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OPTIONS

Policy Issues in Expanding Private Sector Family Planning

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POLICY ISSUES IN EXPANDING PRIVATE SECTOR FAMILY PLANNING

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A

PREFACE

OPTIONS for Population Policy II is a five-year project funded by the Office of Population of the U.S. Agency for International Development. The goal of the project is to help A.I.D.-assisted countries formulate and implement policies that address the need to mobilize and effectively allocate resources for expanding family planning services. The project provides technical assistance to:

- ▶ improve the analytic capacity of developing country institutions to design, manage, and monitor family planning programs;
- ▶ assess legal and regulatory policies affecting the delivery of family planning services;
- ▶ promote efficient use of public sector resources in family planning programs; and
- ▶ increase private sector participation in service delivery.

The OPTIONS II Project has developed special policy approaches to promote expanded support for family planning. Technical experts have prepared working papers aimed at codifying project experience and analytic approaches. The papers are intended to provide uniform guidance to OPTIONS current and future staff, furnish A.I.D./W and Mission staff with analytic tools to improve program and strategic planning, and help developing country policy makers and analysts to conceptualize and critically analyze policy aspects of the population sector.

The papers are being published as part of an ongoing Policy Paper Series focusing on various aspects of operational policy in family planning. Titles in the Policy Paper Series include:

- (1) Assessing Legal and Regulatory Reform in Family Planning
- (2) Strategic Planning for the Expansion of Family Planning
- (3) Policy Issues in Expanding Private Sector Family Planning
- (4) Communicating Population & Family Planning Information: Targeting Policy Makers
- (5) Cost Recovery and User Fees in Family Planning

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OVERVIEW

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The extent to which a country's private sector contributes to family planning is often determined by a number of public and private sector policies. The majority of these policies are governmental and affect such factors as the price of contraceptives, legality of methods, eligibility of providers, and availability of financing. Strictly private sector policies are generally less critical but include important factors such as employers' practices regarding family planning benefits, private insurance programs' treatment of health benefits, and contraceptive manufacturers' marketing strategies. The OPTIONS Project is concerned with these and other policies affecting private sector behavior in a number of settings. This paper draws upon the experiences of the OPTIONS Project and its predecessor projects to provide project designers, evaluators, and technical experts with a broad understanding of some of the policy issues affecting private sector family planning.

The paper further suggests specific operational guidelines for the selection, development, monitoring and evaluation of activities. These guidelines will assist project designers to narrow the scope of activities to focus on several key private sector policy issues. The approach is intended to increase the potential for effective policy change, and leave a clear record of how to achieve and measure such change.

DEFINITIONS

THE PRIVATE SECTOR

In Agency for International Development (A.I.D.) population assistance work, the private sector is usually divided into two groups. These are the "non-profit" and "for-profit" subsectors. Non-profits are usually referred to as non-governmental organizations (NGOs) and include private voluntary organizations (PVOs) such as local family planning groups, and international groups such as International Planned Parenthood Federation and Family Planning International Assistance. In some countries, this subsector includes church-sponsored health groups. NGOs are generally financed by charitable contributions, government contributions, donor grants, and some user fees. The "charitable and user fee" categories are usually minor portions of most of these groups' incomes, making them heavily subsidized by public funds. Because they are principally funded as intermediaries by governments and donors, they are not generally responsive to market incentives or directly to public sector constraints. NGOs play an important role in a handful of countries.

In contrast, the for-profit private sector is entirely dependent on the marketplace for its income, except in those cases where governments or donors have chosen to subsidize certain for-profit activities. On the supply side, the for-profit group consists of medical providers (hospitals, clinics, medical doctors, midwives, traditional healers), product retailers (pharmacies, drugstores, dispensaries, grocery markets, and small miscellaneous retailers), and product manufacturers and distributors. On the demand side, the group consists of individual consumers who finance their own consumption, and those who provide financing for risk pools of family planning users. The latter include employers, indemnity-type insurance plans, and pre-paid plans (best known as HMOs). In many countries, the for-profit private sec-

tor is the main source for many contraceptive users.

MIXED PUBLIC/PRIVATE SUBSECTOR

Millions of couples in the developing world receive health services from social security organizations. The majority of these are in Latin America, where more than 50 percent of all people are covered (on paper) by social security health services. Social security organizations are governmental entities which theoretically are financed by the private contributions of employers and employees. To the extent that for-profit employers and employees make social security contributions, their health and family planning services are financed by the private sector. However, these contributions are often compulsory, making the organizations' financial base more like a tax than like voluntary payments for services. In addition, many social security organizations are subsidized by governments because contributions are not sufficient to cover the costs of services provided, and in part because many employers (especially governments) regularly fail to make their contributions. However, because the majority of financing is contributed directly by private entities, and because in some cases services are provided by the private sector, such public/private financing and provider schemes should be included in any analysis of private sector family planning and health policies.

Other less significant areas where there is public/private collaboration include government-mandated private health and family planning programs and the public financing of services through private providers. In the Philippines, for example, the government requires that all large employers provide family planning services to employees at company expense. In Brazil, the government subsidizes family planning services provided by the private sector.

RATIONALE FOR EXPANDING THE ROLE OF THE PRIVATE SECTOR

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The public sector presently provides the great majority of family planning services in developing countries.

However, in many countries, the private sector (mainly the commercial private sector) is a key source for many contraceptive users. The for-profit private sector accounts for 10 to 50 percent of all family planning use in most of the countries that have conducted a Demographic Health Survey (DHS). Promoting policies (both public and private) that expand the provision of services through private sector channels will assure increased financing of and better access to quality family planning services.

