Assessing the Private Sector: Using Non-Government Resources to Strengthen Public Health Goals

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Glossary

ARI	Acute Respitory Infections
CCCD	Combating Childhood Communicable Diseases
CDD	Control of Diarrheal Diseases
DALY	Disability Adjusted Life Year
DHS	Demographic Health Survey
EEC	European Economic Community
ICD	International Classification of Diseases
LSMS	Living Standards Measurement Surveys
MRI	Magnetic Resonance Imaging
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
SDA	Social Dimensions of Adjustment
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNDP	United Nations Development Program
USAID	United States Agency for International Development

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Introduction and Summary

The overall objective of these guidelines is to develop more effective policies and projects for the private health sector in Africa in order to help governments, AID and other donors better achieve their goals of strengthening the capacity of national health systems to equitably and efficiently improve the health status of their populations.

For many years the focus of government policy has been on the actions of the public sector in financing and providing health services. Growing recognition of the diversity, size, and scope of non-government actors in health service financing and provision has, however, led to a reassessment of both the potential of the private sector to support the attainment of public health goals and the appropriateness of existing public/private linkages. One implication of this reassessment is that the traditional realm of public policy needs to be extended to include the multiplicity of non-government actors. In particular, three policy areas look promising in terms of changing the nature of public/private interactions in health service provision and financing in support of improving health outcomes. These three areas form the core of the private sector assessment process, and shape both the data collection requirements and methods which are the subject of this methodological briefing paper. The three policy areas and related subquestions are as follows:

Increasing the private sector contribution to the public health agenda;

- What is the existing private contribution to public health activities?
- What are the predominant supply and demand conditions underlying this contribution?
- How can this contribution be increased, and under what incentive conditions?

Reassessing the mechanisms and appropriateness of the public sector subsidy to the private sector;

- What are the mechanisms of the existing public subsidy to the private sector?
- What is the magnitude of this subsidy?
- What services and populations are subsidized?

- Where should the subsidy be decreased and where increased in order to improve the efficiency and effectiveness of public expenditure?

Substituting where possible private for public provision;

- What services should the public sector be providing? What should it not be providing? What criteria should be used to assess? How does appropriateness differ across geographic areas and population groups?
- What services is the private sector capable of providing? Where are existing supply constraints? What incentives are required to encourage the private sector to increase its production of certain services?
- What are the social costs of this substitution and how can they be minimized?

Unfortunately, the legacy of a policy-making process which primarily emphasized publicly financed and provided health services means that many governments are ill-equipped to reorient their attentions towards the private sector. At the national and sub-national levels little concrete information is available about the different types of non-government providers of health services, their numbers and distribution, their activities, the populations being served, and the factors explaining these particular patterns of provision and demand.

One way of answering some of these questions is through a *private sector assessment* process, of which these guidelines are meant as a starting point. They are intended to outline the relevant issues, the key data requirements, and suggestions as to the ways in which data can be collected and analyzed.

Some Methodological Issues

Using Existing Data Sources

Making the maximum use of available data is a key guiding principle to this assessment process. Although some new data will certainly need to be collected, many studies have already been undertaken which, either directly or indirectly, contain much of the information needed to assess the above policy issues. New data collection efforts should focus to the extent possible on filling the gaps left when all possible existing sources have been identified.

Qualitative Data Collection Techniques

Because of the preliminary and evaluative nature of this assessment, new large-scale population-based survey work is unlikely to be a component of the data collection process. Interviews with key individuals, small targeted surveys,

focus group discussions and other techniques of rapid assessment will be used.

Flexibility and Responsiveness

Clearly, guidelines such as these cannot hope to identify in advance all the possible issues which may arise in the course of such a case study. The intention is that they signal the types of issues which are of interest so that the research team undertaking the private sector assessment process can be guided in identifying what is relevant and what is not. Clearly, both flexibility in deciding what is interesting and responsiveness to new information which has not previously been identified are key to successful and relevant data collection and analysis.

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Section 1. Defining and Describing the Private Sector

Key Issues

A common understanding of what is meant by the private health sector is essential before considering possible policy options, since the term is often used without a clear definition. The "public sector" is usually understood to refer to actions of the government or of agents whose actions are principally determined by government. The private sector refers to activities of agents who are largely outside the control of government: these may include individuals, corporations or non-profit agencies.

A further distinction is usually made between *private provision* and *private financing* of health services. This distinction is needed because privately-provided services can be publicly financed, and vice versa, with very different implications for the incentives faced by providers and users, and hence, different policy implications. The distinction between public and private provision refers to the ownership or control of the providing institution. We define public financing to mean financing by central or local government, state-owned enterprises, or social insurance. Private financing includes private out-of-pocket payments, private insurance premia, or services provided by the private corporate sector. The following matrix shows the different permutations of financing and provision with examples of combinations frequently encountered in African countries.

Financing -> Provision	***Public***	***Private***
Public	Free services provided in government clinics or hospitals.	Services in government facilities for which user charges are paid.
Private	Services provided in mission or other NGO facility where salaries are paid by government.	Services provided by private practitioner and financed through private insurance.

Although the emphasis in these Guidelines is on private provision of services, we will include the collection and analysis of information concerning private financing where it is relevant to the policy issues being assessed. This section deals first with provision and then with financing.

a. Private Provision

i. Constructing a Typology of Private Providers

The non-government sector in health care provision in many countries is highly diverse, and a failure to take into account the diversity of private providers will certainly lead to faulty policy advice. This is because form, behavior, and importance with respect both to size and range of activities is likely to differ significantly between types of provider. Policy implications, too, will certainly differ between provider-types. Thus, the first task of a private sector assessment is to *define and categorize the different types of non-government actors in health service provision* so as to develop a country-specific notion of what constitutes the private sector. An additional benefit of such an exercise is to ensure that as broad and comprehensive an approach as possible is taken to thinking about the private sector. Once the importance of each provider-type has been assessed it may be analytically desirable to narrow the focus to certain provider categories. It is also possible, indeed likely, that different actors in the private sector will be of differing importance in considering each of the policy areas outlined in the introduction to these Guidelines.

