition and education to mothers; referral health services for unvaccinated, severely malnourished, and sick children; home visits	Monthly growth monitoring; weekly nutrition and education to mothers; referral health services for unvaccinated, severely malnourished, and sick children; home visits
<b>Service delivery</b>	Groupement d'Interet Economique (GIE) comprising four young people from the community	Community Nutrition Workers (CNW)
<b>Supervision</b>	GIE or NGO	NGO
<b>Remuneration</b>	Minimum salary to the community GIE	Community Nutrition Workers paid in-kind (rice) equivalent to salary
<b>Impact</b>	Reduced malnutrition	Reduced malnutrition
<b>Replicability</b>	Expanded nationwide—23 CNCs in 3 cities to 176 CNCs in 14 cities	Expanded nationwide—2 regions to all the regions
<b>Sustainability</b>	Private contribution: 39% Training at community level—community nutrition community members and GIEs Contracting out with local institutions and consultants.	Private contribution: 50% Training at community level—community nutrition community members and GIEs Contracting out with local institutions and consultants.
<b>Community involvement and ownership</b>	Communities form a local steering committee in charge of monitoring the community nutrition center's performance Financial contribution	Communities form a local steering committee in charge of monitoring the community nutrition center's performance Financial contribution

***Table 3.2: Contracting out preventive health care***

### 3.1.2 *Other direct and indirect financial incentives based strategies*

An alternative to directly contracting for services is to indirectly support the demand or consumption of targeted child health care services.

#### 3.1.2.1 *Providing tax breaks and subsidies for increasing the coverage*

Provision of incentives and support of innovations ensure that the private sector can grow to its full potential and provide quality services to the poor at the same time. Providing tax breaks and subsidized capital are two commonly used incentive schemes in practice that increase health coverage, particularly in underserved areas.

- Subsidies to increase market penetration and affordability of health care

By using product and market subsidies and removing import and local taxes, developing countries can make specific services and products more accessible and affordable to the private sector. For example, liberalization in Tanzania and pro-private sector policies in Rajasthan, India, led to increased participation of the private sector in both provision and financing of health care including child health care (Winfrey et al. 2000; Munshi 1997) (See **Box 3.2**).

#### **Incentives to increase private sector participation**

Incentives for growth that the government of Rajasthan, India, bestows on private health institutions under the recent private sector policy include allotment of land at subsidized rates, sales tax relief on medical equipment, and eligibility for other fiscal benefits provided by government financial institution.

In exchange, medical institutions in specific categories are required to provide at least 10 percent of the beds free to economically weaker sections and to poor patients referred to by the authorized government officer. They are also required to provide an OPD facility free for one hour in the morning and one hour in the evening to economically weaker sections and poor patients referred to by the state government.

(Winfrey et al. 2000)

#### **Box 3.2**

- Tax advantages on important ingredients and materials

A recent survey of the tax treatment of three public health commodities—vaccines, ORS and contraceptives—in 22 countries found that specific tax relief arrangements are in existence and that vaccines receive the most favorable tax treatment (i.e. exoneration of most types of taxes for the greatest number of purchasers) (Krasovec et al. 1998). In almost all developing countries, government regulatory bodies give preferential tax and import treatment to “essential drugs.”

- Encouraging investments through tax breaks
  - The Board of Investment in Thailand helped establish new private hospitals by providing tax breaks (Bennett et al. 1997).
  - Pakistan has been successful in using tax incentives to convince private primary health care providers to set up operations in rural areas (Bennett et al. 1997).

#### 3.1.2.2 *Joint Investments as means to increase capacity and reach*

Joint investments are a non-regulatory means to influence private sector behavior. In exchange for investment, governments can claim a certain percentage of beds for poor patients (Newbander et al. 1997). In 1997, the government of Delhi, India, proposed joint venture schemes under which the government contributes part of the equity capital of the proposed organization in the form of land. The proposal indicates that the government's contribution should not exceed 26 percent of the share capital. In exchange for its contribution, the government expects the private sector to provide free care to a certain percentage of poor (about 30–40%) patients and participate in government public health programs (Bhat 2000).

#### 3.1.2.3 *Subsidizing costs of operations to increase viability of private health care providers*

Donors and governments provide financial support to encourage NGOs that meet priority health needs of the target group. Often, this support is provided

to meet operations and maintenance expenses for sustaining service delivery (See **Box 3.3**).

**Subsidizing recurrent costs of mission facilities**

In Malawi, the government collaborates with the Christian Health Medical Association. It subsidizes about 15 percent of recurrent costs in mission facilities in exchange for collaboration in providing a range of FP and IEC services.

(Krasovec et al. 1999)

***Box 3.3***

**3.1.3 Using government resources to increase coverage**

Some governments have provided resources to the private sector, resulting in increased coverage. Governments have provided

- Various incentives, such as free airtime on government-managed media (Slater and Saade 1996); and
- Free vaccines from government sources (See **Box 3.4**)

**Free vaccines as an incentive to deliver immunization services**

In some countries, such as India, Nigeria, Oman, Panama, and Zimbabwe, the government provides free vaccines to NGOs as an incentive to deliver immunization services. Government also provides insurance coverage for immunization services to encourage the private sector to deliver them. For example, the government of Korea provides medical insurance for the entire population, including the cost of immunization services obtained through the private sector.

(DeRoeck 1998)

***Box 3.4***

**3.1.3.1 Other examples**

Other direct and indirect financial incentives include

- Public subsidies and tax exemptions for health care providers;
- Extension of government's free insurance to cover immunization services provided by private providers;

- Channeling of donor funds to the public through NGOs;
- Use of joint investment programs to spur private-provider involvement in underserved areas;
- Provision of free vaccines to the private sector as an incentive to deliver immunization services;
- Easing of restrictions on advertising of child health products;
- Mandated inclusion of child health care services in health insurance policies.

**3.2 Regulation of Producers and Providers**

This sub section reviews a range of regulatory instruments for influencing the behavior of private health providers. It outlines prevailing strategies for putting pressure on private health providers to improve sector and provider performance.

**3.2.1 The need for government regulations**

Because governments and international agencies have substantial influence over private child health care market, government regulations can alter the behavior of the private sector and prevent market failures. Government actions and policies influence the activities and priorities of the private sector in many ways. For example,

- Government drug regulatory authorities approve the production, importation, and marketing of drugs on a national scale, thus influencing the marketing, distribution and promotional activities of the drug industry;
- Price and quality regulations protect clients against malpractice, monopolistic exploitation, and unreasonable escalation of prices;
- Government mandates and regulations guarantee good quality by setting service delivery standards for private providers, certifying the appropriateness of drugs and medical procedures, providing investment subsidies, and providing information (Bloom 1999).

### 3.2.2 *Types of regulations affecting the private health care*

Governments often focus on laws that do not address implementation, incentives, and capacity. Government regulations commonly cover (Bennett 1997)

- Aspects of quality-of-care, such as entry to the market (licensing) and use of hi-tech equipment;
- Competitive practices, such as advertising, a patient's right to change doctors, the right of primary practitioner to sell drugs, and so forth;
- Various aspects of market structure, such as the relationship between primary-level practitioners and hospitals; and
- Occasionally, regulation of health care fees.

### 3.2.3 *Laws and regulation-based strategies*

When governments remove unnecessary limits on the for-profit sector, they encourage it to increase its participation in child health care. Since the private sector comprises a wide range of players, governments need to specify carefully what their policies will promote and what they will restrict (WHO 2000).