There are three main reasons why it is worth governments' and donors' efforts to increase the role of the private sector in family planning. The first is that it seems unlikely that governments alone can meet the growing financial demands for family planning. The private sector, where many people prefer to obtain family planning services, is an obvious place to stimulate additional investments to obtain the necessary coverage. The second reason is that many poor people already obtain their family planning services from the private sector. They do this because they prefer it (e.g., more convenient, less waiting time, same cost as public sector), or they do not have adequate access to public services. It makes sense to devote some effort to improving access to quality services for those persons most in need.

Finally, survey data show that many higher income couples obtain their family planning services from the public sector. From an economic standpoint, social welfare is not improved if the public sector attracts users who could otherwise pay for services in the private sector. Government programs should be geared to attracting new users

who could not otherwise afford to adopt family planning. However, the private sector must have the capacity and incentives to absorb the financially better-off public sector users, allowing public sector programs to target those who otherwise could not afford to pay for services.

In short, well-conceived government policies that affect the private sector directly and indirectly are needed to help stimulate the expansion of privately provided family planning. Almost as important, private entities that finance or might finance family planning need to be motivated to include family planning services as a health or employee benefit.

CONSTRAINTS TO THE EXPANSION OF THE PRIVATE SECTOR

This section identifies and discusses the major policy constraints to the expansion of private sector financing of family planning.

- ▶ **Lack of Information.** Lack of information for policy work translates into a broad-based constraint to the increased allocation of private financial resources for family planning. This is a generic issue that is often central to all policy work in the private sector. It is difficult to design, monitor or evaluate an effective policy project or subproject without accurate and timely information. A first step in any private sector policy activity is to collect basic information about the characteristics of the private market, including descriptions of the major users and providers, the method mix, prices, and the policy environment. This information contributes to an understanding of the consequences of current and proposed policies to be addressed by a subproject. Therefore, information collection on different levels is essential and should be incorporated into any activity design. Without such information, designed activities can only be based on conventional wisdom and belief.
- ▶ **Macro- and Micro-Economic Environments May Not be Conducive to Private Sector Expansion.** Economic conditions have a large impact on the performance of the private sector. Economic prosperity can greatly increase private investments in health services and products that include family planning. Poor economic performance can cause the private sector to contract, reduce per capita income, and discourage any thoughts by entrepreneurs to experiment with new services,

products, or financing arrangements. In addition, the high inflation and unfavorable balances of trade that inevitably accompany economic decline make it difficult for businesses to import low profit commodities such as contraceptives. An unfavorable economic environment, therefore, can severely degrade even the most well-conceived projects. For example, a TIPPS Project (Technical Information on Population in the Private Sector) cost-benefit analysis convinced a mining company in Peru to invest in family planning for its employees. However, as a result of the declining economic environment in Peru at the time, the company was not able to implement its decision to invest in family planning. At the household level, countries with largely rural, poorly educated, low income populations tend to produce less demand for privately provided services.

- ▶ **Governments and Donors are Unaware of How to Utilize the Private Sector to Provide More Family Planning Services.** Governments and donors have traditionally channeled most of their population assistance through the public sector. Because family planning is generally viewed as a public good, it seems reasonable that the public sector should fund this socially valuable service. Partly because of the success of family planning programs, prevalence levels are rising along with the costs of providing the services. As a result, there is an increasing pinch on governments' and donors' family planning budgets. These government and donor budget constraints emerged at a time when survey data began to show that the private sector provides a large proportion of services in many countries,

and that significant proportions of middle and high income users obtain services from the public sector. Despite these trends, governments appear to have little ability or knowledge of how to incorporate private providers into their strategies and programs. Government appreciation for the role of the private sector is an essential ingredient for achieving public policy reforms aimed at stimulating private investments in family planning.

Besides the absence of a private sector role in most government planning, there is also a general lack of appreciation for how the private sector can directly provide services for the public sector. In a few countries, such as Brazil, the government obtains a level of efficiency by having the private sector provide the services. As demand increases, governments may need to become aware of the potential efficiency gains from the private delivery of public services

- **Government and Donor Family Planning Programs Crowd Out the Private Sector.** One of the major constraints to A.I.D.'s private sector work has been that private sector projects have had difficulty achieving their objectives because of the presence of subsidized public programs. In Zimbabwe, about half of the high and middle income insured population targeted by a TIPPS subproject were using heavily subsidized public services in the late 1980s. In the same country, pharmaceutical distributors have virtually given up importing contraceptives because of the widespread availability of low cost public commodities. A similar withdrawal of pharmaceutical distributors occurred in Nigeria.

When government services are cheaper or more available than private services, it makes no sense for the rational consumer, no matter the income level, to use the private sector. Until consumers are stimulated to use the private sector, prospects for its expansion will be limited. Because government programs have such influence over private markets, it will be difficult to improve the private sector family planning picture until governments become active collaborators in the effort to switch certain groups from public to private sources.

- **The Regulatory and Tax Environment Inhibits Private Sector Growth.** Long-established conventional wisdom points to the regulatory and tariff environment as a major constraint to the expansion of private sector family planning services. Past social marketing and private sector work has shown that regulatory bottlenecks can adversely affect private initiative. However, not much has been documented about the principal regulatory issues in countries and regions and how much they affect private behavior. This points to a need to distinguish between the current impacts of regulation and the potential consequences, if any, of policy changes. In addition to regulation that inhibits private sector growth, another concern is inadequate regulation of the quality of private care. This particular issue is expanded upon in the *OPTIONS' Manual on Legal and Regulatory Reform* (Kenney, 1993).
- **Private Employers, Providers, Associations and Third-Party Payers are not Aware of the Benefits of Financing Family Planning.** Family planning traditionally has not been viewed by employers, providers and insurers as a preven-

tive health measure in less developed countries. Therefore, it is not surprising that many firms and organizations that could finance family planning are not aware of the positive health and financial benefits that family planning confers on their risk groups. Raising awareness of the benefits of family planning has been a major objective of past International Labor Organization and A.I.D. projects, however, much work remains to be done to attract the interest of potential private financiers.

