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**Framework for Selection of Priority
Research and Analysis Topics in Private
Health Sector Development in Africa**

Technical Paper No. 1
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**Health and Human Resources Analysis
for Africa Project**



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FORWARD

The demand for more and better health care in Africa is increasing at an accelerated rate due to unprecedented growth in population, urbanization, higher rates of literacy, and the increase in the prevalence of endemic and emerging diseases. At the same time, the capacity of African governments to provide the required quantity and quality of services is diminishing due to the gradual decline in real per capita allocation of resources to the health sector and the persistence of inefficient allocation of the available meager resources. The private health sector presents an opportunity to narrow the growing resource gap in health services. This document examines major issues regarding private health sector development in Africa and points out topics for research and analysis in which USAID may have comparative advantages. The first draft of this paper served as background material for a consultative group meeting on the same topic. The report on results of the meeting is presented in the Appendix.

For too long the private health sector has been neglected. In fact, in many countries in the region it has been actively discouraged. Socialist policies of the 1970s and early 1980s, the donor community's insistence on primary health care, and the popular association of private health sector with curative—and "inefficient and inequitable"—care contributed to negative attitudes towards the private health sector. Yet, the sector persevered, and in some countries (Zaire is the most interesting but not a unique case) it continued to play a significant role not simply in curative care but also in preventive care and the management and supervision of rural health services.

The ever increasing resource gap and the prevailing environment of political and economic liberalization in the region present the need and opportunity to study the potentials of this sector and factors that contribute or hinder its development. Our interest is to help African governments, USAID, and other donors develop policies and programs that would enable the private sector perform close to its maximum potential in the delivery of more and better health care in Africa.

Based on issues raised in this document and consultations with our African partners we commissioned four country case studies of private health sector development. The studies done in Kenya, Senegal, Tanzania, and Zambia focus on the following points:

- The size, scope and distribution of private provision of services;
- Actual and potential role of the private sector in promoting the public health agenda;
- Areas for public/private sector collaboration; and
- The regulatory environment and possibilities for creating an enabling environment for private sector development.

The studies will be used as background material for a conference on private health sector development in Africa that will be held late in 1994. We believe that frank and rigorous discussion of these issues is imperative to the development of policy and programs

that would allow the private sector to participate in health care provision up to the limits of its potentials.

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ACRONYMS

ARI	Acute Respiratory Infection
DHS	Demographic and Health Surveys Program
EPI	Expanded Program for Immunization
HFS	Health Financing and Sustainability Project
HHRAA	Health and Human Resources Analysis for Africa Project
IRD	Institute for Resource Development/Macro Systems, Inc.
LSMS	Living Standards Measurement Survey
NGO	Non-Governmental Organization
NFP	Not-for-Profit
ODA	British Overseas Development Council
ORS	Oral Rehydration Salts
PFP	Private-for-Profit
PRITECH	Technologies for Primary Health Care Project
SDA	Social Dimensions of Adjustment Project
STD	Sexually Transmitted Disease
TIPPS	Technical Information on Population for the Private Sector
UNDP	United Nations Development Program
UNICEF	United Nations Children's Emergency Fund
UNSO	United Nations Sahel Organization
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Good health is a fundamental objective of social and economic development. In this respect African countries¹ have made tremendous strides since independence, not only in increasing access to public health services, but also in terms of improving the health status of their populations. Yet most African countries continue to perform poorly in terms of achieving better health in comparison with other developing countries, even those at similar levels of development, and efforts to control population are still at an early stage in many countries. In the 1980s, this has become more critical as major economic and fiscal crises have threatened to slow or even reverse progress.

Fiscal crises have been particularly severe in much of Africa, resulting in limited public resources (Sahn and Bernier, 1993), which have limited the capacity of African governments to directly provide family planning and health services. In the medium term, it is unlikely that most governments will have the option to expand significantly the volume and extent of public provision and financing. At the same time, continuing high population growth is generating increasing demand for health services, while the need to improve economic performance is placing a greater premium on increasing the quality of Africa's human capital.

The challenge facing African decision-makers, USAID, and other donors in the 1990s is to improve the capacity and performance of African health systems despite the considerable financial constraints. Public health systems face significant problems in providing adequate health care and access to family planning services. These problems include low efficiency and low quality services, resource misallocation, and insufficient human and material resources. Private expenditures on health already account for a major portion of total health spending in most African countries. Development and improvement of contributions by the private sector to both the financing and provision of population services and health care represent one potentially important area for strengthening current health systems. There has been increasing interest on the part of African governments, USAID, and other donors in recent years in greater utilization of the private health provision and financing in the development of the health sector as a whole (World Bank, 1993a). From USAID's perspective, enhancing involvement of the private sector is also desirable because it increases the participation of people themselves in the process of development and thus sustainability, and promotes more social and economic pluralism within countries.

Despite this, relatively little is known about the current activity and contribution of the private health sector, especially in sub-Saharan Africa. There is insufficient evidence on the role of private health care provision in Africa on which to base good policy and programming. There is even less experience and understanding of the public interventions and policies that are available to manage the development and contribution of the private

¹ The term Africa in this document refers specifically to sub-Saharan Africa.

health sector. Development of strategies that make more effective use of the private health sector will require much better understanding of the current and potential activity of the private health sector in different parts of Africa, its coverage, quality and efficiency, the important factors affecting its development, and the appropriate policy instruments for use by the public sector. Lack of this type of information and understanding is the major constraint to greater use of the private health sector in Africa. This not only restricts governments in designing more effective national strategies, but also limits the potential for USAID action in the area.