#### 3.2.3.1 *Lowering legal and regulatory barriers*

Countries such as Malawi, Mozambique, and Tanzania have been successful in increasing private sector participation by eliminating unnecessary regulatory practices (Bennett et al. 1997). Some successful strategies and policies adopted by developing countries include

- Relaxing state-imposed restrictions on the use of revenue for health care—One initiative that has recently received a considerable amount of attention is the introduction of Medicare Relief Societies (MRS) in Rajasthan. MRSs are autonomous organizations that aim to complement and supplement existing service provision in public hospitals. The state provided incentives to form these societies by relaxing state-imposed restrictions on the collection, retention, and use of revenue by hospitals, thereby encouraging the use of

alternative financing mechanisms, such as user-fee schemes and in-hospital pharmacies. In addition, both the Ministry of Health and the Ministry of Family Welfare demonstrated a high level of commitment toward revenue generation, privatization, and managerial flexibility by granting essential autonomy and providing societies with seed money (Sharma et al. 2001);

- Increasing product choices for public health—In many countries, existing laws and regulations limit the population's access to child health care services and products. Some countries are loosening the regulations and controls on sale of public health products in order to increase access to these products. For example, in Sub-Saharan African and Latin American countries, private pharmacies provide immunizations after obtaining approval to sell vaccines from the government (Slater and Saade 1996)

#### 3.2.3.2 *Facilitating self-regulations among competing entities*

In health care markets where large NGOs and for-profit health care providers compete for clients, quality is critical to retaining clients; consequently, competing entities are not averse to self-regulation. Governments can encourage this practice by influencing the rules and regulations governing standards and norms for health care services and by subsidizing technical training and data systems that facilitate self-regulation. Some successful examples of self-regulations are as follows:

- PROSALUD self-regulates for quality and abides by the standards set by the MOH (Krasovec et al. 1999); and
- Under an NGO umbrella, the public and private sectors can jointly undertake regulatory functions with the NGO performing ratings and watchdog functions (**Box 3.5**).

#### 3.2.3.3 *Enforcing regulatory controls to ensure safe and affordable private services*

Because the heterogeneity of service providers and the wide range of services make regulation difficult, governments should implement a legal

### NGO participation in setting protocols and quality standards and assessing compliance

INSALUD, a nodal organization for more than 100 NGOs in the Dominican Republic, participates in the National Commission for NGO Qualification and Accreditation. INSALUD collaborates with the State Secretariat of Public Health and Social Welfare in the development of systems that seek to ensure that services provided by NGOs receiving public funding comply with minimum requirements, standards, and norms.

ASAPROSAR, in El Salvador, contracted with the MOH to establish quality-of-care requirements (norms, protocols, and procedures) and assess compliance. Similarly, CIES and PROCOSI in Bolivia and MEXFAM in Mexico have participated in and supported the development of protocols, norms, and procedures for their respective governments. The government and local NGOs adopted the norms, standards, and protocols that BEMFAM-Brazil used for self-regulation.

NGOs also provide quality assurance consulting and advisory services. CARE Guatemala recently carried out an evaluation of several health divisions to assess the quality of services.

(Rosenthal 2000)

#### **Box 3.5**

and regulatory framework that stimulates safe and affordable private services. An unregulated private sector leads to serious quality and equity problems. “The private sector is, to a large extent, motivated by profit, which sometimes leads it to ration care to those whose willingness and ability to pay allows providers to make a profit” (Bloom 1999).

Though private health facilities generally offer higher-quality care and operate more efficiently than their public sector counterparts (Rosen et al. 1999), in many countries there are legitimate concerns regarding the quality and cost of services provided by the private sector. Government mandates and regulations can be useful in guaranteeing quality by setting service delivery standards for private providers and by certifying the appropriateness of drugs and medical procedures (Bloom 1999). Wherever governments were unable to enforce such regulations, the private sector performed badly.

- Periodic renewal of personnel licenses is an effective regulatory mechanism. It forces private practitioners to maintain high quality standards and up-to-date knowledge.

- Accreditation of practitioners and facilities by professional bodies to conform to a defined minimum quality standard promotes informed decision making at the consumer level. In such programs, providers’ skills and physical facility are assessed, accredited (assigned quality ratings), and promoted among potential users.

#### *3.2.3.4 Enacting consumer protection laws and raising awareness of consumer rights*

Consumer interests and rights are weakly protected in most developing countries. Widescale promotion of the notion of “patients’ rights” and establishment of a mechanism to investigate violations quickly and fairly can help safeguard consumer rights effectively (WHO 2000). For example, consumer protection legislation is used as a means to protect consumers in India from private provider malpractice and negligence (See **Box 3.6**). To implement regulations effectively, patients, providers, and the media must know about these rules and regulations.

### Consumer Protection Act protects against private provider malpractice and negligence in India

The Consumer Protection Act, COPRA, came into effect in 1986 to protect consumer interests by establishing consumer councils. The purpose of this act is to promote and protect the rights of consumers, provide accurate information, protect consumers against unfair trade practices, and ensure that consumer interests receive due consideration in appropriate forums. There are about 500 consumer courts in the country. Such consumer protection acts can be effective in changing provider behavior and improving quality. But the experience so far indicates that COPRA, on its own, has limited effectiveness for changing provider behavior to improve quality standards.

(Bhat 1999)

#### **Box 3.6**

### 3.2.3.5 Introduction of exemption schemes for poor children

During the last 20 years, as the value of the world economy increased exponentially, the number of people living in poverty grew to more than 1.2 billion, including more than 600 million children (UNICEF 2000). Governments could introduce exemption schemes for priority target groups to

government's regulatory role both difficult and challenging (Rosenthal et al. 1997).

Corruption is a major factor in a government's ability to carry out its assumed responsibility, including regulation. Centralized decision making and a lack of accountability/transparency are important contributing factors in the promotion and sustenance of corruption.

#### Delivering basic health care services through an alternative system in Bolivia: PROSALUD model

Under a cooperative agreement with USAID, MSH provided technical assistance and financial support to PROSALUD, an autonomous, nonprofit Bolivian organization. PROSALUD and MSH worked together to develop a network of self-financing primary health care clinics for low- and middle-income people. These clinics are located throughout Bolivia and offer affordable, high-quality services, supported by community participation. The number of people using PROSALUD's health services grew from 200,000 in 1991 to 1 million in 1998. PROSALUD clinics provide free care to 10 percent of their patients, and their cost recovery is 70.9 percent. Achievement of full financial sustainability is supported by the endowment fund. The model has been replicated successfully in several places.

(Cuellar et al. 2000).

#### Box 3.7

ensure equity (See **Box 3.7**) and offer low-cost or free care to poor children. Both the public and private sectors may offer priority health services, such as immunizations, free-of-charge to all children. A survey conducted by Initiatives indicates that low-income women and children in Ghana already use private providers. A large number of private clinics discount or waive the fee for up to one-third of their patients (Sclafani 1997).

However, user fee without an effective mechanism of exemptions is not recommended. The WHR 2000 identifies out-of-pocket payment as the most regressive way to pay for health, and the way that most exposes people to catastrophic financial risk.

### 3.2.4 Government's capacity to initiate and maintain an effective regulatory system

Governments often lack the capacity to initiate and maintain an effective regulatory system that has legislative authority, a strong organizational structure, and the ability to monitor the use and quality of health care services (Newbrander et al. 1997). The complex structure of the health care market, with a large number of formal and informal providers, diverse distribution, and low capital investment coupled with generally poor public records and registration, makes the

Case studies on regulation of the private sector in India (Bhat 1997) find that

- 1) Little effort is spent on implementing and enforcing rules and regulations;
- 2) No policy exists to establish a common set of regulations for the private health care sector at the national level;
- 3) Private providers resist accepting the applicability of certain regulations for their profession;
- 4) Regulations have lost their relevance because they have not been revised; and
- 5) The private sector is not a high-priority on the government's policy agenda.

### 3.2.5 Limitations of current regulatory practices

Even though the private sector invariably plays a large role in the production and delivery of health goods and services, it does not receive due attention, which influences the child health outcomes. The government's focus on improving the performance of public sector providers is not sufficient for achieving health goals. Government policies can improve the quality and cost-effectiveness of private production and distribution (Buse 2000).

Current practices and regulations in developing countries restrict the private sector's ability to respond to the market, causing unnecessary delays in product registration processes, licensing, and certification. Some restrictions on the advertising of public health products discourage commercial sector participation in the production and marketing of public health commodities.

Governments sometimes control and constraint rather than allow the marketplace to function freely. For example, the Indian government developed a common label for ORS that commercial producers can use if they follow government product guidelines. The commercial sector, however, needs to differentiate its products (packaging, presentation, or appearance) in order to compete successfully (Rohde 1997). Similarly, government over-regulation is one of the most common constraints in motivating the commercial sale of ORS (O'Malley et al. 1990).