- ▶ **Employers, Providers, Associations, and Third-Party Payers Do Not Have the Organizational or Technical Capability to Design and Manage a Financing Program.** Once private groups are convinced that it makes sense to finance family planning services, they must analyze the demand, consider costs and prices, develop delivery packages or contract with providers, and set up evaluation systems. Many firms/organizations do not have the capability to conduct these kinds of assessments and analyses, and need assistance in developing the appropriate expertise. Without such expertise, these groups will have a difficult time in correctly fixing demand, pricing services, and making the necessary adjustments over time. The difficulty of correctly pricing services has contributed to the failure of many developing country prepayment plans. Once a decision is made to finance services, provider capacity to implement this decision becomes an important issue.
- ▶ **Public Insurance Programs (financed through private sector contributions) Could be Providing More Family Planning.** Public insurance programs are mainly comprised of social security

administrations (although national insurance plans similar to those in Canada and Great Britain are increasingly being discussed in developing countries). Public insurance programs that finance health care are mostly concentrated in Latin America although there are several large programs in Asia. The coverage of almost all Latin American social security institutes has increased over the past decade (with the exception of Guatemala). This expansion has placed great strain on their financial operations. Despite this expansion, they still provide services principally to middle and upper income city dwellers.

It makes sense, therefore, for several reasons (cost containment being the principal one) that public insurance programs finance the majority of family planning services for their beneficiaries, particularly if the beneficiaries would not otherwise pay for the services. In fact, many of these programs do not feature family planning as a major benefit. Mexico is an outstanding exception with its aggressive social security family planning program. If all other social security administrations in the region emulated Mexico's program, much of the future expansion in family planning services in Latin America would be financed from private sources.

A less formal method of public insurance is for the government to mandate that individuals or groups obtain insurance coverage. This is done in some African countries, where employers are mandated to take payroll deductions from employees for health care.

PRIORITY OBJECTIVES FOR PRIVATE SECTOR POLICY WORK

This section provides a brief assessment of the policy constraints outlined in the previous section, focusing on the issues most feasible to address through policy assistance. The lack of information constraint underlies all private sector issues. The macro- and micro-economic environments are not feasible to address other than as a general constraint or incentive. It should be noted that there are some necessary overlaps among the priority objectives which follow.

OBJECTIVE 1: REDUCE GOVERNMENT COMPETITION WITH THE PRIVATE SECTOR

Governments can compete with the private sector in a number of ways. First, in the consumers' eyes, governments often provide contraceptives and services at lower cost than private providers since they generally do not charge for either. Second, governments may have successful programs that offer contraceptive methods (mainly clinical) that are not readily available in the private sector. Third, family planning demand may be concentrated in older women who favor methods largely offered by the government. Fourth, precipitous declines in income in some countries may force people to rely on the public sector. And, fifth, government programs may have internal incentives that could result in family planning workers attracting already motivated users from the private sector.

Research has suggested that this "crowding out" of the private sector may be the single most serious issue affecting the growth of the sector. It will be important for governments to limit the potential negative impacts of their programs on the private sector. One way to accomplish this is to eliminate subsidies to higher income groups who

use the public sector, thus providing them with an incentive to use the private sector. (Cost recovery in this manner can also increase government revenues.) Another way is to lower the cost of private services to consumers through regulatory or policy incentives.

OBJECTIVE 2: INCREASE GOVERNMENTS' AWARENESS OF HOW TO UTILIZE THE PRIVATE SECTOR

Only a few governments have a full grasp of the scope of the private sector, and actively incorporate the private sector into their overall strategy. Governments that are aware of the potential contribution of the private sector will help promote policies and regulations that encourage, or at least do not inhibit private family planning markets. Similarly, they are not likely to undertake programs that directly compete with private providers. Helping governments to understand the benefits of the private sector as a partner should be a feature of most policy assistance strategies

OBJECTIVE 3: ELIMINATE REGULATORY AND LEGAL BARRIERS TO PRIVATE GROWTH

Research suggests that a restrictive regulatory environment can inhibit the growth of private sector family planning. Regulations dealing with the price and availability of contraceptives are especially important to potential expansion of the private sector. As long as there are duties, complicated licensing procedures, or value-added taxes, the private sector will be limited in its desire to provide more family planning. Similarly, if private practitioners, pharmacies, clinics, or third-party payers are restricted from providing certain kinds of contraceptive services (sterilizations, for example), the private sec-



tor will not grow. Policy assistance strategies, therefore, should also consider helping governments and private groups to evaluate and reform regulatory and tax policies that act as disincentives to private services.

have major impacts on a large number of beneficiaries. This means working with large insurance companies, HMOs, or cooperatives that can set standards in their industries and affect a substantial share of the private family planning market.

OBJECTIVE 4: ENCOURAGE PUBLIC INSURANCE PROGRAMS TO FINANCE AND/OR PROVIDE MORE FAMILY PLANNING

Public insurance schemes deserve attention because of the large number of current and potential users, and because in some cases, greater use of social security for family planning could result in the switching of clients from ministries of health to sources financed by users themselves. Another reason to work with social security organizations is to promote them as financers of privately provided family planning services.

Another approach would be to encourage government-mandated private provision of family planning services through employers. This could be accomplished through the development of a generic cost-benefit model which would identify the conditions under which employers could reasonably provide services. The results from the analysis could foster policy dialogue on government-mandated family planning services.