USAID objectives already include increasing the participation of the private sector in meeting population and health goals in Africa. The primary purpose of the Health and Human Resources Analysis for Africa Project (HHRAA) is to increase the utilization of research, analysis, and information in support of USAID's strategic objectives in the social sectors. The private health sector is one area where further research and analysis is a prerequisite for future policy-making, and where HHRAA can make a significant difference to the impact of USAID policy.

REVIEW OF THE LITERATURE

In formulating policy towards the private sector in Africa, there are three sorts of basic information that are required:

- (1) Information on the size and composition of the private sector;
 - (2) Information on the contribution of the private sector (i.e., what it does, who uses it, and its cost, quality, and health impact); and
 - (3) Information on potential interventions that can influence the activity and development of the private sector. In general, the existing literature and information on Africa's health sector are particularly weak in these areas.
- This section provides a brief and concise overview of what is currently known.

In assessing the size and composition of the private sector, information is required from two perspectives: financing and provision. When analyzing the extent of private provision, there must be a clear classification of what is meant by private provision, as the "private sector" or "privatization" are potentially misleading terms, which combine aspects of both financing and provision. This strategic framework document focuses on private provision, thus, the private health care sector is defined as including all those health care providers working outside the direct control of the state. It includes both for-profit and not-for-profit providers, formally-trained providers as well as traditional healers, and fully-private providers, as well as public employees who provide services on a private basis. Although the focus is on provision, information on private financing is useful and important. The strategic framework on health care financing (which is forthcoming from the HHRAA project) explores this in greater depth, and it is also discussed briefly below.

Size and composition of private expenditures

Private providers can be financed, in theory, by both public and private sources. Public subsidies to not-for-profit (NFP) providers, such as church-run services, have been considerable in some countries. For example, in Malawi, church-run health services receive 39 percent of their funding from the government (Banda and Simukonda, 1993), while in Zambia, more than 50 percent of the revenues of church hospitals are from government subventions. In contrast to NFP providers, private-for-profit (PFP) providers in Africa have generally not been publicly financed, and most financing is from private, mainly household, sources. For virtually all African countries there is a lack of reliable and accurate information on the level and composition of private expenditures. Very few countries in the region have carried out systematic surveys of national health expenditures by source and use. What data is available is often of poor reliability and subject to considerable error, especially on the private sector side (Rannan-Eliya and Berman, 1993).

For most countries in Africa, available private expenditure numbers are mostly "guesstimates," derived from limited, if any, empirical data. They may also be systematic underestimates, as it is often difficult to measure private expenditures on traditional healers and other informal providers. The two reviews of national health expenditures in Africa currently available, by Vogel (1993) and in the World Development Report 1993, are based on the analysis of secondary data sources, often the same ones (Murray, Govindaraj and Chellaraj, 1993). The data available in these reviews therefore should be used with caution. Nevertheless, they do suggest that private financing is important in Africa, in contrast to what is often assumed. Table 1 gives the best available figures for a number of African countries. The data indicate that private financing, mostly by individuals, comprises a substantial proportion of expenditures in most countries. At an average of 43 percent it is not as high as in Asia, but is substantially greater than in Latin America. Public sector expenditures (including aid flows²) seem to be quite significant, more than in Asia, but less than in Latin America. However, the role that international aid plays is much more important in most of the smaller African countries, to an extent not seen in other regions.

It should be noted that these private expenditure numbers are totals. What is often more important, from the policy-making viewpoint, is the composition of such spending by source (e.g., how much from households, enterprises, etc.) and population group (e.g., regions, income classes), but this information is even less available.

Health insurance systems in Africa are small and highly diverse, and consist of both public and private insurance schemes. Health insurance schemes are potentially an important source of financing for private providers, but the extent of population coverage is small,

2 In practice, not all donor assistance is channeled through the public sector. Substantial amounts are channeled through NGOs and other private providers.

TABLE 1: Health Care Expenditures by Source in Selected African Countries, 1990, in Comparison with other Regions.

	Public Health Expenditure as a % of Total Expenditures	Aid Flows as % of Total Expenditures	Private Health Expenditure as a % of Total Expenditures
Benin	32	46	22
Burkina Faso	10	75	15
Burundi	62	13	25
Cameroon	40	18	43
Chad	31	53	16
Côte d'Ivoire	68	5	27
Ethiopia ¹	28	8	64
Ghana ²	30	14	56
Kenya	40	22	38
Madagascar	29	21	50
Mali ³	20	21	61
Mozambique	21	54	25
Nigeria	47	8	45
Rwanda	19	50	31
Senegal ⁴	31	17	51
South Africa ⁵	52	0	48
Tanzania ⁶	11	27	62
Uganda	13	34	53
Zaire ⁷	5	16	80
Sub-Saharan Africa	47	10	43
Sub-Saharan Africa (Excluding South Africa and Nigeria)	36	20	43
China	58	1	41
India	20	2	78
Other Asia and Islands	38	1	60
Latin America	76	< 1	24

Source: Derived from estimates prepared for the World Development Report 1993. Where indicated, the WDR estimates have been replaced by DDM estimates when warranted for reasons of accuracy. The regional groupings are used in the report. Regional averages are weighted according to GDP, and reported as in the WDR. All figures are for 1990, except where indicated below. Figures may not sum to 100 because of rounding.