### 3.3 Information Dissemination

Information dissemination entails the use of both education and persuasion to change the behavior of providers as well as patients in ways that improve child health care services. This section discusses the prevailing strategies for information dissemination at policy, provider and community level.

#### 3.3.1 Policy level strategies

Because of an absence of relevant information about the extent and nature of private sector health care activities, the private sector receives little attention in policy formulation and implementation even though it has a strong presence in the delivery and financing of health care services in developing countries. Government policymakers know little about the commercial sector; consequently, they unintentionally hamper the growth of the commercial market. Thus, availability and use of comprehensive information on commercial sector potential are extremely important in formulating health care policies.

Most developing countries lack information to

foster communication and open discussion between the public and private sectors. Syntheses of existing and new information are necessary for effective planning. These syntheses should

- Include analyses of sources and uses of government expenditures;
- Examine segments of the market by income, source of services, and child needs;
- Compile data on markets and market potential; and
- Examine policies, laws, and regulations that affect private providers and commodity availability.

The availability of such information can facilitate analysis-based discussions of the respective roles of public, commercial, and NGO sectors. Information on the market can promote dialogue with the public sector and, consequently, help it identify segments of the child health market that truly need subsidized services.

USAID-funded POLICY Project activities in Brazil, the Central Asian Republics, Egypt, Ghana, Guatemala, India, Indonesia, Jamaica, Morocco, Philippines and Turkey illustrate the value of sharing data in seeking private-public collaboration. For example, market segmentation studies served as centerpieces for discussions during meetings of public and private sector stakeholders in Turkey, Morocco, and Jordan. Stakeholders examined the findings, evaluated the efficiency of the current market structure, and discussed visions of a perfect market structure with a greater role for the private sector. Participatory analysis-based decision making facilitated private sector participation (Smith et al. 1998).

The POLICY Project facilitated an analysis-based policy dialogue among key stakeholders regarding private sector participation in Morocco and the Philippines. In some countries, POLICY successfully involved public and private entities in collection, analysis, and transmission of health care information.

UNICEF promoted information sharing and networking between government and NGOs in

South Africa. It helped define roles in program implementation and adoption of bottom-up policies that defend children's rights. The process involved influencing national regulation, contributing to national thinking, and defining relationships between government and NGOs (Vanormelingen 1999).

### 3.3.2 *Provider level strategies*

Various studies indicate the existence of gaps between knowledge and practices among private practitioners, misuse of antibiotics for the treatment of simple diarrhea, and improper instructions to clients regarding doses and other information (Murray et al. 1998). "Village doctors" provide a bulk of health care to sick children in rural areas of India. The doctors lack formal training and sources for up-to-date information. Government has an important role to play in providing training to private sector providers. The private and public sectors can work together to improve knowledge and practices of public and private sector providers. For example, medical representatives, who are a major source of information about advances in treatment techniques and new products, have great potential to convince practitioners to change their prescribing behaviors.

A recent study conducted by Hudelson (1998) highlights several interventions undertaken to train private practitioners in integrated management of child health care. For example,

- In Bihar, private providers entered into a contract with NGOs regarding case management practices. After training, provider compliance with their contract was monitored and verified by consumer interviews (Chakraborty et al. 2000).
- In Kenya, shopkeepers were trained in dispensing antimalarials (AMs) and antipyretics (APs), advising purchasers how to administer AMs and APs, and referring patients to a health facility when appropriate to improve home management of childhood fevers.

- Training sessions for unlicensed drug retailers in Nepal and licensed drug retailers in Kenya, Indonesia, and the Philippines were organized to improve practices regarding dispensing drugs and advising and referring consumers. Moreover, providing training to traditional healers in South Africa and Sub-Saharan Africa highlighted the possibility of improving the quality of services provided by village doctors.

All these experiences indicate remarkable improvements in the behavior and practices of private practitioners after undergoing tailored training sessions.

### 3.3.3 *Community level Strategies*

Health education and information sharing sessions are effective mechanisms for promoting healthy behaviors and creating demand for preventive care at the community level. These sessions mobilize and empower the community; identify, clarify, and communicate the benefits of healthy behaviors; and provide information on how and where to access assistance when problems arise. Various international NGOs successfully use IEC to organize and mobilize communities in Bolivia, Ethiopia, Guatemala, Honduras, Madagascar, and Malawi to promote sustainable change at the household and community levels in key child survival behaviors (Salagado 1998; Bhattacharyya 1998; Alvarado 1998; Burkhalter 1997 and 1998, Sharma et al. 1999). Promoting healthy behaviors and creating demand for preventive care are highly cost-effective strategies in which NGOs can play a critical role.

#### 3.3.3.1 *Generating demand for preventive health care*

IEC campaigns and NGOs help create demand for preventive services, which are critical to child health care and attractive to the for-profit sector. NGOs can integrate their ORT promotion and education efforts into the public health care system.

NGOs are generally involved in providing health education and creating demand for preventive health care. International NGOs, such as CARE and Save the Children, undertake a variety of relief, development, and technical assistance activities. Health education includes informing mothers about the health benefits of hand washing, breastfeeding, feeding during malaria, and so forth. NGOs also help health workers set up ORS depots, carry out health education activities (See **Boxes 3.8 and 3.9**), mobilize the community to launch

illnesses (Murray et al. 1997). Promoting healthy behaviors is a cost-effective intervention in which NGOs have an important role to play.

- Children born within two years of the previous child are at least twice as likely to die in the first year of life as those born after an interval of two years.
- As compared with infants who are breastfed exclusively, non-breastfed infants have a risk of death from diarrhea that is 14 times greater,

#### **NGOs can play an important role in generating demand**

Thirty-nine tea estates in Malawi collaborated with Project HOPE to provide MCH services to their employees' families under the USAID child survival grant. Each estate hired a health promoter to provide MCH care to all families. The health promoters helped establish specialty clinics, build and maintain water and sewer systems, clean up residential compounds, and provide community education, immunizations, and other preventive measures. The tea estates continued to fund the program on their own following the end of the grant. A BASICS survey shows remarkable improvement in health as a result of this program. Well-child care improved from 20 to 55 percent during 1990-96; exclusive breastfeeding increased from 30 to 48 percent during 1994-96; and satisfactory housing, water, and sanitation improved from 71 to 88 percent during 1990-96. At present, there are 58 estates owned by 11 companies providing preventive care under this scheme to 55,000 workers and 270,000 family members.

(Burkhalter 1997 and 1998)

#### **Box 3.8**

preventive services such as immunization, and establish village health insurance systems (e.g., revolving drug fund) (Northrup 1997).

These activities can also help get patients to participate in "regulation."

#### *3.3.3.2 Promoting healthy behaviors*

Behavior changes reduce morbidity and mortality considerably. Simple actions such as breastfeeding, appropriate complementary practices, basic hygiene practices, and a full course of infant vaccines help considerably to prevent childhood

a risk of death from respiratory diseases that is 4 times greater, and a risk of death from other infections that is 2.4 times greater.

- Nearly 3 million children die each year from vaccine-preventable diseases.
- Various studies document a reduction in malaria disease rates of 20 to 63 percent following the introduction of insecticide-treated mosquito nets.
- Numerous studies report that improving hand-washing practices with soap and an adequate volume of water can reduce overall diarrheal

#### **Empowering community to participate actively in health care**

CARE's Integrated Nutrition and Health Program (INHP) in India serves 4.5 million women and 3.7 million children under the age of two. Under this program, nutritional and health care needs of pregnant and lactating women and children under two years of age are met by means of a package of goods and services provided at the village level. The package includes take-home kits of nutritional supplements, immunizations, local drug funds, and health education. A unique aspect of the program is the concept of self-management under which the rural people (women's groups) themselves manage the program with the guidance of CARE/India staff. These groups initiate various need-based health financing schemes, and group members generate, manage, and control funds. Working with the women's groups is an indirect means to empower the women with resources, training, and better health.