OBJECTIVE 5: INCREASE PRIVATE SECTOR AWARENESS OF THE BENEFITS OF FAMILY PLANNING; IMPROVE ORGANIZATIONAL OR TECHNICAL CAPABILITIES OF PRIVATE GROUPS TO DESIGN FINANCING PROGRAMS

There are literally thousands of opportunities to promote the financing of family planning services through insurance providers in developing countries. Working directly with these private sector entities can

APPROACHES TO PRIVATE SECTOR POLICY ISSUES

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The first decision is whether to work in the private sector at all. This decision depends on several factors, including the potential role of the private sector in a given country, and the interest of the government in expanding private sector coverage. Because resources are usually limited, the potential demographic impact of activities may also be an important selection criterion. Once it is concluded that there will be a private sector policy component in a country program, the following types of analyses will guide the selection of a particular approach:

- Identification of policy barriers to private sector expansion, either in the public or private sector.
- An analysis of the feasibility of removing policy barriers or improving existing policies.
- An analysis demonstrating the potential impact of the desired policy improvement on the private sector (including the impact of proposed private activities on public sector family planning). Some quantitative indication of impact must be argued during the design process of a private sector activity.
- An assessment of why this particular approach is more effective than alternative approaches.

Other factors to consider include:

- Existence of measurable performance indicators, or a specified policy framework to judge progress and evaluate the achievement of activity objectives.
- Opportunities to link with other similar project activities (e.g., A.I.D. health financing projects, World Bank or Inter-

American Development Bank loan activities) that would result in large benefits for minimal investment.

- Evidence that the activity is consistent with the local government strategy.
- The availability of staff, consultants, or local collaborators to carry out the work. For local collaborators, some evaluation of their capacity to perform their tasks is necessary.
- An estimate of reasonable costs and an achievable timeframe.

SPECIFIC APPROACHES BY OBJECTIVE

The following tables present approaches to private sector policy issues for each of the priority objectives identified previously. For each objective, one or more approaches are identified, policy activities are suggested, and examples are provided. This is followed by guidelines for project selection and development. Policy analysts, consultants, or host country researchers can use these simple formats as a guide when developing private sector elements of country strategies.

The guidelines are meant as criteria for activity selection and development. Information related to the guidelines should be collected when formulating the activity. The information will easily feed into any country strategy that includes a private sector policy component. Successfully followed guidelines should enhance the chances that the activity will achieve its objectives. The guidelines will also provide early indications that the activity may not be viable and should not be pursued. Finally, these guidelines will provide project and A.I.D. managers with a checklist with which to evaluate proposed activities and to assess key issues.

Examples of some of these issues for Objective 5 might be: Can HMOs finance low cost contraceptive services while keeping capitation fees constant? Are cooperatives which finance their own health care viable providers of family planning? What is the feasibility of incorporating family planning into community health financing schemes? Will indemnity insurance plans in developing countries cover family planning services, and under what circumstances? One possibility for addressing some of these issues would be to identify and evaluate existing activities rather than taking a demonstration approach. That is, rather than promoting the introduction of reimbursement for family planning into a large insurance company, find a firm that already is reimbursing and conduct the appropriate policy analysis and evaluation. This latter approach would be more cost-effective, and would result in the same kinds of information that would be used to convince industrial and professional associations, governments, and donors of the utility and means of generating private investments in family planning.

OBJECTIVE 1: REDUCE GOVERNMENT COMPETITION WITH THE PRIVATE SECTOR		
Objective	Policy Support Activity	Examples
Identify areas of competition.	Review of government programs; analysis of who receives what services from whom; demand/supply analysis.	1986 USAID/Lima Population Strategy; analysis of social marketing in Indonesia (Smith, 1992).
Identify key government activities inhibiting private sector.	Analysis of specific impacts of government activities (e.g., types of public sector users, price differentials, structure of government incentives).	Akin and Schwartz study of Thailand (1985); Indonesia assessment (OPTIONS, 1988); Kenney and Lewis analysis of contraceptive source (1989).
Identify program changes that would promote private sector; eliminate subsidies to higher income groups.	Policy analyses of changes in program emphasis, proposals to better target public subsidies (government and donor); proposals to affect demand through user charges; revisions of overall government population strategy	Assessment of private sector expansion in Indonesia (OPTIONS, 1988); studies of user fees and contraceptive use in Thailand; policy work through A.I.,D. or World Bank non-project assistance.
Develop consensus for policy and program reforms.	Presentation of results to senior government managers; workshops for program managers; various dissemination activities.	Various OPTIONS dissemination activities over past years.
<p>Guidelines:</p> <ol style="list-style-type: none"> 1. The government and local donors should be interested in improving the efficiency of their programs by better targeting their resources to those most in need. 2. The government needs to guarantee the policy analyst undertaking the work access to information about the government program. This includes any information based on service statistics, contraceptives disbursed and consumed, personnel allocations, facility locations, etc. 3. Donors need to be willing to reveal details on their activities, including characteristics of users, and financial inputs. 4. There should be a database (i.e., DHS or other population-based survey) that allows for estimates of demand and use of contraceptives. 5. Depending on the analysis chosen, there must be adequate information available or relatively easily obtainable to undertake the analysis. If the analysis is a price study, then price series must be available or a feasible plan proposed to obtain them. 6. The political feasibility of effecting policy or program improvements should be demonstrated. 7. There should be some identifiable capacity in the private sector to meet family planning demand. 8. Make sure that activities are coordinated with other donors that may be working on similar objectives through different means (e.g., World Bank loan development). 		