One way of thinking about the key axes of such a typology is in terms of *organizational form, therapeutic system and commercial orientation*. Each is described briefly in the following paragraphs:

Organizational form

This characteristic refers to the size, the internal structure and complexity of a particular type of provider. We could also think about a distinction between the "formal" and "informal" sectors, based on, for example, whether the provider works from a fixed location. Naturally, as is the case for all three of these characteristics, it is more useful to think of a spectrum of complexity rather than a pure dichotomy. Characteristics which have been proposed to assist in locating the various providers on a spectrum from simple to complex structure include:

- the number of providers (single or multiple);
- whether inpatient services are provided or not;
- the number of beds;
- the level and diversity of care provided (preventive/promotive, general medical, specialized medical care);
- type of ancillary services provided;

- fixed or mobile location.

At the one extreme, we can think of simple organizational forms with single providers and basic service structures, perhaps even without a fixed consultation facility, such as an informal drug peddler. At the other extreme would fall the most complex institutions, such as tertiary hospitals.

An Example of a Spectrum of Organizational Form for the Private Sector

Traditional healer practice with single provider.

Multi-physician private practice in urban area, providing laboratory services.

Mission health center with operating theater.

Mining company hospital providing tertiary and specialist care.

Commercial orientation

For profit and not-for-profit are the key distinctions generally made when considering different patterns of commercial orientation. Organizations such as non-governmental organizations (NGO) hospitals or clinics usually fall into the category of not-for-profit agencies[1]. Traditional practitioners could fall under either of the categories, depending on the particular environment in which the exchange occurs. For example, traditional practices in urban areas may be as commercial in orientation as that of a private, for-profit, modern practitioner, and may differ from similar exchanges in rural areas where the relationship between a provider and her client may have a different basis in terms of rights and obligations.

Therapeutic system

This characteristic recognizes that care given by private providers may be based on different medical paradigms. The different healing traditions do not carry with them specific implications for the economic incentives facing the provider and thus, this constitutes a third axis of interest. “Modern” medicines may be an important component of services provided by an informal practitioner such as an injection-giver. Additionally, the obvious distinction between traditional and “modern” medicine disguises the diversity that may exist within either two of these extreme positions. Faith healers, herbalists or exorcists may, for example, specialize in the treatment of different diseases, implying differing importance with respect to public health activities.

1/ “Non-commercial” orientation could be used to describe certain types of industrial medical facilities. In this situation, depending on the nature of their remuneration arrangements, staff practitioners would not be acting so as to maximize profits but to, say, maximize the health status of the attending population subject to some overall budget constraint for the facility.

Building a Typology

Taking account of the diversity of the private sector requires taking a broad perspective. The informal and traditional sectors should be included, as should ancillary medical services, such as private laboratories or other diagnostic facilities, pharmacies, etc. Informing the typology may require extensive discussions with different actors within and outside the health system. These may include health professionals, insurance companies who reimburse different private providers, and mission and NGO coordinating bodies.

Typically, researching the informal modern and traditional sectors is more difficult. Determining the range of providers which exists in a country will require asking all of the sources mentioned above, as well as researchers in other related areas. This might include, for example, the anthropology or sociology departments in universities.

Recall that this process is an adaptive one. It may not be possible to identify all provider-types at the beginning, and new providers should be added to the typology as they become known. Similarly, although providers should initially be classified according to the above three axes, new axes of the typology which are particularly important may be identified and should be carefully considered to determine if they have a significant bearing on the behavior of different provider-types.

Sample Analysis Matrix for Typology of the Private Sector

The following table is an example of the way the above axes can be used to conceptualize the complexity of the private sector. The vertical axis represents organizational complexity, the horizontal axis considers the commercial orientations, while the interior of each cell represents differences in healing system along a spectrum from traditional to modern.

Level of Organizational Complexity	***Commercial Orientation: For Profit***	***Not-for-profit***
High	*Modern*	*Modern*
	Private hospital	Mining company hospital
		Mission hospital
	Traditional	*Traditional*
Medium	*Modern*	*Modern*
	Private clinic	Mission clinic
	Multi-practitioner Traditional clinic	
	Traditional	*Traditional*
Low	*Modern*	*Modern*
	Private sole-practitioner	
	Urban injection giver	
	Urban single provider herbalist stall at market	Traditional birth attendant in rural area
	Traditional	*Traditional*

ii. Describing private provision: magnitude and activities

Once the nature of the private sector has been defined, the next step is to begin to describe the different provider-types in more detail. Typically, very little is known about the numbers, geographical distribution and activities of non-government providers. Available information needs to be collated, and new data may need to be collected. The overall objective of this part of the study is to assemble the basic information needed to support an assessment of the importance of different parts of the private sector, with respect to both activity types and levels.

Describing the Private Sector: Data Requirements

For each provider-type, the following information is required:

Number of providers:

Distribution:

- Between regions
- Urban/rural

Number and qualification of staff:

Services provided:

- Preventive/promotive
- Primary illness treatment
- Specialized curative care: types of specialties
- Diagnostic services: radiology, laboratory, etc.

If inpatient services available, number of beds:

Level of activity/throughput: number of patients per day/month/year; length of stay or occupancy rate of inpatient facilities; number of prescriptions filled for pharmacies; number of lab tests done for private laboratories.

Patient distribution: (male/female; age; socioeconomic status)*

* Having this information by provider-type would be ideal: it is likely to be very difficult to collect and to ensure its accuracy.

Because of the increased difficulty in collecting this information for the informal sector, there is a very real potential for bias in this part of the data collection process: in studying only those sections of the private sector which we can easily observe or for which official information is readily available, it is impossible to make a valid assessment of the importance of other parts of the non-government sector. As a result, discussion of the private sector tends to revolve around the urban formal sector, while the importance of this sector with respect to coverage and services provided may be much less than the informal or traditional sectors. The dangers of bias pose a particularly serious threat in this section of the assessment, since the emphasis of the further data collection efforts will be determined by the findings of this section.

In order to avoid this bias, particular care needs to be taken in considering the magnitude or coverage of services provided in the informal and traditional sectors. Little-published information is likely to be available, although there may be professional organizations of traditional healers which will enable an estimate of the number of providers. Survey data such as the DHS may enable an evaluation of the level of utilization of informal or traditional providers (see Section 3 for more details). An awareness of the potential for such bias is at least a

starting point in ensuring that important parts of the private sector are not excluded from the study due to the difficulty of collecting information about them.

iii. Data collection and analysis

Depending on the numbers of providers in the country, it is unlikely to be possible to collect this information for every single provider. Ideally, a purposive sample of providers would be studied in more detail. In the first instance we would want to ensure that information is gathered from all different types of provider. A second stage is to be able to measure both the total number of each provider-type and the extent of variation in these characteristics within a particular provider group.