(Sharma et al. 1998)

#### **Box 3.9**

- disease mortality by 30 to 50 percent.
  - Mortality will likely decline 23 percent when vitamin A status rises to normal values
  - Iodine deficiency is the world's greatest single cause of brain damage and mental retardation. Consumption of iodized salt is the most cost effective way to reduce iron deficiency.
  - Correct application of ORS can reduce diarrheal mortality by 70 percent.
- Efforts to promote healthy behaviors, combined with interventions to improve service quality and accessibility, can bring about remarkable improvement in child health care (See **Box 3.10**).

#### Promoting healthy behaviors

BRAC, an NGO in Bangladesh, taught about 6 million households about using a homemade sugar-salt solution to treat diarrhea.

(Northrup 1997)

A peer-to-peer training program to improve the skills of health workers was conducted in 13 of the province's 110 health centers in Maluku during 1993-94, leading to a 40 percent increase in immunization coverage rates. The program was developed by an NGO that included both provincial and district ministries with funding support from USAID.

(Burkhalter 1997)

La Leche League International and La Leche League Guatemala established a community network of mother-to-mother support in poor areas of Guatemala City. About 214 community volunteer mothers were trained and supervised as breastfeeding counselors. The selected volunteers organized and operated mother support groups and provided individual counseling and referrals to mothers and children in health facilities.

(Burkhalter 1998)

#### Advertising soap as a public health product

In Central America, soap producers and public sector health and development organizations collaborated to promote hand washing as a means to prevent diarrhea, using a social marketing strategy. Behavioral change reduced prevalence of diarrhea by up to 60 percent in selected groups. Advertising soap as a public health product resulted in a significant increase in sales for commercial soap producers.

(Miller 1997)

#### **Box 3.10**

## 4 Expanding the Role of the Private Sector in Child Health Care: Strategies and Instruments

The available evidence suggests that usually the public sector is overextended and engaged in activities, which could be done by the private sector. A clear assessment of the private sector can reveal areas where the private sector is already active and is contributing to sectoral objectives. In such cases, “easy- win” reform strategies may be developed for enabling growth in these sub-sectors. Such a strategy requires: identifying the easy win sectors; identifying constraints to their enabling environment over which the government has influence; developing and implementing changes in the enabling environment (reducing barriers to entry, transaction costs, improving access to financing, inclusion in (public) referral systems etc.

The private sector has an enormous potential to help meet the increasing demand for high-quality child health care because it has large untapped sources. Some developing countries have been successful in leveraging this potential. The strategies and instruments they used are summarized in *Table 4.1*.

### 4.1 Strategic use of resources—division of labor between the government and private sector

Many countries are seeking strategies and solutions that will allow them to use both public and private sector resources and services efficiently and effectively. The central issues in determining an appropriate mix of public and private health care provision and financing are as follows:

- Defining which sets of services each sector can handle most effectively, and
- Ensuring that the work done in each sector complements the work done in the other.

An appropriate public-private mix must be found to increase equity or correct market failure. Public and private sector roles should consider country-specific conditions, including market size, demand for child health care, and the ability and willingness of consumers to pay for child health care. The two sectors must build an understanding of common objectives and complementary

STRATEGY	INSTRUMENTS	Strategies for POLICY MAKERS and PROVIDERS	Strategies for COMMUNITY
GROWING THE PRIVATE SECTOR to facilitate the use of scarce government resources on priority interventions and objectives	Creating an enabling environment	<ul style="list-style-type: none"> <li>- Creating an enabling environment for private sector growth</li> <li>- Involving the private sector in promoting and selling child health care products</li> <li>- Social marketing- subsidized products sold through commercial channels</li> <li>- Using commercial product promotion and distribution channels</li> <li>- Delegating responsibility to NGOs for geographic areas, populations, or specific health services</li> </ul>	<ul style="list-style-type: none"> <li>- Encouraging wealthier clients to use commercial sector services</li> </ul>
	Privatization	-	-

**Table 4.1**  
**STRATEGIES AND INSTRUMENTS FOR EXPANDING THE PRIVATE SECTOR**

resources (see **Box 4.1**), taking into account the following factors:

**Appropriate roles of the public and private sectors**

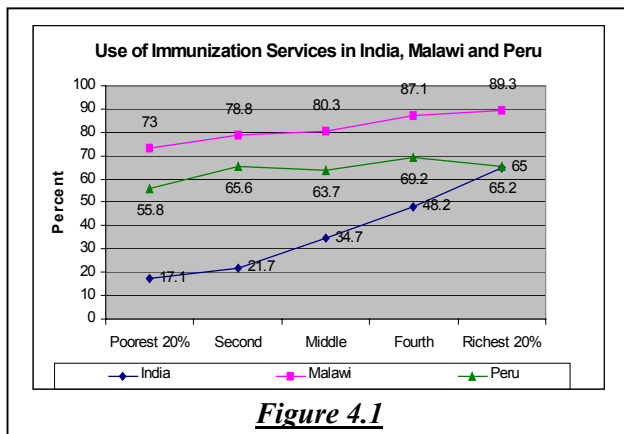
Generally in the private sector, private practitioners treat children; NGOs provide health education to communities for better mother and childcare; and commercial sector manufactures market health products such as ORS.

(Northrup 1997a)

**Box 4.1**

1. The “Haves” versus the “Have-Nots”: those who can and those who cannot afford to pay

Various studies confirm that the government resources available for child health care services are not being targeted effectively (See **Figure 4.1**). Relatively wealthy patients are equally or more likely to use subsidized government health care than their less wealthy counterparts. By redirecting public funds to poor and hard-to-reach communities, the government can attract commercial sector interest. In this way, governments can complement rather than displace commercial sector efforts. Governments hold the ultimate responsibility to ensure accessibility and affordability of child health care services to poor and needy.



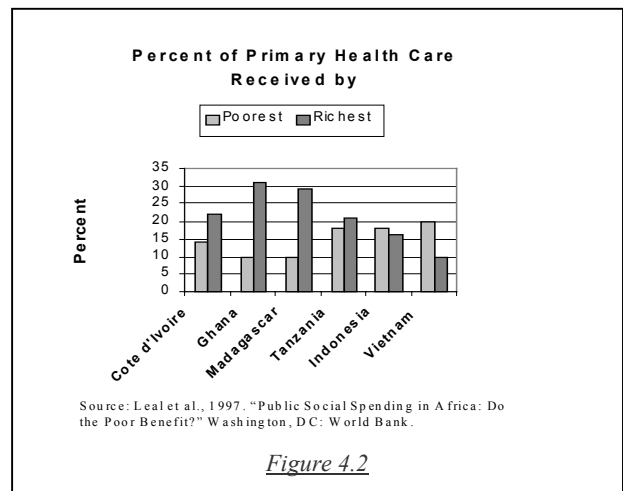
2. Rural and remote versus urban

The private sector usually serves the urban elite, who can afford to pay, as opposed to urban slum dwellers and rural populations, who may not be able to afford to pay. For example, in Tanzania, 78 percent of private for-profit units are located in urban areas (Munshi 1997). Similarly, in Nepal and South Africa, 100 percent and 63 percent, respectively, of private hospital beds are in urban areas. In this case, NGOs and government sectors can assume responsibility for providing services to remote and rural areas.

3. Primary and preventive versus tertiary and curative care

In Botswana, Gambia, Guinea, Namibia, Seychelles, Uganda, and Zimbabwe, tertiary care hospitals received a larger share of public sector health funds than did primary care facilities, indicating that more public sector funds are going toward curative health interventions, which tend to be more expensive and less cost-effective than preventive care. **Figure 4.2** shows that in four of six countries, the richest group captures a greater share of primary health care spending than the poorest group.

Emphasis on commercial sector participation in production and distribution implies greater allocation of public resources to prevention and health promotion.



Other preventive services that NGOs can provide include demand generation and health education because NGOs are generally involved in educating mothers about the health benefits of hand washing, breastfeeding, and feeding during malaria. They can also inform community and health workers about how to set up ORS depots or carry out health education activities, mobilizing and organizing communities to launch preventive services such as immunization.