OBJECTIVE 2: INCREASE GOVERNMENTS' AWARENESS OF HOW TO UTILIZE THE PRIVATE SECTOR		
Objective	Policy Support Activity	Examples
Promote government awareness and desire to define and use the private sector.	Analyze role of private sector (size, number and characteristics of clients served); assess potential for expansion; make projections of use under alternative policy and program options.	RAPID/TIPPS-type presentations which develop arguments for policy change. Work with Population Unit or MCH/FP dept. to produce report and disseminate results. OPTIONS Contraceptive Market Model.
Promote awareness about the barriers to private sector growth.	Analyze all potential barriers to private expansion; make assessment of which have greatest negative impact; examine effects of removing barriers.	Private sector assessment in Indonesia (OPTIONS, 1988).
Assist governments to develop a private sector strategy as part of overall population strategy.	Work with governments to conceptualize, draft and adopt a private sector strategy.	Implicit project design for bilateral agreement "Innovations in Family Planning Services" in India, especially its use of NGOs and for-profit providers.
Disseminate strategy to private sector providers and producers to encourage their participation.	Sponsor meetings with donors, private providers and producers to seek support for strategy; produce and distribute copies of strategy.	
Seek opportunities to privatize select government services; develop reimbursement or voucher systems for private use.	Assist governments to identify certain services more efficiently provided by private sector; conduct analyses showing benefits; help define terms of privatization or reimbursement scheme.	IUDs and sterilizations in Taiwan; Sterling in Nigeria distributed donated commodities through commercial outlets; Brazil's Social Security reimburses for family planning services.
Guidelines:		
<ol style="list-style-type: none"> 1. Government should have interest in expanding coverage of family planning services and in spending their resources more effectively. 2. There should be available data for assessing the current and future participation of the private sector. 3. Alternative policy/program proposals must be politically and administratively feasible. 4. Government should have an overall strategy for implementing its population program. 5. Donors and private producers, distributors, and providers must be willing to cooperate with government program. 6. Concept of privatization or vouchers must be politically acceptable and administratively feasible. 		

OBJECTIVE 3: ELIMINATE REGULATORY AND LEGAL BARRIERS TO PRIVATE GROWTH		
Objective	Policy Support Activity	Examples
Improve incentives to private providers.	Policy analyses of tax, regulatory and foreign exchange incentives on local providers; project effects of alternative incentives.	Orals placed on essential drug list in Sudan; tax exemptions to large employers in Korea; potential non-project assistance benchmark analyses.
Reduce disincentives to private providers.	Policy analyses of pricing, tax, regulatory, exchange, advertising, certification, practice disincentives; estimate effects of eliminating disincentives.	OPTIONS policy analyses in Morocco examining effect of removing tax disincentives; potential policy work through A.I.D. (non-project assistance) or World Bank loans; efforts to permit wider role for NGOs.
Strengthen lobbying capabilities of private associations and providers.	Build capacity in local entity (industrial assoc., insurance assoc., medical assoc., etc.) to carry out and present policy analyses to achieve tariff, tax and regulatory concessions for health care.	Virtually all U.S. industrial and professional associations.
<p>Guidelines:</p> <ol style="list-style-type: none"> 1. To effect legal and regulatory changes, which often requires cooperation across sectors, a strong government population policy or commitment is generally required. 2. The government needs to have an overall population/family planning strategy that has expanded private use as one of its objectives. 3. In the absence of active government support, there should be some other incentive mechanism (i.e., non-project assistance benchmarks, pending Bank loan) to induce policy improvements. 4. There needs to be enough information or data available to carry out policy analyses (e.g., for a tax analysis one needs volume of imports or sales, effects of tax on final price, estimates of elasticity of demand for commodity, demand for commodity, etc.). 5. For potential sponsorship of local policy dialogue activities (i.e., lobbying), there should be a local institution which has the ability and experience to represent its position to the government. 		

OBJECTIVE 4 ENCOURAGE PUBLIC INSURANCE PROGRAMS TO FINANCE AND/OR PROVIDE MORE FAMILY PLANNING

Objective	Policy Support Activity	Examples
Promote greater provision of family planning services by social security organizations.	Financial and budget analyses; health benefits analysis; planning and programming for country soc. sec. organization.	OPTIONS work in Bolivia and Philippines; TIPPS work in Peru.
Generate support for social security-provided family planning.	Dissemination of results from country cases to managers of other country soc. sec. organizations. Presentation of results to other entities (e.g., Min. of Fin.) within country.	OPTIONS social security conference in Central America; presentations of OPTIONS analyses to Philippine Medical Commission (Griffin et al., 1992).
Mandate employer-provided or financed family planning.	Develop generic model (cost-benefit, health benefit) for presentation to government policy makers.	Employers with over 200 employees in Philippines are mandated to provide family planning services to workers; similar regulation in India.
Provide public facilities for private practice.	Policy dialogue; feasibility analyses; technical assistance in financial planning.	Khartoum: Health Commission opens public clinics for private practice in afternoons.
Provide access to loan or grant capital.	Identify and assess feasibility of publicly sponsored loan or grant fund.	Considering special development fund for health activities in Belize.

Guidelines:

1. There needs to be available data on the characteristics of social security beneficiaries (demand for family planning, current prevalence, method mix, current source, etc.). Social security health schemes whose beneficiaries have high modern method prevalence and who rely on the private sector should not be candidates for this project component. If this data is not available, then data suitable for estimating characteristics (e.g., DHS) should be.
2. Preferably, the social security organization covers some portion of lower income workers and their dependents.
3. The issue of equity needs to be addressed before taking on a social security activity. In what way will this activity achieve direct or indirect benefits of poorer members of society? Project designers must take care that the activity is not just providing better benefits to higher income groups, but that there is some equity pay-off (e.g., efficiencies gained will allow government to better target scarce resources). These justifications need to be agreed upon by participating organizations.
4. Social security organizations must be interested in cost-containment and in improving efficiency, and they need to demonstrate a commitment to increase resource allocations based on project findings.
5. For the private use of public facilities, governments need to recognize that health facilities are underutilized; political and administrative feasibility must be demonstrated.
6. For a loan or grant fund, the government must recognize the utility of promoting private growth, and must have available funds (either internally or from donors).
7. The last two activities might be best undertaken in conjunction with health financing work either by other A.I.D. projects or the World Bank.