Notes to table: (1) DDM estimate for 1987; (2) DDM estimate for 1990; (3) DDM estimate for 1990; (4) DDM estimate for 1989; (5) DDM estimate for 1990; (6) DDM estimate for 1991; (7) DDM estimate for 1990.

ranging from less than 1 percent in Ethiopia to 11.4 percent in Kenya (Vogel, 1990).³ The actual contribution to total health expenditures is even less, with private insurance payments exceeding 1 percent of total health expenditures only in Kenya, Senegal, and Swaziland. It has been suggested that the absence of widespread health insurance is a major constraining factor in the development of the private sector in Africa and elsewhere (Lewis, 1988), but the historical experience in other countries suggests that private insurance would follow rather than precede development of private demand and provision, although a rigorous analysis of this issue has not been done (Berman and Rannan-Eliya, 1993). Provision and financing of health services by employers does occur in Africa, and in some countries is significant, especially in the large mineral-extraction industries. However, there has been very little analysis of it, and no systematic review exists in the literature (Hanson, n.d., b).

Although there have been few high quality surveys of private health expenditures in African countries, some data is available from the various Living Standards Measurement Surveys (LSMS), Social Dimensions of Adjustment Project (SDA)⁴ and other household surveys that have been carried out in various African countries in recent years. These may underestimate the true level of private expenditures, but they do give some indication of the incidence of private expenditures across population groups. In general, they suggest that while most households spend significant amounts of their income on health services, expenditures are highly concentrated in upper-income and urban households in most countries (Hanson, n.d., b; World Bank, 1993a). For example, one study in Kenya found that 83 percent of all private health expenditures were accounted for by the 15 percent of families that lived in urban areas, while 56 percent of expenditures were accounted for by the richest 5 percent of families (Bloom et al., 1986). It is not evident from existing studies how much of this is due to existing income inequalities and how much is due to differential access to formal, private health services.

Information about the private services purchased by these private expenditures is limited as well. This is partly due to the paucity of good quality household surveys of health care utilization, and partly due to inherent difficulties in eliciting information about utilization of traditional healers. Nevertheless, the available data suggest that as in most low-income countries, approximately one half of all private health expenditures are used to purchase pharmaceuticals (World Bank, 1993a). For example, medicines accounted for about 48 percent of household expenditures on health in Senegal between 1981-1989, and 54 percent in Ghana in 1987-1988 (World Bank, 1993a). While most pharmaceuticals are purchased from pharmacies and other retail outlets, very little is known about the role that these providers play in health care provision. This is despite the fact that lack of access to essential drugs is recognized as a major problem in the health sector in Africa (World Bank, 1993a), and evidence that indicates that drug sellers both diagnose and independently prescribe in most countries.

3 This discussion excludes South Africa, where insurance coverage is significant, although concentrated mostly in the white population.

4 The SDA Project was launched by the UNDP, African Development Bank, and the World Bank, in collaboration with other donors, to strengthen the capacities of governments in the African region to integrate social dimensions in the design of their structural adjustment programs. It has made a special effort to enhance the capacity of countries to develop and maintain statistical data bases on the social aspects of adjustment.

Size and composition of private provision

In general, very little is known about the number of private providers, the quantity and composition of services provided, and the composition of users. Most information sources usually fail to distinguish between PFP and NFP providers. Data on the amount of services provided privately are typically systematic underestimates, since they fail to take into account those services provided privately by public-sector health personnel.

There are only seven countries in Africa for which reports are available of quantitative national data on the levels of formal private provision, even at the most basic level of description, such as the number of full-time private practitioners or the number of hospital beds in the private sector (Hanson, n.d., b). Even for these countries, the data is incomplete, as registration systems are often not updated or sufficiently detailed. For example, in Senegal it is known that 14 percent of all hospital beds are in for-profit facilities and 45 percent are in not-for-profit facilities, but it is not known how the 37 percent of all doctors who are employed privately full-time are distributed between the two types of private facilities. So it is not possible at the moment to compile an accurate description of what the private sector consists of and its activities in large parts of Africa. What is known indicates that the NFP sector is particularly large in much of Africa compared with other developing regions, accounting for 40-50 percent of all hospital beds in countries such as Malawi, Senegal, Tanzania, and Zimbabwe.

There is a long history of church- and NGO-run services in many countries. These services often are better distributed to underserved and rural areas than are government services. However, as noted above, many of these facilities receive significant subsidies not only from international donors, but also from their own governments.

The formal for-profit sector is generally small in most countries. The numbers of full-time private doctors and for-profit hospital beds are very much lower in Africa than elsewhere. For example, the number of full-time private doctors per 1000 population is less than 0.015 in countries such as Malawi and Zambia, while figures greater than 0.100 are typical in most countries in Latin America and Asia for which there are data.⁵ Formal PFP providers tend to be restricted to urban areas (e.g., of the 260 private practitioners in Senegal, 206 are located in Dakar), although there is evidence suggesting that they are growing in some cases. Significant and widespread formal, for-profit private provision appears to be found only in Nigeria, South Africa, Zimbabwe, and Kenya.

Traditional healers also appear to be a major source of accessible care for many rural populations, but it is difficult to assess their relative importance (WHO, 1978; DeJong, 1991). Traditional healers probably serve 80 to 90 percent of the population in Africa, and in many countries may outnumber biomedical practitioners by at least 100 to 1. They also appear to be more equitably distributed in rural areas than are other providers (Hogle and Prins, 1991).

⁵ These numbers are taken from an ongoing analysis of global private health expenditures and provision being carried out by DDM.

Traditional healers comprise a large part of the informal provision sector. This sector also includes other sources of care such as traditional birth attendants, spiritualists, itinerant drug peddlers, and other unlicensed and untrained practitioners. Much less is known about their numbers and the roles they play in health care provision.

When the available limited data on provision is analyzed, it would appear that there is very little correlation between the level of private provision and the level of private financing or level of income in different African countries (Hanson, n.d., b). This is consistent with comparable global private provision data, and suggests there is not a simple relationship between income, financing, and provision (Hanson, n.d., a). This and other analyses (Rannan-Eliya and Govindaraj, n.d.) also suggest that determinants other than income level and the level of public financing and provision, such as historical background and institutional factors, are also important in private sector development.