#### 4. Public versus private goods and services

An analysis of DHS data of 11 countries shows lower use of private sector services for the more “public” goods, with significant demand-side market failures, such as immunization, and it shows higher use for private goods, such as treatment of childhood diseases (Berman et al. 1994).

Governments provide some public goods in the form of advocacy and information, research and development, subsidies for the poor, and specific services with substantial externalities, such as immunization and communicable disease control. In many cases, public goods focus specifically on the needs of children and complement essential health care services that could be provided by the private sector.

## 4.2 Strategies to grow the private sector

### 4.2.1 *Creating growth environment for private sector growth*

By creating a favorable environment for the private sector and particularly for NGOs, governments and donors encourage greater NGO participation. The following strategies have been used to create an enabling environment for private sector growth in service delivery:

- The World Bank’s NHP projects in Africa stimulated greater NGO participation. NGOs were given an important role in the World Bank-financed NHP projects, and their share of involvement in the projects increased from 43 percent in 1990 to 100 percent in 1996 (Elmendorf 1999).
- In Malawi and Haiti, the MOH formally

requested that Save the Children Federation (SCF) provide and manage provision of health services in general, and child health care in particular. The district assumed a regulatory role. MOH staff in Maissade was incorporated into the SCF community health team as much as possible. The program expanded to the regional level and served a population of 500,000 in 1993. The SCF introduced and financed new programs, such as revolving drug funds, which later achieved self-sufficiency and are now managed by local health committees (Swedberg 1999).

- Donor agencies are channeling an increasing amount of funds in developing countries through NGOs; for example, since 1998, 15 percent of overseas development aid filtered through NGOs (Buse 2000).
- In 1999, the Global Alliance for Vaccines and Immunization (GAVI), a coalition of public and private interest groups, was formed to ensure that every child is protected against vaccine-preventable diseases. This coalition of governments, businesses, private philanthropists, and international organizations is working toward covering at least 80 percent of immunizations by 2005. Coalition participants are providing and managing a multimillion-dollar global fund for children’s vaccines (WHO 2000).
- In some countries, donors provided commodity support to nurture healthy commercial markets. For example, in Indonesia, USAID promoted the use of a leading soap, Lifebuoy, as a hand washing and hygiene product, thereby increasing its market share remarkably (Slater and Saade 1996).

### 4.2.2 *Encouraging wealthier clients to use commercial sector services*

A desire for respect, dignity, and good standing in the community are very important motivating factors for the commercial sector to work in the social sector (Slater and Saade 1996). Government and donors play an important role in creating demand for private sector services by improving the image of private sector providers. This strategy is effective in encouraging wealthier clients to use

commercial sector services (see *Box 4.2*). Other incentives for diverting wealthier patients to the private sector include user fees in public hospitals, restrictions on use of public services, and mandated inclusion of child health services in health insurance policies.

#### Improving image and status of private providers

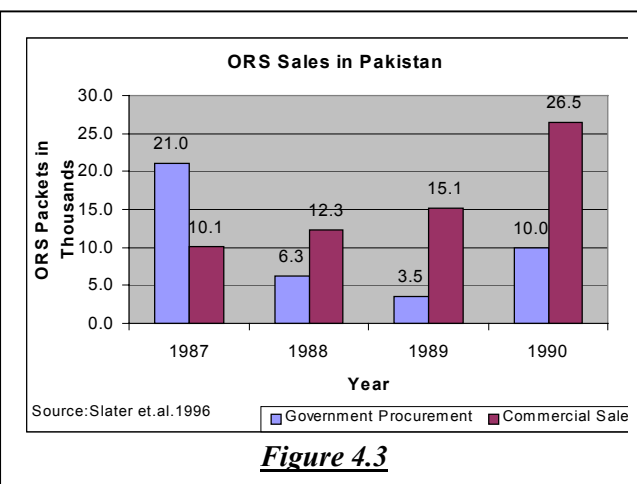
The government of Indonesia launched a "Blue Circle" campaign that aimed to improve the image and status of private doctors and trained midwives as high-quality providers of family planning services. After a 5-week campaign, the average weekly FP caseload increased by 28 percent for doctors and 36 percent for nurses.

(Krasovec et al. 1999)

#### *Box 4.2*

#### 4.2.3 Involving the private sector in promoting and selling child health care products

Private sector distributors can prove effective in promoting and selling health related products directly to consumers. For example, the public sector's inability to distribute free ORS led to greater private sector participation in Pakistan. The sale of ORS packets increased from 10 million to 26 million during 1987–90 (See *Figure 4.3*) (Slater et al. 1996).



*Figure 4.3*

#### 4.2.4 Social marketing—subsidized products sold through commercial channels

Distributors are getting involved in active social marketing of critical public health commodities. Products include ORS packets, soap for hand washing, insecticide-treated bed nets to prevent malaria (See *Box 4.3*), Vitamin A supplements, foods fortified with Vitamin A and iron, and vaccines (Northrup 1997a). In Bolivia, collaboration between public and private health sectors succeeded in improving child health care: after realizing the limitation of its own distribution system, the government encouraged the private sector to participate in increasing and sustaining the ORS availability (Slater and Saade 1996; BASICS 1999; Northrup 1997a).

#### Social Marketing of Insecticide-Treated Mosquito Nets (ITNs) in Tanzania

"In Tanzania, donor resources are used to generate demand for and access to ITNs in order to reduce the incidence of malaria. A social marketing organization is working with three local mosquito nets manufacturers. The NGO and private sector outlets are selling nets, with or without an insecticide treatment, at subsidized rates. The project resulted in increased coverage of households and greater private sector participation. The market for nets doubled to one million in three years and a third net manufacturer entered the market. Commercial marketing led to reductions in prices from net manufacturer, wider choices of nets, and greater awareness regarding the efficacy of insecticide-treated nets."

(Smith et al. 2000 draft paper)

#### *Box 4.3*

#### 4.2.5 *Using commercial product promotion and distribution channels*

Commercial product promotion and distribution networks can be used to make public health products such as ORS, insecticide-treated bed nets, iodized salt, iron supplements, chlorine bleach, and

Similarly, SIFPSA undertook a rural social marketing project with a private company (See *Box 4.4*).

#### 4.2.6 *Delegating responsibility to NGOs for geographic areas, populations, or specific health services*

##### **Contraceptive and ORS marketing in UP using commercial channels: SIFPSA Example**

In Uttar Pradesh, India, Hindustan Latex Limited (HLL) undertook a rural social marketing project for the State Innovations in Family Planning Services Project Agency (SIFPSA) in 1997. The company was supposed to cover 43 districts in UP in three years. The distribution strategy adopted by HLL included creation of distribution points in feeder towns and *tehsils*, direct van sales promotion, sales through CBD workers of PVO projects, sales through dairy cooperatives. HLL has appointed 97 stockists to cover all 28 districts. HLL is collaborating with 58 NGOs and milk cooperatives in 10 districts. SIFPSA evaluates the reported sales promotion through an independent audit system. All these distribution channels are also being used for the social marketing of ORS. In addition, SIFPSA has invited competitive bids from commercial firms with marketing strengths to promote sales of contraceptives in rural areas.

(SIFPSA 1999)

##### **Box 4.4**

so forth, available to even the smallest retail outlets and information distribution systems. Developing countries are increasingly using commercial networks to distribute contraceptives. For example, in Andhra Pradesh, India, the state government signed a one-year Rs. 44 million contract with Hindustan Latex Limited to initiate a statewide social marketing program for condoms and ORS.

NGOs often function like an additional arm of government by providing services in areas where government services are not available (See *Boxes 4.5*). In many cases, the government provides financial support to NGOs to provide additional services. Also NGOs can help identify problems and explore and test innovative solutions.

##### **NGOs complement government services**

NGOs in Bangladesh provide an estimated 50 percent of immunizations in urban areas, mainly because of the lack of government primary care services in cities, while the public sector is the main provider of immunization services in rural areas.

(DeRoeck et al. 1998)

In El Salvador, the NGO FUSAL signed a three-year contract with the MOH assuming full responsibility for primary health services in the Municipality of San Julian, a difficult-to-reach, underserved rural area.