OBJECTIVE 5: INCREASE PRIVATE SECTOR AWARENESS OF THE BENEFITS OF FAMILY PLANNING; IMPROVE ORGANIZATIONAL OR TECHNICAL CAPABILITIES OF PRIVATE GROUPS TO DESIGN FINANCING PROGRAMS		
Objective	Policy Support Activity	Examples
Promote private insurance, HMO, and other third-party payer coverage of family planning.	Develop decision-making information; demand and financial analyses.	TIPPS work with Medical Aid Societies in Zimbabwe; women's credit unions in the Dominican Republic; credit unions in Ecuador; Chamber of Commerce in Belize.
Develop financial and pricing structures for groups that finance or could finance private family planning.	Prepare financial and market analyses; develop pricing and service packages; policy dialogue with providers to set prices, schemes, etc.	TIPPS work in Zimbabwe; possible work with HMOs in Dominican Republic and with cooperatives in Ecuador; community financing schemes in various countries.
Promote business contributions to family planning activities.	Presentations to senior management and boards of directors of large national and international firms.	TIPPS presentations to Chevron Corporation.
Guidelines: <ol style="list-style-type: none"> 1. There must be a fairly low-cost, quality source of private family planning providers for reimbursement schemes to be successful. 2. The risk pool should have a substantial proportion of females and children if a financial benefit is likely to be shown. 3. There should be adequate secondary information (DHS), existing primary information, or an efficient way to collect new data (e.g., through an already planned survey). 4. It must be determined either by direct or indirect estimates, preferably in advance, where current users in the risk pool are obtaining family planning services. 5. Broad government policies and/or specific regulations should permit to encourage private entities to finance preventive health care. 6. The collaborating insurance company, cooperative, HMO must be willing to "open up its books" for any analysis or follow-up monitoring. 7. The collaborating firms ideally should be profit-making. 8. The macroeconomic environment should be positive for the collaborating business sector. 		

MONITORING AND EVALUATION

One of the major shortcomings of previous private sector policy work has been the lack of evaluation of project progress or outcomes. For example, both the A.I.D.-funded Enterprise and TIPPS Projects stimulated companies to provide more family planning services. Yet, because there were few evaluation components in their combined 70-plus subprojects, very little is known about whether or not these efforts achieved their intended results (e.g., attracting new users, attracting public sector users, or providing more effective services). Similarly, despite the nearly universal references to regulatory and tax constraints in analyses of private sector family planning, it is difficult to find any study of the actual effects on supply or demand resulting from policy changes in this area. Therefore, even the most modest evaluation plans will make a substantial contribution to understanding which policies are important to private sector behavior/performance.

Policy development activities aimed at the private sector could benefit from the following evaluation steps:

1. Specify the objective. In the case of the OPTIONS Project, the objectives of policy support to the private sector are:
 - (a) increase private sector resources allocated to family planning programs, and
 - (b) improve the environment for private sector family planning through public policy reforms.
2. Develop a theoretical framework which establishes relationships between inputs and outcomes. For example, economic theory indicates that, holding other things equal, a lowering of the price of contraceptives will increase demand for them. Thus, theory tells us that a policy exempting contraceptives from import duties is likely to increase contraceptive use.
3. Develop indicators to measure change. In order to determine whether an intervention has the desired effect, performance and outcome indicators need to be defined at the outset. In the import duty example, the performance indicator would be whether the tax regulation had been changed. Outcome indicators would be changes in the number and share of private sector users, the numbers switching from public sources, and the numbers of new users.
4. Collect information on indicators before and after the intervention. Once the indicators are defined, they need to be measured before and after the intervention to gauge the extent of change associated with it. [Note: this can pose problems since many broad indicators, such as the proportion of persons using the private sector, are only collected several times per decade. In these cases, the project designer needs to find proxy indicators such as trend data on the quantity of contraceptives sold on private markets.]
5. Analyze indicators and rule out alternative explanations for differences. If the indicators show a change in the direction sought, it is important to take into account other events that may have contributed to the change as part of the evaluation analysis. In the import duty example, the evaluator would want to check the distributor prices of contraceptives over the analysis timeframe to make sure that the decline in observed prices was the result of the policy change and not a lowering of wholesale markups on commercial prices. There could be other factors at play that should be analyzed. For example, if the public sector greatly stepped up its recruiting, or if a recession lowered real incomes during the timeframe, the effects of a tax reduction could be mitigated. This approach allows

the evaluator to judge the net contribution of the policy intervention to the desired policy improvement. This can be a challenging task; however, a solid conceptual framework can help take into account and rule out alternative explanations for success.

The indicators that can be used for evaluating private sector policy work are generally straightforward because the objectives are well specified. Developing the causal linkages between policy activities and national-level data is more difficult to establish. Some broad indicators suitable for evaluation are:

- Numbers and proportion of contraceptive users obtaining methods from the private sector at the national level. (Sources: Demographic and Health Surveys, other country surveys, service statistics, pharmaceutical sales data.)
- Numbers of contraceptive users obtaining methods from sub-national organizations such as social security, insurance industry, employed sector, etc. (Sources: social security service records, employers' surveys, insurance association surveys, service statistics from groups like the Association for Voluntary Surgical Contraception, etc.)
- Amounts of financial resources allocated to family planning at the national level. (Sources: expenditures derived from DHS data and estimates of the costs of methods; estimated expenditures derived from method and source switching from DHS or other survey data, multi-round household surveys, e.g., Living Standards Measurement Surveys, or various multi-round household surveys sponsored by the U.N.)
- Amounts of financial resources allocated to family planning at the organizational level. (Sources: social security budgets, expenditures, service statistics and expenditures by method; employer surveys; insurance association questionnaires; private hospital and medical association questionnaires; etc.)