Costs, quality, and effectiveness of the private sector

Available information on the costs and quality of private provision remains scarce. It suggests that private providers, missions in particular, may often be technically more efficient in the provision of services (Bennett, 1992; Green, 1987). However, there have been too few cost studies either to confirm this or determine possible reasons. There is also evidence to suggest that private providers are perceived by patients to be of higher quality than public services (Attah, 1986; Bennett, 1991; Green, 1987; Berman and Rannan-Eliya, 1993), but again, there have been too few studies to assess quality as professionally-determined.

Information about the actual activity and contributions of the private sector in Africa to national health goals is very weak. It does not exist in any systematic form that would allow one to draw any definitive conclusions. Where data exists, it often does so only for certain disease categories or types of services, usually having been collected as a part of a larger donor-funded program, such as diarrhea control or EPI. For example, analysis of DHS survey data reveals that in Uganda 20.9 percent of tetanus toxoid vaccinations were delivered by private providers, and 44.1 percent of family planning services were also provided by private sources. For some services such as family planning, it would appear that the private sector does make an important contribution, but this may merely reflect a concentration in the literature on its activity (Hanson, n.d., b). Even when good survey data, such as DHS surveys, is available in the area of population control, it is often tantalizingly incomplete in what it says about private sector activity (Rose, n.d.).

Nevertheless, a number of USAID-funded programs, such as those of Pathfinder, Technical Information on Population for the Private Sector (TIPPS), and Enterprise, have successfully used private companies and providers to deliver health and population services. This experience, discussed below, confirms the potential of private providers to contribute to the broader public health agenda.

Policy interventions

There are potentially a wide range of tools available for intervention in the private provision sector. These can be categorized into the areas of: (1) public provision/production, (2) economic incentives/disincentives, (3) regulation and licensing, (4) interventions in factor or input markets, and (5) public information (Berman and Rannan-Eliya, 1993). However, a key information gap in Africa relates to knowledge of and experience with such public interventions, and how they can influence the private sector (Berman and Rannan-Eliya, 1993; Gilson and Mills, 1993).

In recent years, there has been increasing interest in these issues as they relate to African countries. This in part related to the general trend towards economic liberalization, and in part to the emergence of new governments in many countries. This has been accompanied by preliminary attempts to share information on issues related to the public/private mix over the past two years (WHO, 1991). This interest and discussion has currently focused on five broad areas:

- (1) Increasing private financing for public provision through user charges. This has had some success in raising revenue in Africa, but the amounts involved have been limited, and it has been associated with some negative equity effects (Creese, 1991). It may have an impact on private providers by improving the quality of public services and by reducing the price differential between public and private providers (Alderman and Gertler, 1989; Gertler and van der Gaag, 1990). However, this impact on private providers has typically been of secondary importance in determining a policy designed primarily for the benefit of public services.
- (2) Contracting out of services to private enterprises, particularly in large hospitals. This has dealt with intermediary inputs such as laundry, food catering, or laboratory services, and has been seen largely as an efficiency measure to improve management of public sector resources. It does not necessarily lead to greater private provision of health services and, in fact, may lead to the opposite if the public sector becomes more competitive.
- (3) Administrative and managerial changes in the running of public sector health units, which involve either bringing in private management on contract or making public facilities more autonomous and more like private facilities in the incentives that they face. This again is essentially an efficiency measure, designed to improve the operation of public services.
- (4) The better use of public financing, in the form of subsidies to NGOs or private providers, to pay for the direct provision of services by private providers. This is an area in which USAID has the most experience, but it does not necessarily involve an expansion in the numbers of private providers that are sustainable in the health sector.
- (5) The repeal of existing restrictive legislation banning private practice in many African countries. This has usually come about as a result of the manifest

failure of public services to meet existing demand and the lack of immediate financial resources to deal with this. It has not usually represented the start of a more ambitious and coherent program to establish and expand a vigorous private provision sector.

WHC efforts in the region have initiated documentation of all the policy measure mentioned. This includes their workshop held in Namibia in October 1993,⁶ which focused on user charges and more effective implementation of current regulatory strategies, and not on provision, despite its title. It must be noted that despite the undoubted importance of these five issues, none of them deal primarily with the private-provision sector itself, and the tools required to actively control the extent, composition, and activities of private providers.

This type of strategy to achieve public goals will be more effectively implemented with full use of all the intervention types mentioned at the beginning of this paper. In addition, what is and will remain lacking is a systematic review of these various types of intervention and their use in Africa, and a framework for choosing between them. In the context of weak states, it is also vital to understand better which interventions are more likely to succeed, and what can be done to improve regulatory capacities where they are poor. This framework is likely to remain lacking at a national level. Despite interest on the part of WHO and individual countries, none have the resources needed to advance beyond information sharing. USAID is better able than any other donor to respond, given its available resources and expertise.

CURRENT RESEARCH AND ANALYSIS

Research on the private health-care provision sectors in developing countries has long been a neglected field and there is little systematic understanding of what the private sector consists of or of its internal dynamics. Knowledge of the Africa sector is even less than scarcer than that of other sectors. At the present, there is no other major regional program of research or investigation into the private health care sector. When research does occur, it tends to be a small part of a more general, national health financing review done by external consultants. As a consequence, it is often of limited relevance, may not be comparable with work done elsewhere, and does little to build up local capacity for analyses and action. Even when analysis of the behavior of private providers is carried out, it is usually done without any attempt to describe the full extent of private provision in a given country.