In Guatemala, CARE operates a project in partnership with the MOH and Ministry of Social Welfare, in which it manages seven jurisdictions where health coverage is minimal and no formal service provision is operational.

(Rosenthal 2000)

##### **Box 4.5**

## 5 Proposed Actions for Effective and Sustainable Private Sector Participation

A comprehensive and integrated approach to child health care is required to harness the full potential of the private sector and find solutions beyond the public health system to meet growing child health care needs. All stakeholders—government, NGOs, the commercial sector, and households—need to share common concerns and actively participate to broaden policy dialogue; and develop a single sector policy (that addresses public and private sector issues), a common realistic expenditure program, common monitoring arrangements, and more coordinated procedures for funding and procurement (WHO 2000).

Governments need to open communication channels with private sector health care providers and recognize the growing role that they play in child health care. Because of a scarcity of government resources, it is critical that resources not be spent on activities that the private sector performs. At the same time, government must support and manage the private sector so that it becomes a cost-effective alternative and encourages affordable health services.

### 5.1 Formulation of conducive policy for private sector participation

Although the private sector plays a critical role in the provision and financing of health care services, it is usually ignored in the formulation of health policy; consequently, policies and programs remain unrealistic and do not achieve the desired impact. Government can involve the private sector in a variety of ways, including sponsoring public-private stakeholder consultations, government-business roundtables, new forums, and so forth. Establishment of a private-NGO sector collaboration division in the Ministry of Health could go a long way in fostering the role of this sector. For example, in Egypt, NGO representatives are included by design on all government strategic planning teams to ensure that NGO interests are represented in strategic plans and that plans foster inter-sectoral collaboration. Similarly, in Ukraine, representatives of the government, NGOs, and the private sector formed

a Policy Development Group, which organized meetings regularly to address legal and regulatory environment issues and develop a national reproductive health program for 2001–2005 (SAR7, 8, and 9).

### 5.2 Role of partners, donors and technical agencies in facilitating and guiding the government in private sector participation and development

Governments and donors need to realize that there is an increasing dependence in developing countries on the private sector for both delivery and financing of health care services to meet health care challenges. In these countries, not only is there a lack of communication between government and donors, but there is also mistrust. Fostering communication and open discussion based on sound information is essential to improving public-private collaboration. For example, dialogue between policy champions and private sector players are critical to effectively implement rules and regulations.

Donors play an important role in facilitating greater private sector participation. Their influence can be used to bring about fundamental changes in health policies, such as reorientation of government health services toward the poor. International NGOs and donors can also help bridge the information gap by supporting research on markets and demand for child health care and sharing this information with the government and commercial sector.

### 5.3 Capacity strengthening of public sector on stewardship function

Good stewardship needs a better information base, an ability to build coalitions of support from different groups, and ability to set incentives (WHO 2000). For performing the stewardship function effectively, governments need proper systems in place and also skilled staff, which can be obtained through recruitment and through training and technical aid to existing staff.

Effective public provision and financing systems are necessary to prevent undesirable market failures.

Stewardship requires a well thought out, analysis based policy, which recognizes and involves the private sector and assigns them roles. It involves setting system goals, identifying priorities, analyzing resource requirements, building consensus and informing people.

For exerting influence, governments require regulatory and advocacy strategies consistent with health system goals and the capacity to implement them cost-effectively. The regulatory and monitoring functions of the stewardship machinery will change in accordance with the policy. Regulation involves both the framing of rules to govern the behavior of the private sector and ensuring compliance with them. Generally lack of commitment, concern and funds impede governments' capacity to carry out regulatory responsibilities effectively. Governments need to build capacity in contracting skills and regulatory oversight. Design and implementation of regulatory oversight and contractual strategies involves high transaction cost in the beginning.

Governments need good intelligence systems, involving both information and understanding about the market, to perform the stewardship function effectively. The availability of such information can facilitate analysis-based discussions of the respective roles of public, commercial, and NGO sectors. Information on the market can promote dialogue with the public sector and, consequently, help it identify segments of the child health market that truly need subsidized services. Governments need the following:

- Analyses of National Health Accounts
- Information on segments of the market by income, source of services, and child needs;
- An understanding of provider market structure and utilization patterns and
- An understanding of policies, laws, and regulations that affect private providers and commodity availability.
- Training needs assessment
- Information on interventions offered by the private sector and their quality of services

## 6 Key Policy and Implementation Issues

### 6.1 Competition from Subsidized Products Can Crowd out the Private Sector

The presence of large public sector programs that provide low-cost or free commodities and services strongly hinders the development of commercial markets. A study of 45 countries shows that strong government programs lead to small commercial presence (Rosen et al. 1999). With its highly subsidized commodities and services, the public sector usually crowds the commercial sector out of the child health market.

### 6.2 People Seek Health Care from a Broad Range of Sources

People seek health care from a broad range (public and private) of sources. Private providers are more popular for child health care. Informed choices involve trade-offs between cost, convenience, and amenity level on the one hand and technical quality-of-care on the other hand. Generally, the private sector responds better to the trade-offs perceived by patients (that is, the patient can perceive consumer quality, but not clinical quality).

### 6.3 The Public and Private Sectors Could Be Competitors Too

There are a number of alternative scenarios in which the public sector might work together with the private sector. The public sector is considered more equitable and the private sector more efficient. At times, the public and private sectors are seen as competitors, which may enhance efficiency of the health care system. However, government collaboration with the private sector has a better chance of improving coverage of public health services. Public-private competition is likely to be most successful in areas where “informational asymmetries are low and monopoly power [is] limited” (Bennett et al. 1997).

### 6.4 The Quality of Services Provided by Private Health Practitioners Varies

Private sector services are generally better in terms of consumer quality, but exhibit problems in clinical quality.

#### *i. Consumer Quality*

Private health care services are generally perceived to be of higher quality and more efficient than their public sector counterparts. However, the quality of services provided by private providers varies greatly and is difficult to monitor by the government. Accreditation of health service organizations by independent professional bodies may be worth considering in this respect.

#### *ii. Clinical Quality*

Numerous studies in developing countries report that the technical quality of care among private providers is inadequate. These studies reveal shortcomings in the private sector’s case management practices for childhood illnesses (Chakraborty, et.al.2000). Some common quality concerns include emphasis on profitable interventions as a result of supplier-induced demand; deferral to the public sector for more complex and chronic cases; and neglect of preventive measures as a result of poor knowledge of consumers. For example,

- A comparative study of private and public sector services in Mexico revealed shortcomings in case management offered to children under the age of five with diarrhea and ARI. In general, the treatment offered by the public sector was better than that offered by the private sector (Bojalil et al. 1998);
- BASICS experiences in several countries revealed that the quality of private practitioners is woefully inadequate in those countries (BASICS 1999);

- The private sector often neglects preventive measures because of poor knowledge of consumers, and it emphasizes profitable interventions that are not medically required (supplier-induced demand). A comparative analysis of public and private sector services in Malaysia indicates limited involvement of the private sector in the delivery of preventive services, raising serious quality concerns. For example, the private sector did not adequately maintain the immunization cold chain (Aljunid et al. 1997);
- Evidence of supplier-induced demand is widespread. A recent study by Thaver reports that there is widespread and excessive use of antibiotics and injections in Pakistan. Kenya, Pakistan, and Zambia also exhibited higher prescription rates of anti-diarrheal drugs by private providers (Bennett et al. 1997);
- A comparison of productivity indicators suggests no clear preference for public or private providers in urban Thailand. The public sector, however, treats more complex and chronic cases and is generally chosen by elderly patients; the private sector is more popular for children (Pannarunothai et al. 1997). The public sector has a clear price advantage for more expensive care (complex and chronic); and
- In Pakistan, non-government physicians, uncertified doctors, healers, drug sellers, and other private sector practitioners treated about 84 percent of diarrhea cases (Northrup 1993)

### 6.5 The Public and Private Sectors' Priorities May Differ

Public and private providers face different types of inducements and constraints. Consequently, both sectors allocate resources differently and, in turn, produce different health outcomes and costs. Commercial motives, supplier-induced demand, and curative biases are largely responsible for the differing priorities.