Many policy activities in the private sector are intermediate steps aimed at achieving the overall objectives of increasing private resources and achieving policy reforms to raise private participation in family planning provision. Indicators for the objectives outlined in this paper listed below:

OBJECTIVE 1: REDUCE GOVERNMENT COMPETITION WITH THE PRIVATE SECTOR

INDICATORS: the adoption of cost recovery practices in the public sector that target higher income users; evidence of switching from public to private sources as a result of charging for public services; increases in the number of private outlets for family planning services that have been mainly provided by the government (i.e., sterilizations); better targeting of public sector users focusing on those who would not otherwise use family planning.

OBJECTIVE 2: INCREASE GOVERNMENTS' AWARENESS OF HOW TO UTILIZE THE PRIVATE SECTOR

INDICATORS: discussion or assignment of a role for the private sector in country population strategies; private sector participation in policy and regulatory development activities; government actions to analyze or reform policies affecting the private sector.

OBJECTIVE 3: ELIMINATE REGULATORY AND LEGAL BARRIERS TO PRIVATE GROWTH.

INDICATORS: comparative analyses of legal and regulatory codes before and after intervention; evidence that barriers have been removed (e.g., importers are relieved of obligation to pay import tax on contraceptives).

will be dependent on the private sector activity selected for the project intervention. At any rate, a clear set of indicators along with a discussion of the rationale for such indicators should be included in every country strategy.

OBJECTIVE 4: ENCOURAGE PUBLIC INSURANCE PROGRAMS TO FINANCE AND/OR PROVIDE MORE FAMILY PLANNING

INDICATORS: social security or national health insurance plan managers are engaged in discussions about family planning; the same management adopts implementation plans to increase family planning services; budgets are prepared that include a family planning line item; staff members are trained; contraceptives are ordered; increased expenditures are made for family planning services; service statistics show increases in users; etc.

OBJECTIVE 5: INCREASE PRIVATE SECTOR AWARENESS OF THE BENEFITS OF FAMILY PLANNING; IMPROVE ORGANIZATIONAL OR TECHNICAL CAPABILITIES OF PRIVATE GROUPS TO DESIGN FINANCING PROGRAMS

INDICATORS: HMOs, private insurance, and third-party payers begin to reimburse for family planning services; private providers attend meetings on family planning; private providers analyze pricing schemes, undertake cost-benefit analyses or design family planning reimbursement schemes; service or claim statistics show the financing of family planning services.

These are just some of the areas in which the project designer can seek indicators for evaluation. The exact configuration

REFERENCES

Akin, J.S. and J.B. Schwartz. 1985. "Price Elasticity of Demand for Contraceptives: Jamaica and Thailand." Unpublished.

Griffin, Charles C., Bienvenido Alano, Maricar Ginson-Bautista, and Rhais M. Gamboa. 1992. "Insurance and Development of the Private Medical Sector in the Philippines History and Prospects for Change." (Draft). Washington, D.C.: The Urban Institute.

Kenney, Genevieve. 1993. "Assessing Legal and Regulatory Reform in Family Planning." Policy Paper Series No. 1. Washington, D.C.: The Futures Group.

Kenney, Genevieve and Maureen Lewis. 1989. "Contraceptive Users' Sources of Supply." Washington, D.C.: The Urban Institute.

OPTIONS Project. 1988. "Policy/Regulatory Constraints to Expanding Contraceptive Distribution Through Private Providers: Indonesia." Washington, D.C.: The Futures Group.

Smith, Janet M. 1992. "Trends in Contraceptive Sales and Social Marketing in Indonesia." Washington, D.C.: The Futures Group.