Given that even cross-sectional descriptions of the size and composition of the private sector are not available for virtually all countries, it has not been possible up to now to carry out any analysis of trends in the growth of private sector development within countries, or to analyze the causes of variations across individual African countries. Since such an understanding does not exist, there have been no efforts to analyze in detail what the effects of government interventions might be. Individual African countries typically do not have the material or technical resources to allow them to carry out research on the private sector.

⁶ The "Intercountry Meeting on Public/Private Collaboration for Health for All," was held in Windhoek, Namibia on October 4-8, 1993.

Even if the human resources exist, it may be difficult to find the financial resources to support research when the private sector is not perceived as being a priority issue.

USAID-sponsored activities

A number of centrally-funded USAID projects have conducted or are currently carrying out research or activities that involve private providers in Africa. These include:

- (1) The Health Financing and Sustainability Project (HFS) managed by Abt Associates. This has included various country-specific projects, but not region-wide activities. It has included work on various aspects of public provision and cost recovery in the public sector, as well as some surveys of efficiency and quality of private providers, the development of private insurance, community financing, private practice by public employees, etc. Major country involvements have included Senegal, Kenya, Central African Republic, and Niger.
- (2) The Demographic and Health Surveys (DHS) Program of the Institute for Resource Development/Macro Systems, Inc. (IRD) funded by USAID has supported the collection of data on fertility, family planning, and maternal and child health around the world. Its various surveys represent a valuable source of high quality data on fertility and health-seeking behavior in many countries. Some of these can provide significant, but limited, information on the use of private providers for fertility and MCH services (Rose, n.d.). However, until now this type of information has not been the objective of all surveys, and so the extent to which the survey instruments used have permitted such detailed analysis has varied. It is hoped that future DHS surveys will routinely emphasize the collection of data on the use of private providers for population and child survival services.
- (3) The Technologies for Primary Health Care (PRITECH) project has conducted some work in relation to the private provision of primary health care services. This has included some useful literature reviews of what is known about traditional healers and an examination for potential collaboration between donors and the public sector and these private providers. However, it has not carried out any systematic, country-wide field surveys of private providers. As a component of projects to increase the distribution of oral rehydration salts (ORS), it worked with private manufacturers and distributors in several countries, including Kenya, Madagascar, Mali, and Cameroon. Efforts were also made to involve other providers in the delivery of certain health services, in particular NGOs and traditional healers; this included attempts to survey and train traditional healers in Uganda and Cameroon. Other projects were envisaged but not implemented during the lifetime of the PRITECH project.
- (4) The Basic Support for Institutionalizing Child Survival (BASICS) project, which recently started operation, will attempt to extend the work of PRITECH. Its activities are intended to include surveying the sources of provision in particular countries, and identifying products and services for which there is unmet demand. This information could be used to identify and then assist private companies and other providers to

develop health-related products and services, which could be supplied on a commercial basis.

- (5) Pathfinder is a major recipient of USAID funds in the population field. It has used these to expand the delivery of population services. Within Africa, Pathfinder has used private providers and organizations in Uganda, Kenya, Tanzania, Zambia, Côte d'Ivoire, Sierra Leone, the Gambia, Togo, and Nigeria to deliver products and services. Typically, these involvements have been developed on a program-by-program basis, and research has been limited to what has been necessary from an operations and evaluation perspective.
- (6) Various other USAID-funded projects, such as the TIPPS project and the Enterprise program, have been involved in encouraging and assisting private companies to deliver population services to their own employees. The Enterprise program also has assisted NGOs to become market oriented and thus improve their performance. Although both programs started with population services, their success has demonstrated the potential for expanding the provision of health services in this way.

A number of USAID missions in Africa have financed health financing studies specific to their respective countries. However, most of these have focused on issues related to public provision, and research directed at private providers has been rare. The only major one to have involved work on the private sector is the current health financing project in Kenya, which has sponsored a number of studies of both private hospitals and private clinics. Other studies financed by USAID missions in the areas of direct service delivery have occasionally examined the potential for delivering certain interventions using private providers. Several programs have actually done so, the most notable examples being provision of family planning services, condoms, ORS, and EPI. In these cases, which have high potential for social marketing, USAID has probably taken the lead within the donor community.

Other donor-sponsored activities

- (1) As part of its health sector programs in a number of African countries the World Bank has sponsored research into various aspects of private health care provision. Most of this research is country-specific, the byproduct of research done primarily for the public sector,⁷ and is not readily transferable across countries. The World Bank has also done some regional work as part of its work for "Better Health for Africa" (World Bank, 1993a), but this has involved mostly evaluation of previous studies and World Bank experience.

One area in which the World Bank has carried out uniquely valuable research and activity is household surveys. It has taken the lead, together with other donors such as UNDP and UNSO, in helping to develop the household survey capacity of a large

⁷ Research is typically related to the giving of loans, which are almost always to sovereign governments.

number of African countries, and it has sponsored a number of national surveys using standardized formats and methodologies. These LSMS and SDA surveys represent the best available data on current private expenditures on health and health care utilization for many countries. This is a very important, but largely underexplored, source of information that could be analyzed on a regional basis.