Private providers respond to the population's

willingness to pay. Hence, the private sector will undersupply the socially desirable services, such as immunization, to segments that may not be able to pay for them. Policymakers need to devise strategies to counter such tendencies and ensure proper delivery of public goods.

### 6.6 Mobilizing the Commercial Sector Is Different from Mobilizing the Non-Profit Sector

Mobilizing the commercial sector does not entail subsidizing production or funding a company's operations. Instead, it demands motivating commercial companies to take responsibility for sustainable production, and distribution and marketing of public health products. Usually, an initial inertia-breaking effort by governments and policymakers is required to support commercial ventures.

NGOs often function like an additional arm of the government by providing services in areas where government services are not available. In many cases, the government provides financial support to NGOs to provide additional services.

### 6.7 Non-Economic Benefits Also Motivate the Private Sector

Health care providers have both economic and non-economic motivating factors. Companies often fail to realize the public health potential of their products. A company's social responsibility can improve its image and attract more business. (See

#### **Improving image and attracting more business**

Local commercial producers and national governments collaborated to increase the production, availability, and use of ORS in countries such as Bolivia, Kenya, Indonesia, and Pakistan. As a result, private sector sales increased three fold in the late eighties.

(O'Neill et al. 1997)

Merck pharmaceutical company is making the drug ivermectin available free of charge to developing countries to fight river blindness.

(Slater and Saade 1996)

#### **Box 6.1**

**Box 6.1).** Policymakers should also consider this factor while designing and implementing strategies that tap health care professionals' non-economic motivating factors.

A study conducted in slum areas of Pakistan reveals that private practitioners are eager and willing to provide preventive services (Thaver et

al. 1997). A survey conducted by the NGO Initiatives reveals that personal financial rewards, professional autonomy, dissatisfaction with government bureaucracy, and a desire to help people are among the important motivating factors that drive health professionals to work in the private health care sector (Sclafani 1997).

## 7 Information Gaps and Future Study Needs

The current report does not cover all areas and information gaps in the available research materials. Many unanswered questions remain, including the following:

- Does the participation of the private sector significantly lower government health care costs?
- What impact does higher private sector provision of child health care have on equity, access, quality, and cost of services?
- What are the advantages and disadvantages of contracting out preventive health care services?
- Can government and private networks complement each other to ensure a constant supply of public health products? Can they monitor the demand for such products?

Additional research studies are needed to fill these information gaps and enable policymakers to perform more effectively in their decision-making and deployment of child health care resources. Some research topics that need to be examined include

- Strengths and limitations of market-based allocations in determining the volume and distribution of health services;
- Non-regulatory means of influencing private sector behavior;
- Impact of an open rating system on quality-of-care;
- Types of contractual relationships between public and private providers;
- Privatization options for the public sector, including hospital autonomy, internal markets, and performance-related pay and contracts;
- Effective approaches for improving the concern and commitment of service providers and determining the proper regulatory role of the government. Both the public and private sectors seem to suffer from a noticeable absence of genuine concern for the well being of those they are supposed to serve. Unless this problem is recognized and addressed, changing the sectors' roles may not bring about the

desired improvements. In fact, services may deteriorate if governments increase the role of the private sector but take a heavy-handed approach in its regulation;

- Design and development of a minimum regulatory package;
- Impact of decentralization on the private sector and its capacity to form effective partnerships with the public sector;
- Effect of privatization of primary health care;
- Stakeholder analysis and reactions to increasing privatization;
- Relative cost-effectiveness of using public funds to improve private provision versus strengthening the public sector itself; and

Access to for-profit sector services by the poor, including the actual degree of current access and barriers; cost to the patients of "free" public sector services; per patient/service cost to the government compared with private sector costs; and the effectiveness and feasibility of a voucher system similar to American food stamps.

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## 8 Proposed Structure for the Toolkit

1. Introduction to the Toolkit
  - 1.1 Why a toolkit?
  - 1.2 What is its approach?
  - 1.3 How to use it?
2. Why Do We Need to Mobilize the Private Sector for Child Health Care?
  - 2.1. Inability of the public sector to meet child health care needs
  - 2.2. Private sector—dominant provider of child health services in low-income countries
  - 2.3. Changing perspectives on the “role of state”
3. What are the Prerequisites?
  - 3.1. Integrating the private sector into health policy
  - 3.2. Building a positive and supportive attitude toward the private sector
  - 3.3. Building on the comparative advantages of each sector
  - 3.4. Capacity strengthening of public sector on stewardship function
  - 3.5. Role of partners, donors and technical agencies in facilitating and guiding the government
4. How to Harness the Private Sector?
  - 4.1. Incentives
    - 4..1.1. Contracting out
    - 4..1.2. Tax breaks and subsidies
    - 4..1.3. Joint investments
  - 4.2. Regulation
    - 4..2.1. Self-regulation
    - 4..2.2. Lowering regulations
    - 4..2.3. Accreditation
    - 4..2.4. Enforcing regulations
  - 4.3. Information dissemination
    - 4..3.1. Policy level
    - 4..3.2. Provider level
    - 4..3.3. Community level
5. How to Expand the Private Sector?
  - 5.1. Growing
  - 5.2. Creating an enabling environment
  - 5.3. Using commercial channels
  - 5.4. Social marketing
  - 5.5. Delegating responsibility to NGOs
  - 5.6. Targeting government services
  - 5.7. Privatizing
6. How to Proceed?
  - 6.1. Gathering information
  - 6.2. Analyze sources and uses of government expenditure
  - 6.3. Examine segments of the market by income, source of services, and child health care needs  
Compile data on markets and market potential
  - 6.5. Examine policies, laws, and regulations that affect private providers and commodity availability
  - 6.6. Identify and involve key stakeholders in dialogue between the public and private sectors to determine terms of collaboration and market niches

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## Annex 1

**Table A1. Lessons Learned.**

<i>Lesson</i>	<i>Country</i>	<i>Source</i>
<b>Contracting with the private sector can work</b>		
Ministry of Health contracted with local NGOs to provide health services. Contracts not yet complete but results positive to date	Cambodia	Smith, L. 2000
Local NGOs provide primary health services in selected areas under contract to the Ministry of Health	El Salvador, Guatemala	Rosenthal 2000
Government requested that NGO Save the Children manage and provide child health care services	Haiti, Malawi	Swedberg 1999
Private providers of child health care services are less effective than public providers	Mexico	Bojalil 1998
Benefits of outsourcing vary directly with the quality of governance; poor countries may be ineffective at outsourcing without technical assistance. Suggests the need for regulation and incentives to improve private provider effectiveness	Multicountry	Broomsberg 1997
Contracted, NGO-managed services provide thousands of children with nutrition assistance	Senegal, Madagascar	Marek 1999
Contracting with church providers to serve clients who would otherwise use public health services may generate technical efficiency	Zimbabwe	Gilson 1997
<b>The private sector, especially NGOs, can focus on poverty</b>		
Prosalud, a local NGO supported by USAID through Management Sciences for Health, offers free or subsidized health care for one million low- and middle-income clients, recovering 70 percent of costs	Bolivia	Cuellar 2000
Half of surveyed private clinic users are from low-income groups. Private sector competes with public sector for poor customers	Ghana	Sclafani 1997
Poorest quintile of households spends 15 percent of income on health care; richest spends five percent. Even “normal” health care spending, and especially a catastrophic health spending requirement, incurs heavily of the budgets of the poor	Multicountry	Fabricant 1999
NGO self-regulation works. In Bolivia, Brazil, El Salvador, and Mexico, NGOs led in setting standards and monitoring compliance	Dom. Republic, other LAC region	Krasovec 1999
Government subsidizes 15 percent of the recurrent costs of mission facilities to provide a range of family planning services and IEC for maternal and child health	Malawi	Krasovec 1999
Project HOPE helped 58 tea estates hire health promoters. Increases in well-child care, exclusive breastfeeding, and hygiene and sanitation attest to program success	Malawi	Burkhalter 1997, 1998