Potential sources of information about the range and activity levels of different provider-types include:

- Professional associations: traditional healers organizations, medical and nursing associations[2];
- Provider associations: Church Medical Associations, associations of private hospitals or NGO umbrella organizations;
- Pharmaceutical companies;
- Government registration bodies (Ministry of Health or Home Affairs);
- Market research groups or other private sector consulting bodies;
- Existing household survey data (e.g., DHS - Demographic and Health Surveys; LSMS - Living Standards Measurement Surveys; SDA - Social Dimensions of Adjustment surveys).

b. Private Financing

i. Types and Magnitude of Private Health Financing

As in the case of provision, it is useful to understand the sources and magnitudes of financial flows from private sources. Although estimates of both public and external financing of health services are generally accurate, this is rarely the case for private financing even though private sources are estimated to account for 40-60% of total health expenditures in many African countries. Household surveys are the only way of estimating private out-of-pocket expenditures, and problems of survey methodology mean that the results of these surveys often significantly underestimate the magnitude of private financing.

2/ Note here that it is important to determine registration procedures such as frequency of re-registration, etc., if using provider associations or official licensing bodies as sources of provider numbers.

As noted earlier, we generally consider private financing to include: private out-of-pocket expenditures for health services, private insurance premia, and other expenditure by private agents on health care. The latter would include, for example, health services provided by private corporations.

Ideally, we would seek to determine the uses of these funds to construct a set of national health accounts. Since this is likely to be outside the scope of the present study, at the very least a review of financing sources and magnitudes will be important in order to inform the remaining parts of the private sector assessment, as well as to identify important policy issues. A matrix of the following type should be constructed:

Sample Analysis Matrix for Analyzing Private Financing of Health Services

Type	***Magnitude (% of total health expenditure)***	***Source of Information***
Private		
Out-of-pocket expenditures		
Private insurance premia		
Services directly provided by private corporations		
Services paid for by private corporations		
Public		
Central government (MOH)		
Central government (other ministries)		
Local government		
Social insurance premia		
Aid		

Potential sources of information include:
- Private out-of-pocket expenditures: Household income and expenditure surveys (national or smaller scale).
- Private insurance premia: insurance company records.
- Direct corporate provision: medical officers of key large corporations; personnel departments.
- AID flows: UNDP review of external assistance, Ministry of Health planners, sectoral officers at Ministry of Economic Planning, key donors, including NGOs.

Section 2. Describing Existing Public/Private Linkages: Public Policy and the Private Sector

Key Issues

The purpose of this section is to describe different features of the overall policy environment within which the private sector operates. There are a number of policy tools through which the public sector directly and indirectly affects the operations of the private sector. Other policy tools available to the government include:

- public provision of health services;
- public financing of health services;
- taxation and subsidies which affect the private sector through the creation of economic incentives and disincentives;
- the provision of public information to alter existing patterns of demand;
- direct regulation and licensing of private providers.

The goal of this section is to describe the different ways in which public policy affects private sector activities, and in so doing to outline the key characteristics of the environment within which providers operate. The following sections draw heavily on Berman and Rannan-Eliya (1993).

a. Public Provision of Health Services

The most obvious way in which the public sector influences the private sector is through direct public provision of services, which affects the demand for private services by creating competition for private providers.

b. Public Financing of Health Services

A second linkage between the public sector and the private sector is through direct public financing of privately-provided services. This includes, for example,

the payment of block grants to NGOs or other organizations for operating costs, a situation commonly found in many African countries. It could also include the contracting of private providers to provide ancillary services at large institutions, or contracting of clinical services, although the latter is uncommon in Africa.

c. Taxation and Subsidies

Taxes and subsidies work by altering the prices faced by consumers and producers. Subsidies are dealt with in more detail in Section 5, where the objective is to determine where subsidies should be reduced, maintained or increased. Here we focus more on taxation. The existence of a tax, determinants of exemption from payment of the tax, and levels of taxation are all aspects of tax policy which need to be considered.

Taxes policy may affect either intermediate or final goods and services. For example, the taxation of physicians' income would be considered a tax on a final product, and would lead to higher costs to the consumer. Tax exemption of income earned by NGOs is another example of a policy which affects the private sector via the tax system. One way to increase the demand for private medical services in countries where there is a high level of income taxation is to make payments for such services deductible from taxable income. In some countries, private insurance premia can be deducted from personal income taxes. Although this is seen as a measure to promote the private sector, there is some concern that the benefits are mainly captured by upper income groups

Taxes may also be levied on sales and/or imports of factor inputs. For example, there may be import duties levied on pharmaceuticals or equipment, increasing the costs of those inputs. In countries where there is a considerable level of production of pharmaceuticals or equipment, firms may benefit from subsidies or tax policies, and may be affected by import duties on intermediate products. Certain types of organization, such as NGOs, may be exempt from the payment of import duties. Some countries have explored ways in which private physicians can be encouraged to locate in underserved areas: these include the provision of subsidized loans for the establishment of practices, and transfer or sale of infrastructure to private physicians. There may be other direct policies to increase the availability and lower the cost of credit to health care providers.

d. Provision of Public Information

The role of public information in shaping health-seeking behavior and consumer demand for health services is an area which has received very little attention to date. Direct intervention through the provision of information about the costs and quality of services in the private sector is one way to increase the role of the consumer in health services. Indirect intervention, through an independent

mass media, could also be used to increase knowledge about corruption and inefficiency in both the public and private sectors.

e. Regulation and Licensing

Like taxation or subsidies, the objective of most regulations is to alter the behavior of agents in order to eliminate market failure or to otherwise alter the market outcome so that it is closer to some social optimum. Two features distinguish regulation from other forms of policy intervention: first, it works through legal or administrative channels, rather than directly through financial ones. The second feature is that regulations are generally coercive in nature, that is, they are not optional. Regulation may be enforced through direct state regulation, state-sanctioned professional regulation or voluntary self-regulation (Moran and Wilson, 1993). Again, regulation may affect final goods and services or intermediate inputs. For example, regulations may control the minimum qualifications for medical practitioners, such as requiring MDs for physicians; there may also be regulations concerning the maintenance of x-ray or other machinery that are monitored by radiology inspectors.

When considering the impact of regulation of the private health sector, it is useful to distinguish between 1) the existence of a regulation; 2) the degree to which the regulation is enforced; and 3) the effectiveness of regulation with respect to achieving its established objectives. Once these have been established, it is possible to consider the impact of the regulation. This can be done by considering the impact on both the public and private sectors; on producers and on consumers; and finally, on prices and level and composition of output.