BIBLIOGRAPHY

- Bailey, Patricia E., Barbara Janowitz, Marcial Solis, Mike Machuca, and Margarita Suazo. 1989. "Consumers of Oral Contraceptives in a Social Marketing Program in Honduras." *Studies in Family Planning* 20(1): 53-61.
- Bruce, Judith. 1990. "Fundamental Elements of the Quality of Care: A Simple Framework." *Studies in Family Planning* 21(2): 61-91.
- Bulatao, Rodolfo. 1984. "Expenditures on Population Programs in Developing Regions." World Bank Staff Working Paper Number 679. Washington, D.C.: The World Bank.
- Chamrathirong, A., A. Bennett, P. Prasartkul, and C. Podhisita. 1989. "Family Planning Program Effort and the Initiation of Contraceptive Use: A Multi-level Analysis." New York: The Rockefeller Foundation.
- Chamrathirong, A. and E.H. Stephen. 1986. *Determinants of Contraceptive Method Choice in Thailand*. Institute for Population and Social Research. Nokornprathom, Thailand: Mahidol University.
- Clyde, Maureen, D. Tennyson Levy, and Joanne Bennett. 1992. "Study of Sustainability for the National Family Planning Board in Jamaica." Washington, D.C.: The Futures Group.
- Cross, Harry E., Virginia Poole, Ruth Levine, and Richard Cornelius. 1991. "Contraceptive Source and the For-Profit Private Sector in Third World Family Planning Programs." Paper presented at the Annual Meeting of the Population Association of America, Washington, D.C.
- Cross, Harry E. 1986. "The Role of the For-Profit Private Sector in Third World Primary Health Care." Paper presented at the Annual American Ethnological Society Meeting.
- Destler, Harriet, Dawn Liberi, Janet Smith, and John Stover. 1990. "Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties." Washington, D.C.: Population Technical Assistance Project.
- Fuangchan, S., C. Siripirom, R. Prasertsri, S. Kaechakupt, T. Montrakul, S. Kiripatr, and S. Chiramanee. 1985. "Research Report on a Comparative Analysis of the Government and Private Family Planning Programs in the Southern Region of Thailand." Bangkok, Thailand.
- Gillespie, Duff, Harry Cross, Scott Radloff, and John Crowley. 1989. "Financing the Delivery of Contraceptives: The Challenge of the Next Twenty Years." Pp. 265-95 in *The Demographic and Programmatic Consequences of Contraceptive Innovation*. Edited by Sheldon J. Segal, Amy O. Tsui, and Susan M. Rogers. New York: Plenum Publishing Corporation.
- Griffin, Charles C. 1989. "Strengthening Health Services in Developing Countries Through the Private Sector." Discussion Paper Number 4. Washington, D.C.: International Finance Corporation.
- Griffin, Charles C. 1992. "Health Care in Asia: A Comparative Study of Cost and Financing." World Bank Regional and Sectoral Studies. Washington, D.C.: The World Bank.
- Hollerbach, Paula. 1989. "The Impact of National Policies on the Acceptance of Sterilization in Colombia and Costa Rica." *Studies in Family Planning* 20(6): 308-324.
- Janowitz, Barbara, John H. Bratt, and Daniel B. Fried. 1990. "Investing in the Future: A Report on the Cost of Family Planning in the Year 2000." Research Triangle Park, N.C.: Family Health International.
- Jensen, Eric R. 1990. "Cost-Effectiveness and Financial Sustainability: The Operations Research Experience." Paper prepared for the International Operations Research Conference. Columbia, Maryland.
- Kenney, Cenevieve. 1989. "The Economics of Private Sector Family Planning Service Provision in Indonesia." Washington, D.C.: The Urban Institute.

- Lande, Robert E. and Richard Blackburn. 1989. "Pharmacists and Family Planning Programs." *Population Reports Series J*, Number 37. Baltimore, MD.: Population Information Program.
- Lapham, Robert and W. Parker Mauldin. 1985. "Contraceptive Prevalence: The Influence of Organized Family Planning Programs." *Studies in Family Planning* 16(3): 117-136.
- Lerman, Charles, John W. Molyneaux, Soetedjo Moeljadihardjo, and Sahala Pandjaitan. 1989. "The Correlation between Family Planning Program Inputs and Contraceptive Use in Indonesia." *Studies in Family Planning* 20(1): 26-37.
- Lewis, Maureen and Genevieve Kenney. 1988. "The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential." Washington, D.C.: The Urban Institute.
- Lewis, Maureen. 1988. "The Private Sector and Health Care Delivery in Developing Countries: Definition, Experience and Potential." Washington, D.C.: The Urban Institute.
- Lewis, Maureen. 1984. "Pricing and Cost Recovery Experience in Family Planning Programs." World Bank Staff Working Paper Number 684. Washington, D.C.: The World Bank.
- Mauldin, W. Parker and Sheldon J. Segal. 1988. "Prevalence of Contraceptive Use: Trends and Issues." *Studies in Family Planning* 19(6): 335-353.
- Musgrove, Philip. 1983. "Family Health Care Spending in Latin America." *Journal of Health Economics* 2: 245-257.
- Musgrove, Philip. 1986. "What Should Consumers in Poor Countries Pay for Publicly-Provided Health Services?" *Social Science Medicine* 22(3): 329-333.
- Population Technical Assistance Project. 1991. "Thailand's Family Planning Program: A Success Story." POPTECH Insights 2(1).
- PROFAMILIA. 1990. *Building an Effective Family Planning Program: The Story of PROFAMILIA*. Washington, D.C.: Population Reference Bureau.
- SOMARC Project. 1985. "SOMARC Country Assessment for Contraceptive Social Marketing in Colombia." Washington, D.C.: The Futures Group.
- SOMARC II Project. 1990. "Ghana Family Planning and Health Policy: Legal, Regulatory, Institutional and Economic Issues and Opportunities." Washington, D.C.: The Futures Group.
- SOMARC II Project. 1990. SOMARC Special Studies: "Pilot Project to Market CSM Products Through CM Distribution Systems in Peru." Washington, D.C.: The Futures Group.
- SOMARC II Project. 1991. "Contraceptive Market Dynamics and Use Effectiveness: Lessons from a Panel Study in Urban Egypt." SOMARC Special Study Number 6. Washington, D.C.: The Futures Group.
- Smith, Janet and Vijay Rao. 1992. "Market-based Services: Strategic Roles in Family Planning Service Expansion." Paper prepared for the Expert Group Meeting on Family Planning, Health, and Family Well-being." Bangalore, India.
- Ross, John A. and Stephen L. Isaacs. 1988. "Costs, Payments, and Incentives in Family Planning Programs: A Review for Developing Countries." *Studies in Family Planning* 19(5): 270-283.
- Vernon, Ricardo, Gabriel Ojeda and Marcia C. Townsend. 1988. "Contraceptive Social Marketing and Community-Based Distribution Systems in Colombia." *Studies in Family Planning* 19(6): 354-360.

Williams, Timothy, Gabriel Ojeda, and Miguel Trias. 1990. "An Evaluation of PROFAMILIA's Female Sterilization Program in Colombia." *Studies in Family Planning* 21 (5): 251-264.

World Bank. 1989. *World Development Report*. Washington, D.C.: The World Bank.

World Bank. 1987. *Financing Health Services in Developing Countries: An Agenda for Reform*. Washington, D.C.: The World Bank.