- (2) WHO has taken an increasing interest in the private sector in recent years. It has attempted over the past two years to bring together ministry officials from various countries, including some from Africa, to discuss national experiences with managing the public-private mix. This effort has focused primarily on informing participating countries of each other's experiences. It has not involved any additional research into the private sector. As part of this more global effort, WHO held its regional workshop in Namibia in October 1993, which produced a useful collection of summary papers on the situation in a number of African countries. The major benefits of this activity will probably be to highlight the more important issues that ministries believe they are facing and to make individual countries aware that they do not face unique problems.
- (3) UNICEF has been a major sponsor of health financing research in Africa, largely through the efforts of its Bamako Initiative Unit. However, while this has done much to examine issues related to community financing and provision of health services, it has devoted less attention to private provision itself. Nevertheless, UNICEF has played an important role in building up the research and analysis capacity of many countries.
- (4) The Health Policy Unit of the London School of Hygiene and Tropical Medicine is carrying out the only other cross-national research effort in Africa. This is the Health Economics and Financing Program sponsored by the British Overseas Development Agency (ODA). This also involves an element of experience sharing, but its main objective is to help individual country groups formulate their own research agendas focused on the public-private mix, and then to obtain the necessary funding. Most of this work is carried out under the umbrella of a collaborative research network on the public/private mix, which currently includes researchers from Ghana, Malawi, Uganda, Tanzania, Zimbabwe, and South Africa.

INFORMATION GAPS OF RELEVANCE TO USAID STRATEGY

USAID's overall goal is to reduce population growth and to improve health status in USAID-assisted countries by strengthening the delivery of and improving access to population and health services. This is reflected in a focus on support for family planning, selective maternal and child health interventions and specific infectious disease interventions, and the infrastructure to deliver them. USAID has had a policy of encouraging private providers to involve themselves in the delivery of services, especially child survival services and family planning, especially where this can supplement a weak government infrastructure. USAID is also supporting significant efforts to reform health sector financing in a few countries. If USAID is to improve the effectiveness of the private sector's contribution to its

overall population and health goals, then there are three main information gaps that must be addressed.

- (1) *Little is known about what types of services private providers now provide or potentially could provide, and in what quantities.* What is known is not assembled systematically to support policy development. Data are lacking on the informal and traditional sectors, pharmacists, and other drug vendors. This is despite evidence that these groups are very important in treating childhood infectious diseases, such as diarrhea and ARI, as well as adult diseases, such as STDs and neuro-psychiatric conditions. Some limited data do exist in the form of household surveys, such as the LSMS and DHS, but they need to be analyzed. Information from the demand/utilization side needs to be combined with information from the provider side in order to assess the relative importance of different providers by population sub-group.
- (2) *The actual and potential contributions of private sector providers to the broader population and public health agenda are unknown.* The benefits of private sector activity have been assessed mostly on the basis of individual program objectives, e.g., the number of condoms distributed or immunizations carried out. There has been little attempt to evaluate the impact or potential contribution of private sector activity on the broader health sector goals that USAID is committed to, such as sustainability of the general health system, availability of and access to population and health care services, improved resource management and effectiveness within the health sector, or overall fertility control and health status.
- (3) *The policy tools that can be used to control the development and activities of the private provision sector are not fully understood.* Support for the private sector and management of public-private linkages have mainly been determined on a program-by-program basis. The size and capability of the existing private sector in a country has largely been accepted as given, but it is clear that private sector development is determined by a number of factors, only some of which are amenable to direct government intervention. While individual USAID programs have supported private sector expansion, other policies may have had the opposite effect. For example, it is possible that the generally high level of USAID financial assistance to the public sector may have had a crowding-out effect and resulted in a net reduction in private expenditures. Similarly, interventions to directly influence the private sector may have been largely ineffectual because of a failure to change more important constraints or incentives.

What is known about financing and provision indicates that the level of private sector activity (defined to include for-profit and not-for-profit, as well as traditional informal and formal modern providers) is sizable in many, if not most, African countries. Public and private services exist alongside each other in a competitive environment, and necessarily influence each other. USAID needs to develop a more coherent strategy towards the private sector, based on how the sector relates to its overall objectives of health status improvement and sustainability of health systems. If the private sector is to be a major mechanism for delivery of particular interventions, then more general support may be required to develop its capacity to act as a partner when

required. This strategy should be much more proactive. It should take into account all the mechanisms by which USAID and national governments can influence private sector activity, including public provision and financing, regulation and licensing, taxation, subsidies and incentives, insurance, and public information.

USAID'S COMPARATIVE ADVANTAGE

For research activities sponsored by USAID to be most effective, they should focus on those areas in which USAID has some comparative advantage. USAID's comparative advantage stems from several factors:

- (1) Field experience working with private providers gained in previous programs. Much research into the private sector is inherently difficult because of the problems involved in gaining the cooperation of private providers. In this respect, USAID has a distinct advantage in that many of its previous programs have built up relationships of significant trust with important groups of private providers in many countries.
- (2) The presence of well-staffed resident missions in a number of African countries with often greater in-country health sector expertise and experience than a number of other donors. The breadth and depth of experience available is important, in that research into the private sector often involves activities and organizations not typically associated with ministries of health.
- (3) Preferential access to the immense experience with diverse approaches to health financing and provision available in U.S. universities, consulting firms, and other institutions. This experience is probably wider in scope than that available to other bilateral donors in a number of areas, such as insurance systems, public financing of private providers, and regulation of the private sector.
- (4) The ability to sponsor, through programs such as HHRAA, research activities that have a region-wide focus, in addition to those within specific country programs or projects. No other donor, except ODA, has the resources available to fund such research. However, ODA has already committed its available funds to ongoing research activities, which do not appear capable of generating the results that are of immediate relevance to the major issues of private health care provision. This is an area where USAID can usefully conduct activity that the World Bank is not in a position to support.