We can also distinguish three main areas into which regulations typically fall:

Altering market structure and functioning

- Entry: many countries control the accreditation and licensing of both practitioners and premises;
- Location: this may be controlled in order to ensure even and equitable distribution of health facilities. It may be a more important factor in rural than urban areas;
- Prices and payment mechanisms: rules established in order to limit the charges that may be imposed for services, or the mechanisms through which fees are levied.

Enforcing or controlling quality standards

- Inspection with penalty for non-compliance with respect to, for example:
  - minimum standards of cleanliness;

- equipment maintenance to ensure safety (for example, x-ray equip ment);

- Requirements regarding training and re-training of medical personnel;

- Liability and malpractice laws.

Improving Efficiency

Regulatory controls established with the objective of increasing the efficiency and effectiveness with which the health system operates. May include features such as:

- technology regulation e.g., limiting numbers of high-tech equipment such as MRI available within a specified geographic area (although this also has a quality aspect in considering effects of provider-induced demand);

- labor market issues - e.g., number of years of public service which must be provided by publicly-trained practitioners; degree of collaboration in in-service training;

- rules relating to the use of the health system, for example, requiring that patients seeing specialists are referred by general practitioners, or that use of the tertiary hospital be limited to those who have been through the referral system;

- reporting and generation of epidemiological monitoring information and the extent to which non-government providers are integrated into a health information system; list of reportable communicable diseases; require-ment to submit monthly ICD tallies to keep track of overall disease pat-terns in the country.

Reviewing Existing Policy Towards the Private Sector

A review of existing collaborative arrangements between the public and private sectors should be undertaken. This is one area where efforts should be made to capture the dynamic effects of collaboration: Can key policy events be identi-fied which signaled changes in the nature of linkages between the private and public sectors? Is it possible to identify changes in terms of provision and utilization of services or improvements in efficiency (or at least reductions in duplication)? A case study approach could be taken to study particularly impor-tant changes in cooperation arrangements.

Policy Interventions

Brief reviews, depending upon the information available and their perceived

importance, should be undertaken for each of the four policy areas outlined above. Suggestions for information that should be collected are as follows:

a. Public Provision of Health Services

- extent to which public and private providers compete (at least by geographic area, potentially by service and clientele).

b. Public Financing of Health Services

- magnitude of public grants to NGOs and other providers;
- nature and magnitude of contracts for private provision of clinical and non-clinical services.

c. Taxation and Subsidies

- direct taxation of medical services and products: levels, exemptions, magnitudes;
- tax deductions for private medical services or private insurance premia? number and distribution of people who benefit;
- enumeration of other ways government intervenes in input markets (labor, capital, equipment, pharmaceuticals) through the taxation system; assessment of the extent to which these policies are constraints to private sector development, as well as the political barriers to changing them.

d. Provision of Public Information

- assessment of the existing role of the press in publicizing incidents of corruption or inefficiency in medical care (review newspapers, television, etc.); assessment of the potential for increasing consumer involvement in the process of care by providing information: what information is needed, and what is the most effective way of delivering it?

e. Regulation

Ideally, reviewing the regulatory framework should involve consideration of the four issues described above: the existence of a regulation; the process and procedures through which it is supposed to be implemented; the degree to which it is enforced and its effectiveness with respect to achieving its desired objectives; and its impact upon the functioning of the health market. Potential

sources of information and issues are discussed below.

i. Existence and Objectives of a Regulation

Consult regulatory authorities (MOH, professional associations - Traditional Healers Organization, Medical Association, Nursing Association, Private Hospital Association, NGO coordinating body). It is also desirable to collect historical information about the original intent of the regulation to assist in evaluating whether it remains relevant to current conditions. This might involve a review of legislation, and interviews with individuals involved in negotiation/drafting of the law.

ii. Process and Procedures

Consult regulatory authorities as above. This should include who is responsible for enforcement, how this is to be enforced, procedures for assessment and penalties for non-compliance.

iii. Effectiveness of Regulation With Respect to Its Own Stated Objectives

(effectiveness of enforcement) - Here we want to assess enforcement at both the qualitative and quantitative levels. a) Qualitative: would want to discuss with parties responsible for enforcement and those who the regulation is intended to control. Could perhaps engage in informal discussions with providers to see whether their behaviors are actually affected by the regulation; b) Quantitative: could develop quantitative indicators of adherence (e.g., no. of monthly communicable disease reports/morbidity reports received; extent of technology duplication in contravention of official policy; number of providers who actually return and work the required number of years in public service after qualifying, etc.) depending on the precise nature of the regulation. The information sources would depend on the precise nature of the indicator; for example, the MOH Statistics Office would be able to provide information on regularity of reporting. The data collection team would need to consult with those responsible for enforcement of such regulations.

iv. Impact of the Regulation

The effect of the regulation should be considered with respect to: the impact on the private and public sectors, on consumers and on producers, and on levels of output and prices.

v. Analysis/Evaluation

This process involves an overall assessment of the above information. The fundamental idea is to determine where the existing regulatory framework needs to be altered: where old, unenforced regulations should be dropped; where existing regulations should be enforced more effectively (including the barriers to effective enforcement - capacity, etc.); and areas where new regulation is needed.

Developing case studies of particularly important regulatory changes may be appropriate here also. The identification of key regulatory changes can be undertaken through discussions with private providers as well as Ministry of Health officials. Additional effort and time can then be spent identifying the key impacts on different parts of the health system and the mechanisms through which they occurred.