<i>Lesson</i>	<i>Country</i>	<i>Source</i>
International NGOs provided IEC to communities in six countries that improved child survival behaviors. Providing IEC may be more cost-effective than paying for commodities or services	Multicountry	Salagado 1998, Bhattacharyya 1998, Alvarado 1998, Burkhalter 1997, Sharma 1999
Donor assistance to NGOs has a positive impact on private sector effectiveness and health outcomes	Multicountry	Buse 2000, WHO 2000, Northrup 1997a
<b>The private sector, basic and essential care</b>		
Training private providers in integrated management of sick children and in dispensing of antimalarials and other drugs improved quality of services	Bihar, India, Kenya, Nepal	Hudelson 1998
Two-thirds of the poorest quintile in Dominican Republic and 48 percent of that quintile in Zambia get ARI treatment in the private sector	Dominican Republic	Gwatkin 2000
Most (80%) Indian families use private providers to treat childhood illness. Ninety-three percent of diarrheal cases are treated privately. In Udaipur, Rajasthan, even users of public services incurred substantial out-of-pocket costs for child health care. The public sector pays too little attention to making the private sector more effective in preventive services. Public services cost less but may still burden the poor	India	Chakraborty 1998; Northrup 1997; Hotchkiss 2000
The Blue Circle Campaign helped shift higher-income clients to private providers, increasing their caseloads by more than 25 percent	Indonesia	Krasovec 1999
Private providers neglect preventive measures	Malaysia	Aljunid 1997
Information dissemination, a public good, can enhance effectiveness of private sector health care provision	Multicountry	Smith 1998; POLICY Project
Six governments (India, Korea, Nigeria, Oman, Panama, and Zimbabwe) provide free vaccines to private providers to encourage delivery	Multicountry	DeRoeck 1998
Behavioral changes that include hand washing, breastfeeding, family planning, immunization, and use of treated bed nets reduce child mortality dramatically. IEC promotion efforts work to effect behavioral change in many settings	Multicountry	Sharma 1998, Murray 1997, Miller 1997
Big public programs can crowd out potentially effective private sector provision	Multicountry	Rosen 1999
Pakistan's government provided tax incentives to encourage private providers to establish themselves in rural areas	Pakistan	Bennett 1997
Slow distribution of public oral rehydration salts led the government to allow the private sector to sell the salts; distribution more than doubled between 1987 and 1990	Pakistan	Slater 1996
Effective outsourcing includes well-baby clinics, immunization, community nutrition assistance, and other preventive services	Senegal, Madagascar	Marek 1999
Social marketing of insecticide-treated bed nets increased coverage and doubled sales in three years	Tanzania	Smith L 2000

<i>Lesson</i>	<i>Country</i>	<i>Source</i>
Commercial sales of condoms	Uttar Pradesh, India	SIFPSA 1999
<b>Regulations and incentives matter....</b>		
Regulation of the private health sector is honored in the breach. Still, government over regulation—of oral rehydration salts, for example—constrains commercial sales. Variability in the application of regulations inhibits their effectiveness	India	Bhat 1996, Rohde 1997, O'Malley 1990
The Consumer Protection Act of 1986 sets standards and provides legal recourse through 500 consumer courts in case of dissatisfaction with private MD services	India	Bhat 1999
Lowering legal and regulatory barriers improved outcomes in private sector child health service delivery	Mozambique, Malawi, Tanzania	Bennett 1997
At least 24 types of regulations governing providers, facilities, commodities, insurance, and self-regulation are available to guide government's oversight of the private health sector. Incentives may work better than regulation. The capacity to regulate is probably low at low levels of income and development	Multicountry	Krasovec 1999
Permitting private pharmacies to provide immunizations and sell vaccines increased coverage and effectiveness	Multicountry	Slater and Saade 1996
Special tax treatment for imported essential drugs can help the private sector assure availability in low-income settings	Multicountry	Slater and Saade 1996, Krasovec 1998
Supplier-induced demand may be an endemic problem raising cost and lowering quality among private for-profit providers of health care in low-income countries	Multicountry	Aljunid 1997, Bennett 1997
Relaxing state-imposed restrictions on the use of health care revenues improved services through Medicare Relief Societies	Rajasthan, India	Sharma 2000

## Annex 2

**Table A2: Involving NGOs in improving child health care services**

Country	Population served	Partners	Objective	Impact	Sustainability
Malawi	55,000 tea estate workers and 275,000 family members	Tea estate companies; HOPE; USAID	To provide MCH services to the families of tea estate employees	Well-child care increased 20-55% (1990-96); exclusive breastfeeding increased 30-48% (1994-96)	Tea estates continued to fund this successful program on their own after the end of the grant
Guatemala city	214 community volunteer mothers and other mothers in the area	La Leche League International and La Leche League Guatemala; Community volunteer mothers; USAID	To establish groups of trained local mother volunteers to promote and support breastfeeding and effective MCH behaviors	Counseling to 25 percent of community women 90 percent of women referred to clinics actually went	Trained counselors and community groups continued working effectively even after the fourth year of grant funding ended
Haiti	1900 volunteers covering a district	A private hospital; volunteer community mothers	To combat childhood malnutrition by feeding malnourished children while educating and motivating their mothers	Reduced malnutrition	Reasonably inexpensive and sustainable by local resources (effective linkage with district institutions)
Vietnam	1 million population	Government; women's organizations; Save the Children Foundation; volunteer community mothers	To combat childhood malnutrition by feeding malnourished children while educating and motivating their mothers	Severe malnutrition was eliminated in preschool children	Reasonably inexpensive and sustainable by local resources (effective linkage with district institutions)
Bangladesh		Christian Service Society; World Relief Corporation; volunteer community mothers	To combat childhood malnutrition by feeding malnourished children while educating and motivating their mothers	Reduced malnutrition	Reasonably inexpensive and sustainable by local resources (effective linkage with district institutions)
Bangladesh	Slum dwellers in 10 cities	BASICS; national EPI project; NGOs; Schools; Social and civic clubs; rickshaw pullers	To change the behavior of slum inhabitants in using immunization services in particular and child health care services in general	Improved immunization coverage	Linkage with NGOs and donors for sustainability
India	110 villages in two rural sub districts with a population of 54,000	BASICS; 3 Bihar based NGOs; village health committees and women's organizations	To improve case management practices for ARI, diarrhea, and fever among unlicensed private providers through community-based interventions	Improved case management practices	Local NGOs and community-based monitoring

Source: Burkhalter 1998; Hussain 1998; Chakraborty 1998

## Notes

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- <sup>i</sup> Inter-agency Working Group comprising WHO, World Bank, USAID and UNICEF - The private sector refers to both for-profit and not-for profit health care providers, including hospitals, primary care physicians in solo or group practice, pharmacies, diagnostic facilities, and non-governmental organizations (NGOs) including consumer groups and community-based organizations that provide health services in addition to other community-based services such as primary education and micro-credit (Chakraborty et.al. 2001).
- <sup>ii</sup> The private markets for child health care goods and services can be classified as:
- Commercial sector: (a) Distributors and wholesalers; retailers (pharmacies, medicine shops, supermarkets, corner groceries, etc.) are engaged in marketing and distribution of child health commodities including ORS packets, soap for hand washing, insecticide-treated bed-nets to prevent malaria, vitamin A supplements, foods fortified with vitamin A and iron, and vaccines, among others. (b) The commercial suppliers of health products include: pharmaceutical companies; soap manufacturers, marketers, and/or distributors; bed net manufacturers; chemical manufacturers (e.g. chlorine bleach); salt, sugar and other food manufacturers (can enrich their products with micronutrients, e.g. iodization of salt, fortifying flour with iron, vitamin A in sugar and dairy products);
  - Non-governmental organizations: Generally involved in health education, growth monitoring programs, providing preventive and curative services, promoting health behaviors, establishing village health insurance systems, motivating community to use vaccination facilities and mobilizing and organizing community to lunch preventive services.
  - Private health providers: Engaged in treatment of childhood illnesses, providing diagnostic services, counseling and preventive and promotive services.