RECOMMENDATIONS FOR USAID STRATEGY

HHRAA is in a unique position to be able to fund and organize research that is of direct relevance to policy-making, but which is unlikely to be carried out otherwise. Given the paucity of information, the results would be of immense value not only to USAID, but also to national governments and other donors. An operational advantage of a HHRAA-sponsored research program would be its region-wide focus and ability to link African researchers and decision-makers with external technical support and resources. It will also have the advantage of being able to focus on issues that might not have immediate program or project significance, yet are of broader strategic relevance.

There is clearly a lack of essential information to formulate an appropriate strategy towards the private sector in Africa. In addition, there is a lack of agreement on what are the important issues in individual countries. The key objectives of HHRAA's research and analysis therefore should be:

- (1) *Description of the private sector in Africa.* Basic descriptive and quantitative data on the size, composition, and structure of the private sector must be collected. Although some might view this as academic, a recent expert meeting convened by HHRAA noted that coherent policy on private contributions to health cannot be developed without a solid foundation of data on the size and composition of the private health sector. Partial views may lead to erroneous conclusions about what is available and how it works. The goal here would be to define the types of private providers that exist and the relative numbers of providers of each type. Care should be taken to define more accurately the health care provision roles of different provider types: informal and traditional providers, drug vendors, and pharmacists in particular, are normally overlooked in analysis. The range and distribution of services offered each should be investigated.

The contribution that private providers make in delivery of services that are relevant to the public health agenda and are of interest to USAID should also be assessed, e.g., family planning, maternal and child health, treatment of malaria and diarrhea, curative services, etc. In addition, the contribution by private providers to the supply of more private goods, and the extent to which they can reduce the burden on the public sector of supplying these goods should also be assessed. The nature of the public-private mix at different levels in the health system should be described, where possible. This should be done both at a regional and country level.

- (2) *Analysis of the determinants of the development and composition of private provision.* This should include a cross-national analysis of differences in private sector activity in order to identify any national level variables that are of importance. Within countries, historical factors and public interventions that have influenced the development of the private sector should be examined in order to determine which factors are most important in shaping the sector.

Close attention will have to be paid to those factors that are amenable to public action and can be targeted explicitly in public policy. An assessment will have to be made

of the feasibility and effectiveness of different types of government intervention in affecting private sector activity from both the demand and supply sides.

- (3) *Assessment of the merits of private sector activity.* The merits of the private sector need to be evaluated in order to determine the role it can play in meeting broader population and health sector objectives. This should include evaluating the general effectiveness of private services, their efficiency and equity, and their impact on the effectiveness of public services. An assessment of how these can in turn be influenced by public action will also have to be made. Detailed evaluation is required of what different provider types can contribute to public objectives in different countries, especially in terms of family planning, reproductive health, and child survival—all important USAID goals.
- (4) *Evaluation of USAID programmatic interventions.* USAID has implemented various measures to encourage or otherwise intervene in the development of private health care provision in some African countries through a variety of projects. The success of these interventions should be measured from the perspective of private sector development and their contribution to broader health sector objectives. Other programmatic interventions in certain countries may also be appropriate, and their potential effects should be studied.
- (5) *Enhancement of national planning and regulatory capacities.* The lack of capacity to stimulate and regulate private providers effectively is regarded as a major potential constraint to development of the private sector in a manner consistent with broader public objectives. Research and analysis is required into which incentives and aspects of regulation are critical, what the constraints to capacity building are, and what can be done practically to overcome these constraints. Given that there may be major difficulties in substantially improving regulation in a number of countries, research is required into what may be the optimum strategies in situations of weak regulatory capacities. Attention is needed both to operational and implementation aspects—i.e., what works, and institutional aspects—i.e., what is needed to do the job.
- (6) *Development of a more substantial agenda for future USAID activity.* This will help guide USAID, national governments, and other donors in future policy-making, as well as in identifying areas that will need more specific investigation. The agenda should have a strategic component that can guide overall policy with respect to the whole population and health sector. More specifically it should identify means by which USAID can effectively support the private sector where necessary, and utilize the sector in achieving broader program goals.
- (7) *Documentation and dissemination of policy-relevant experience and research and capacity building in Africa.* Discussion with experts in the field revealed that a large amount of research has been already carried out in areas relevant to the policy agenda. In addition, there is much experience with particular types of intervention, even in Africa. However, much of the documenting material is neither publicly accessible, nor widely known. There is a need to collect this material and then make it available to policymakers and researchers in Africa. If a process exists to do this, then the results of any HHRAA research are much more likely to be utilized.

There is a need for consultation and discussion with missions and particularly with Africans themselves, especially when identifying the issues of importance to objective (4). Most of the effort should be focused on items (1), (2), and (4). Items (1) and (2) are both necessary in order to deal with the other two. Item (3) will probably require a much longer time frame, and parts of it are being carried out as segments of other USAID-sponsored work, such as those done by HFS. Some initial work on item (3) should be carried out in the initial phase, but more substantial efforts will be required later.

If research is to be both relevant to policymakers and non-replicative of that being done elsewhere, there is a need to ensure maximum discussion of the research strategy with Africans, other donors, and research groups. In addition, to ensure use of the eventual research outcome, it is necessary that the results be disseminated widely among potential users. Given the difficulty that most African policymakers face in learning about these issues, it is recommended that concerted efforts be made to make results available within Africa as well as amongst donors. This should be done in addition to efforts to collect and disseminate previous research.