Sample Analysis Matrix for Assessing the Regulator Framework

Regulatory Area	***Substance: Objectives and who to enforce.***	***Process and procedures: How is it envisaged that the regulatory process should work?***	***Outcome: Effectiveness of regulation with respect to intended objectives.***	***Impact: On public and private sectors; On consumers and producers; On levels of output and prices.***	***Assessment: Effective; Ineffective - need to increase enforcement; Ineffective and no longer needed.***
1. Market Structure					
Entry					
Location					
Prices					
Labor market					
2. Quality Standards					
Premises					
Equipment					
Training & re-training					
Liability/ malpractice					
3. Efficiency					
Epidem. Reporting					
Technology					

Section 3. Normative Issues in Policy Analysis: Assessing Priorities for the Public Sector

Key Issues

Although the notion of "appropriate" use of public funds has been referred to in a number of places, it is important to note that not everyone agrees upon what criteria should be used in assessing public expenditure priorities. Three broad streams of thought have emerged, and while it is not clear which one is the "right" one, transparency as to which set of assumptions is being adopted is an important way to ensure that debate about what services should be bought with public funds takes place on an even ground.

a. Market Failure and Public Finance Criteria

One approach to determining public expenditure priorities is what we can call the "market failure" or "public finance" approach. This emerges from the public economics literature that points out the types of goods that, because of their nature, are likely to be under-provided if production and consumption decisions are left to private agents. The first of these is "public goods", or goods for which consumption is non-rival. By this we mean that my consumption of a good is not precluded by your consumption, and that there is no marginal cost to the consumption of an additional unit. The corollary of this is that public goods are the sort of goods susceptible to free-rider problems. For example, with a malaria vector control program, such as spraying for mosquitoes, even though I do not participate in the program I will benefit from the reduction in the number of mosquitoes in my neighborhood.

Related, but slightly different, are those goods which produce significant positive externalities. These are benefits which I incur from your consumption of a private good, benefits which are not included in the valuation of the benefits of that good. In the health field, the positive benefits associated with immunization programs such as herd immunity, are said to be positive externalities.

The third type of good that public economics say will tend to be under-produced

in the private market is “merit goods” - goods or services which we believe have a certain value just because they are a good thing. One example of this type of service is health care for the poor, such as Medicaid in the US.

The rationale for government intervention, according to the public finance criteria, is that in the absence of public involvement, the market will tend to lead to outcomes in which there is either over- or under-provision and consumption of these particular types of goods. Thus, one way of assessing public expenditure priorities is on the basis of whether the goods fall into the above three categories, leaving private markets to provide for the production and consumption of other services.

b. The Cost-Effectiveness Approach

A second set of criteria for setting public expenditure priorities relates to the cost-effectiveness of interventions. Cost-effectiveness analysis is a tool for combining information about the cost of an intervention with its anticipated health benefits. The recent World Development Report promotes the use of Disability Adjusted Life Years (DALYs) as the appropriate basis for comparing interventions, although a number of different measures have been promoted in the past.

The basic idea for the promoters of cost-effectiveness criteria is that public resources should be spent on the production of services with the lowest cost per unit of health outcome (cost/DALY). The implications for public expenditure are that the government should be responsible for ensuring access of the population to a “basic package” of the most cost-effective services. This does not mean that these services necessarily have to be entirely produced or financed with public funds, but that there is a particular role for public intervention to guarantee this action, particularly to poor communities where production (and consumption) by non-government actors is unlikely.

The proponents of cost-effectiveness criteria as an approach to priority setting argue that a particular strength is that the basis for comparison of interventions is perfectly transparent. One concern, however, has been the absence of consideration of the match between this package of cost-effective services and demand for those services. The actual modalities of rendering operational this basic package are still being discussed and hotly debated.

c. The Utility-Maximizing Approach

A third school of thought in determining the criteria for allocation of public resources says that some priority should go to those services that utility-maximizing individuals will demand, even if these are not always cost-effective

services or public goods. Consumers know best how money should be spent even if the resources being devoted to these services are public resources. For example, one of the main reasons consumers and taxpayers want government intervention through the provision of social insurance is so that they can be guaranteed protection from the costs of catastrophic illness. Although there are significant problems with this approach, it receives considerable support in some circles.

Part of the problem with this "market-oriented" approach is related to the characteristics of some health goods discussed above. Where there are important public good or externality elements to health services, it is likely that individuals will demand sub-optimal amounts or too much of the wrong things. Another important factor is the fact that because of the technical complexity and expertise required to make decisions about medical care, individuals may depend entirely upon the advice received from their provider as to the quantity and type of care they receive. This means that the real choices are being made by providers in their capacity as agent for the patient.

Priority Setting and Public Policy

In the three sections that follow, objective information about private sector activities and opportunities to alter the public-private mix need to be combined with a normative analysis of the appropriate role for the public sector. It is most likely that any pragmatic approach to policy making will combine elements of the three approaches to priority setting above.

Section 4. Increasing the Role of the Private Sector in the Public Health Agenda

Key Issues

The overall purpose of this section is to arrive at some assessment of the potential for increasing private production of public health services to increase overall coverage and utilization of these services, as well as the policy actions which would be required to stimulate such an increase. The way this is to be undertaken is to determine the magnitude and nature of the existing non-government contribution to public health activities and to evaluate the reasons for this particular pattern of demand and supply. Sub-issues in this section include considering where changes could usefully be encouraged in the existing pattern of provision and utilization (for example, integrating concerns of quality); determining the extent to which supply constraints exist; and finally, explore the ways in which supply constraints can be overcome and incentives created to effect this increased provision. Note that in this section the overall issue is not the substitution of private for public provision of public health services, but increasing the overall level of coverage and/or utilization of these services. Issues of provider substitution are explored in Section 6.

In this section more emphasis is placed on issues concerning the private provision of health services than private financing. This is due to the fact that we generally think of public health activities as comprising the provision of public goods such as water and sanitation services, vector control and other classical public goods; goods with significant positive externalities, such as communicable disease control; and merit goods (goods which are believed to be intrinsically good), such as preventive care and early detection of disease. These are all types of goods which economic theory predicts will be under-provided if it is left purely to private individuals to choose the amount they wish to consume. As a result, it is unlikely that the generating of additional private revenue will be an important policy issue here.

A country-specific definition of the public health agenda needs to emerge out of discussions with national authorities and donor agencies about existing and upcoming priorities. Additional sources of information to determine national priorities include national health policy and planning documents. Donor project

documents can be used to identify donor program priorities.

a. Measuring the Existing Private Sector Contribution to Public Health Service Provision: What Explains the Existing Pattern of Supply and Demand?

The issue of measuring existing private sector provision and utilization of public health services is the key empirical question of this section. Structuring the analysis around provider and consumer issues is helpful. The type of questions we would like to address and answer are the following:

Issues related to providers

- What is the current pattern of public health service provision (i.e., service availability)?
- What factors explain this pattern?
- Which private sector actors are involved?
- Which services are they providing?
- What are the key incentives prompting them to provide these services?
- What are the constraints to a) increased provision of these services; b) encouraging other private sector providers to enter into this market?

Issues related to consumers

- What is the current pattern of demand for public health services (i.e., utilization)?
- What factors explain this pattern?
- What proportion is utilization of services provided by public sector and by different non-government providers?
- What are the key dimensions along which this pattern varies (e.g., by service, by gender, by age, by socioeconomic status)?
- What are the constraints to increased utilization of privately-provided services?