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APPENDIX

Consultation on the Private Health Sector in Africa

CONSULTATION ON THE PRIVATE HEALTH SECTOR IN AFRICA

Summary of Proceedings

Washington D.C., September 22-23, 1993

**Data for Decision Making
Intercultural Communication, Inc.**

EXECUTIVE SUMMARY

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

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

The following key policy themes emerged:

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

DESCRIBING THE PRIVATE SECTOR

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

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

KEY ISSUES RELATED TO PRIVATE HEALTH CARE PROVIDERS

Having identified the most important private health care providers in terms of public health impact and utilization, the participants agreed that more study is needed to assess the quality and efficiency of privately-provided services, particularly those in the mission sector. The magnitude of public subsidies (both explicit and implicit) to the private sector also needs to be considered. Policy interventions regarding the private sector that should be assessed include the legalization of private practice, the impact of contracting out of clinical and non-clinical services, regulation of private providers and other policy experiments promoting a

more important role for private provision. A more supportive approach to the private sector would also consider the information needs of private providers, ways to convey this information, as well as other aspects of the sustainability of private services. Finally, the group noted political sensitivity of many issues concerning the private sector and participants recognized the need to identify which issues are politically feasible and open to negotiation.

KEY ISSUES RELATED TO CONSUMER DEMAND FOR PRIVATE CARE

While relatively more emphasis has been given to demand issues in studying the health sector in Africa, a number of key questions remain unanswered. Although there have been a number of household surveys that examine provider choice and household expenditures on health care, for most countries the magnitude of private health expenditures is unknown. The determinants of provider choice are also relatively ill-understood. More study is needed into the demographic, socioeconomic, and perceived quality dimensions of provider choice. Existing data that examines health-seeking behavior in a number of condition-specific circumstances (such as family planning services or diarrheal disease studies) provides a valuable starting point for such research. There is also much to be learned from the considerable experience of social marketing of family planning commodities, including condoms. The provision of consumer information to influence the demand for health care is relatively little-explored. Finally, there is need for longitudinal data with which the dynamic aspects of policy changes can be examined.

CURRENT RESEARCH EFFORTS

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

RESEARCH DESIGN AND DISSEMINATION

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

SUMMARY OF PROCEEDINGS

BACKGROUND:

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

PURPOSE:

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

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

The workshop was organized around four sessions:

- to define the private health sector in Africa;
- to assess private health care provision;
- to identify points of private sector intervention in achieving public health goals;
- and to identify research priorities.

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

1. KEY POLICY ISSUES

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

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

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

2. INFORMATION GAPS AND RESEARCH ISSUES

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

a. *What constitutes the private sector?*

While recognizing that there is an important role for the private sector in health care provision in Africa, participants agreed that our current knowledge about private health providers is limited. Discussions during the first session revolved around the need for a typology of private providers. The construction of such a typology, which will necessarily vary by country, needs to strike a balance between strategic needs - that is, responding to important policy questions and focusing on those providers likely to be of strategic importance from an intervention perspective - and the collection of basic descriptive

information about all parts of the private sector, much of which is not currently available. There is also a need to distinguish between those parts of the private sector which are direct providers of health services, and those which play a role in the production of intermediate services, such as diagnostic and ancillary services. The former should focus on those providers which are of actual or potential importance in the provision of services which form the basis of the public health agenda, whilst the latter are of significance because of their present or potential contribution to the reallocation and increased efficiency of public expenditures. There was concern that descriptions of the private sector, while necessary, not be a purely "academic" exercise.

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

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

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

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

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

The meeting explicitly addressed the following topics:

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

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

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

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

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

COMMUNITY-BASED FACILITIES: Hybrid organizations, such as community-managed facilities, do not fall easily into the public-private distinction: although health workers may be paid by the government, community involvement in the management of facilities makes the traditional distinction on the basis of ownership not very revealing.

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

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

b. Key issues related to private health care providers

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

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

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

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

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

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

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

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

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

REGULATION: Regulation is a key area where the public sector interacts with the private sector. Participants noted that the regulatory function in Africa has been seen as a means of controlling rather than enabling private provision. Although most countries have regulations controlling the quality of services, the extent to which these are effectively enforced is mixed. Rwanda is one of the few countries to have experience with price controls. The official fee schedule for private providers is published in the government gazette, and providers are obliged to post the fee schedule on the door. In addition, there have been efforts to establish maximum mark-up levels for pharmaceuticals. This has been less successful because of difficulties in monitoring, as well as the shortage of pharmacy inspectors. In Nigeria, the licensing of patent medicine sellers has been decentralized from state to local government area level in an effort to make monitoring more effective. Little is known about the cost of regulation and monitoring the activities of private providers, and there are concerns that existing public structures do not have the capacity for effective regulation.

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

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

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

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

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

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

IMPORTANCE OF POLITICAL FACTORS: Finally, participants also reminded each other about the political environment in which discussions about increasing the role of the private sector occur. "Privatization" through transfer of ownership of facilities has been a particularly sensitive issue in many countries. Care is needed in identifying those issues which are open for negotiation and those which are politically unfeasible. For example, it was suggested that much of the potential efficiency gain from privatization can be gained at a much lower political cost from instituting managerial autonomy rather than actually selling public facilities.

c. Key issues related to consumer demand for private care

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

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

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

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

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

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

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

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

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

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

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

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

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

<i>Service availability:</i>	Public services only	Both public and private services	Private services only
<i>Service use:</i>			
Use public services only			
Use both services			
Use private services only			

3. CURRENT RESEARCH EFFORTS

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

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

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

4. RECOMMENDATIONS FOR HHRAA-SPONSORED RESEARCH ON THE PRIVATE SECTOR

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

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

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

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

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

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

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

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

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

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

5. DISSEMINATION

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

PLAN: There is a need to plan for dissemination.

CONFIDENTIALITY: Ease the restrictions on data access and flow.

LENGTH: Reduce the length of documents: policymakers only want one page.

CLARITY: Reduce the technical complexity of data presentations.

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

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

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

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

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

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

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