Clearly these two sets of questions require an immense amount of information to answer definitively. Since available time is likely to limit the possibilities for basic research, review of available studies and documentation is the best way to begin. Luckily, in many countries large amounts of information are already available, although perhaps not in a form which is immediately useful. Relevant

data will have to be extracted in a way which contributes towards answering the above questions.

i. Disease-Specific Approach

The basis for this approach is that in many countries there are existing studies which look at patterns of service utilization for specific types of health care. This might include, for example, DHS surveys which look at the source of family planning services, distinguishing between public and private provision of consultations and commodities. There are likely to be studies which look at other disease-specific programs (e.g., ARIs, CDD, malaria, immunization) which also provide a good starting point for understanding existing utilization patterns. Such studies also often have information about the quality of care available by provider-type (for example, the % of cases of diarrhea treated with anti-diarrheals, or ORS), information which is useful for evaluating the appropriateness of existing utilization patterns. Provider studies may also have been undertaken in conjunction with user studies.

Getting hold of this information requires generating an inventory of existing disease-specific studies which contain information about utilization patterns. This in turn is likely to involve direct requests to the many possible sources of such studies: Ministries of Health, multilaterals, bilaterals with health projects, NGOs and independent research institutions (e.g., universities, medical schools, etc.).

Once the relevant studies have been located, the following types of information should be extracted:

- the proportion of patients using each type of provider
- any information about nature of treatment/quality of care by provider

ii. General Utilization Approach

Once the disease-specific studies have been reviewed and relevant details extracted, other sources of utilization data can be considered. Facility-based data, for example, monthly or annual returns from mission clinics, might include detail about number of immunizations given or antenatal consultations provided. Other household survey data might distinguish between curative and preventive care utilization, or might have only one or the other. Household income and expenditure surveys which contain information about health service utilization and expenditures, such as LSMS or SDA surveys, might provide information about important determinants of health seeking behavior, such as income, gender or age.

Sample Analysis Matrix for Assessing Disease-Specific Patterns of Utilization

Service	*% Cases Treated*		*Issues*	*Quality/ Effectiveness Issues*	*Source*
	Public	*Private**			
Family planning	30	70	Differs importantly by method		DHS
Diarrheal disease	40	60*	Most of private treatment is by traditional healer; appears to depend on mother's perception of etiology	Evidence of higher proportion of treatment with antibiotics in mission than government clinics; no ORS use in traditional sector	CCCD field study, December 1990
	* of private, 60% is in mission clinics; 40% by traditional healers				
STD treatment	30	70*		No antibiotic use in traditional sector	EEC STD study, January 1991
	* of private, 70% by traditional healers; 30% in private clinic				

* Ideally, private provision should be broken down into as much detail as possible by provider-type. One of the key objectives of this exercise is to identify precisely which private providers are involved in public health service provision. We would expect certain providers to be more important than others, and for these providers to be main points of policy intervention.

iii. Provider Interview

Another study method which might prove useful and provide different information from the above two methods is provider interviews, with providers selected by way of purposive sampling of different provider-types identified in the previous section. These would enable some description of the services provided, utilization levels, and user profiles, as well as at least a qualitative indication of the reasons why such services are provided, the extent to which the provided faces supply constraints, and the types of incentives which would be necessary to encourage increased overall production of these services.

b. Assessing the Potential for Increased Private Provision of Public Health Services

The descriptive information described above can be used to assess which providers are the most likely targets for a policy intended to increase private provision of public health services. The following are the types of additional questions which should be brought to bear in evaluating the desirability, feasibility and necessary modalities of encouraging increased production of public health services.

i. From the Provider Side

Assessing the relative importance of these different provider-types as potential focal point for public policy:

- quality: what do we know about the quality of services provided by provider-type;
- efficiency: what evidence do we have about the relative magnitude of average costs across providers; what are the most important factors affecting average costs;
- prospects for increasing overall supply of these services:
  - supply constraints and extent to which they bind;
  - ways they could be overcome;
  - incentives which could be effective in increasing the supply of services.

ii. From the Consumer Side

- reasons for particular patterns of utilization;
- the extent to which an increase in private supply will result in increased utilization and the existence of important demand constraints;
- what incentives could be used to increase use of privately-provided service (for example, if the binding constraint is cost, we could think about subsidizing private provider to produce rather than increasing public provision).

Section 5. Assessing the Public Sector Subsidy to the Private Sector

Key Issues

The overall theme of this section is to assess the magnitude and appropriateness of the existing public subsidy to private sector provision of health services, with the objective of increasing the efficiency and effectiveness of public expenditures. Naturally this requires first enumerating the mechanisms through which the private sector is subsidized and estimating the magnitude of this subsidy. The "appropriateness" of the subsidy can only be assessed with respect to some set of public policy objectives, although clearly political considerations come into play in this type of resource allocation decision. Two suggested criteria for assessing the public subsidy are the services which are being subsidized, and the population benefiting from the subsidy. These two features together can broadly be described as the *incidence* of the subsidy. Being able to describe the impact of the subsidy according to these two criteria is an important step towards assessing what future policy directions should be with respect to subsidizing private provision. Ideally, we would want to be able to describe where public subsidies should be reduced, where increased, and where they should be left the same in order to maximize both efficiency and effectiveness of public investment.

The emphasis in this section is predominantly on public and private financing, since a subsidy is a financial tool. Decreasing or eliminating a subsidy involves transferring the source of financing from the public to the private sector. The payment of a public subsidy involves either a new injection of funds, or a transfer from private to public sources. At the same time, the existence of a subsidy may make investment opportunities more profitable, thereby attracting more private resources.

Before beginning with this process, it is essential to define what we mean by a subsidy. A subsidy is a financial transfer from the state reducing the prices or costs faced by agents (producers or consumers), through which changes in their production or consumption decisions are induced.

This definition describes a range of policy actions. For conceptual clarity we need to distinguish between *direct* and *indirect* subsidies. We can think of a

direct subsidy as a direct payment or other change in the price being faced; indirect subsidies act through other systems, for example, through the tax system.

In addition to the type of mechanism, we are also concerned with distinguishing between the different types of decisions being affected by the subsidy. On the one hand we have *consumer subsidies*, for example, free health services in the public sector, the objective of which is to increase consumption of health services; *producer subsidies*, on the other hand, generally act through changing the cost of inputs into the production of health services. Producer subsidies may be intended to increase the production of health services or to lower costs, although the extent to which these outcomes arise depends in part on the structure of the health care market. Although we are specifically concerned with subsidies that have an ultimate impact on the services provided in the non-government sector, the complexity of interactions between the public and private sectors means that in principle we ought not limit ourselves to subsidies that affect the private sector directly. The existence of free services in the public sector constitutes an explicit consumer subsidy in the public sector, but as this has an effect on the choices made by consumers about which providers to consult, there is ultimately an effect on non-government providers also.

The following matrix describes the type of subsidy mechanisms we might observe in the health market:

Subsidy Types	***Direct***	***Indirect***
Consumer subsidy (demand side)	Subsidy for low income households (e.g., payment of insurance premium/ provision of health card).	Tax deduction for private health insurance.
Producer subsidy (supply side)	Government provides staff for mission hospital; Allow use of public facilities for private practice; Credit scheme to assist establishment of private practice; Free vaccines.	Publicly-financed medical education; Import duty exemptions for medical equipment; Preferential access to foreign exchange; Tax exemptions for non- profit organizations; Tax deductions for corporate own-provision of services.

a. Describing Mechanisms and Magnitudes

i. Identifying Mechanisms and Quantifying Their Magnitudes

The first stage in this part of the private sector assessment involves identifying the specific mechanisms through which private provision of health services is subsidized. This may involve constructing a matrix similar to the one above in which all of the different mechanisms are categorized. The next stage involves assessing the magnitude of this subsidy: what quantity of public resources goes towards the direct or indirect support of private health service provision?

The identification of different subsidy-types and their quantification will require discussions with government agencies (for example, Ministry of Health Financial Controller, Department of Customs and Excise Tax, etc.) and providers themselves. Direct subsidies will be easier to quantify than indirect ones, since direct payments will generally appear in routine accounting records. Determining the magnitude of indirect subsidy will generally require a counter-factual approach and additional estimations. For example, the magnitude of an import duty exemption is the amount that would have been paid on the value of goods imported. Estimating the value of a profit tax exemption requires an accurate estimate of profits, something which may be difficult to recover from accounting records. Additionally, there may be considerable sensitivity and suspicion associated with the measurement of implicit subsidies to private providers.

ii. Determine Which Activities are Being Subsidized

Activity-types can be distinguished along a number of different axes. Possible distinctions include:

- public goods vs. private goods (in the public finance sense)
- preventive vs. curative care
- public health goods (as considered in the previous sections)
- primary vs. tertiary care.

When considering specific subsidies to particular providers it may be possible to determine which activities are being subsidized. One clear case is where all vaccines are provided free to private clinics. Breaking the subsidy down between activities may be considerably more difficult, for example, in the case where government is subsidizing a NGO hospital by paying all of the staff. Here it may be necessary to break down all of the hospital's activities into the relevant analytical categories.

iii. Who is Benefiting?

Closely linked with the above, the next step is to consider the *incidence* of the subsidy, that is, what population groups benefit from the subsidy. The population breakdowns we would be concerned with include:

- rural/urban
- gender, age
- socioeconomic status

Essentially the same difficulties as described for the activity breakdown case apply here. In certain cases it may be necessary to consider the entire activity package broken down by population group to determine the incidence of the subsidy.

b. Assessing the Subsidy Framework: What Changes are Needed?

The final component of this part of the assessment is to normatively evaluate the subsidy: what can we say about the desirability of each subsidy identified, given the magnitude, the activities being subsidized, and the beneficiaries of such an explicit or implicit commitment of public funds? The policy implications of such an assessment are clear: for certain areas, it is desirable to maintain the subsidy as is; for others, it will be optimal to increase either the magnitude or coverage of the subsidy; finally, and probably most politically contentious, there may be areas where subsidies should be removed. This will be the case where public funds are being used to subsidize services which, for example:

- do not benefit key target populations;
- are for services of limited cost-effectiveness;
- are for private goods with an inelastic demand, for which there will be no change in quantity demanded if the price increases;
- are for services of limited public health value.

When the subsidy has been broken down into all of the relevant categories, the information can be summarized in the form of a table such as the following:

Sample Analysis Matrix for Assessing Subsidy Structure

Subsidy Type	***Magnitude (K)***	***Type of Care Subsidized***	***Recipients***	***Policy Assessment (increase, decrease, or maintain)***

Section 6. Reducing Inappropriate Public Provision of Services: Making the Best Use of Public Resources

Key Issues

In many countries, major responsibility for service financing and provision lies with the public sector. In thinking about a new role for the private sector, our driving motivation is to ensure the most efficient and effective use of public resources in terms of health outcomes. This implies specific patterns of public financing but also means encouraging provision by most efficient providers. This in turn requires that we recall the distinction between public and private financing and provision, as shown in the diagram below. The key issue which this section addresses is the question of which services should be publicly financed, which should be publicly provided, and which criteria should be used in assessment. The role for the public sector as provider of last resort must also be considered in the case where there are severe supply constraints.

This section follows much the same pattern as the previous ones: first, we consider how to describe the patterns of public provision, and then move on to the evaluation of the optimal set of public sector activities in terms of the following policy issues:

- in what service areas should the government maintain current financing and provision of services? (stay at A in the diagram below)
- where should government seek to transfer responsibility for provision (move from A to C)? What subsidy/incentive is needed to encourage non-government providers to provide? (some form of contracting out)
- where should government cease both financing and providing a service, transferring responsibility for both to the private sector? (move from A to D)

Financing -> Provision	***Public***	***Private***
Public	A	B
Private	C	D

In this framework we can also consider the possibility of transferring responsibility for providing parts of services - e.g., ancillary services such as laundry, meals, cleaning. This possibility raises particular questions about nature of market and the extent to which the competition needed to generate efficient outcomes exists. The existence of adequate capacity in the public sector to draw up and monitor contracts is also an important determinant of the efficiency of contracting out.

a. Identifying Key Areas for Intervention

It is not possible in the context of this study to undertake a comprehensive review of public sector financing and provision. The intention in this part of the assessment is to consider public activity in its broad categories and to evaluate whether or not public resources are being used effectively and appropriately by considering the following criteria:

Which services should be publicly financed: allocative efficiency and equity

- public finance criteria (role for public financing of goods with important positive externalities, public goods, “merit goods”)
- cost-effectiveness (role for public guarantee of access to a basic package of services fulfilling cost-effectiveness criteria)
- equity issues: which services fulfilling cost-effectiveness criteria would be exorbitantly costly for private financing, hence requiring public subsidy (for example, effective but expensive tertiary care)
- equity issues: geographical, socioeconomic status (targeting mechanisms)

Which services should be publicly provided: technical efficiency and equity

- technical efficiency (supply side); relative capacity for risk bearing and expensive but effective capital intensive investments
- private sector supply constraints
- demand side factors
- “provider of last resort” where it is too costly to get private sector to provide

Note that the level of analysis should include both activity or service types and entire institutions. Since very heterogeneous services may be provided within a particular institution, there will be a need to consider services separately. An example would be a major urban tertiary care center where different services would perform differently when assessed according to the criteria above. For example, in some circumstances anurban

urban referral hospital also fulfills the role of the primary care unit for the urban catchment population. We could thus assess this function separately from that of hospitalization or specialist care. We would also want to consider some of the ancillary services and whether efficiency could be enhanced by contracting out.

b. Assessing Feasibility of Substituting Private Production and/or Financing

Once the desirability of transferring either the financing or the provision of services to the private sector has been considered according to the criteria above, the feasibility of such transfers needs to be considered. Naturally this includes aspects of political feasibility as well as consideration of issues such as:

- the existence of a private market in provision of those services
- the existence of demand constraints

This stage should be undertaken in conjunction with an assessment of the incentives which would be required in order to encourage private production, as well as the equity implications of any price increases which might result transferring responsibility from the public to private sector.

Sample Analysis Matrix for Assessing Policies to Alter the Mix of Financing and Provision

Service Type	*Cost of Service*	*Population Benefiting*	*Assessment (criteria)*	*Proposed Action*
e.g., MRI in teaching hospital	$100,000 per year for operation and maintenance.	Very low: 12 MRIs per month; Primarily urban. Few referrals.	Low cost-effectiveness; Private good. Benefiting well-to-do population.	Divest to private financing and provision.
Hospital laundry service	$20,000 per year.		Could be more efficiently provided by private firm.	Contract out.
Hospital outpatients department	Serves as primary care facility for urban community; high fixed costs.	Urban poor.	Services could be more efficiently provided by non-government provider; certain services should remain free of charge.	Contract to NGO to provide services; ensure sufficient subsidy to maintain free public health activities.
TB hospitalization center	Primarily referred patients for first 2 months of short course.	General population of adult males.	Public good (communicable disease control); supply constraint faced.	No change.

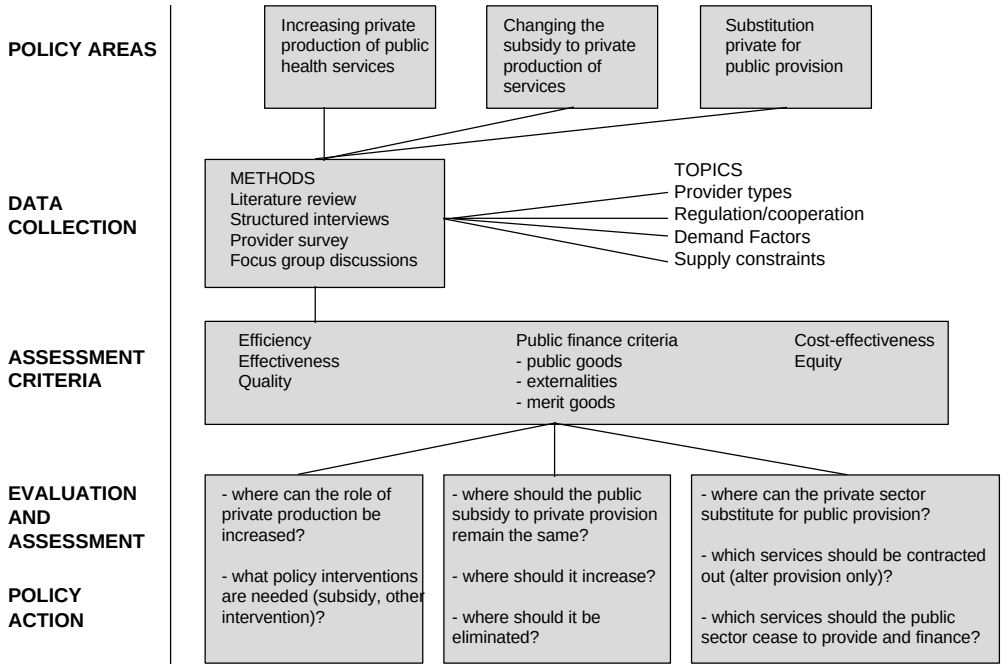
Section 7. Conclusions

The preceding sections review how to go about a policy-focused private sector assessment. The data collection and analysis efforts are oriented towards three specific policy areas. These policy areas are ones through which public goals can be pursued by making better use of the private sector and by reducing unnecessary and inappropriate burdens on the public sector. It is hoped that by remaining focused on these three areas, these guidelines can provide a unique tool for policy makers and donors in helping to reconsider the role of the public and private sectors in health service provision and financing.

Figure 1 on page 41 shows how the different sections of the Guidelines fit together, paralleling the way each section has been laid out in this document: first, describe the key issues; second, determine which data is required and the most efficient way to collect and organize it; third, use a set of criteria to evaluate the current situation; and finally, use this assessment as the basis for proposing concrete policy actions. A matrix describing the relationship between information requirements and data collection possibilities appears on page 42.

Particular emphasis has been placed on initially taking as broad a perspective as possible on the private sector: this is rooted in a desire to avoid the bias which results from studying only those private sector agents for which information is readily available. It is also rooted in the perception that the parts of the private sector which are likely to be most important in terms of existing coverage of public health services will be very different from those to whom government may seek to transfer the production of purely private goods with a low level of cost-effectiveness. For these reasons it seems to be particularly important to use a definition of the private sector that includes all non-government agents, including the informal and traditional sectors.

Figure 1 **Assessing the Private Sector: Methodological Guidelines**



Assessment Methods: Data Collection Matrix

Data Collection Technique: -> Policy Areas:	***Literature Review and Analysis of Existing Data***	***Structured Interviews with Key Informants***	***Regulatory Review***	***Provider Study/ Interviews***	***User Study (focus groups?)***
Defining and describing the private sector					
Existing public and private linkages Increasing private provision of public health services					
Altering the public subsidy to private providers					
Substituting private for public provision					