

## Capacity building to constructively engage the private sector in providing essential health care services

### Report by the Secretariat

1. The renewal of primary health care and more rapid progress towards the achievement of universal coverage of basic services requires examination of the role of all health-care providers. This report focuses on private providers and the capacity for a constructive relationship between private providers and the public sector. It does not discuss private financing or involvement with private entities outside the health sector.
2. The term “private provider” covers, for purposes of this report, a variety of health-care entities, including for-profit and not-for-profit bodies. It includes faith-based organizations, national and international nongovernmental and civil society organizations; private-for-profit providers, including pharmacies, small private clinics and large hospitals; doctors and nurses working privately; and informal practitioners and retailers of medicines. Although in many countries private provision is more common for ambulatory care, in others it dominates both inpatient and outpatient care.
3. Globally, millions of people use private health services every day. In sub-Saharan Africa (excluding South Africa), out of a total health expenditure of US\$ 16 700 million in 2005 about half is estimated to go to private providers. In Malawi, for instance, 58% of all health-care financing was spent on private provision mostly by individuals and private companies. In Africa as a whole the private health-care sector is expected to grow by more than 100% between 2005 and 2016, compared with an increase of about two thirds in the public health sector.<sup>1</sup>
4. Poor people use private providers because these services may be nearer and have more flexible hours, shorter waiting times or greater availability of medicines than public facilities, despite the direct costs they have to pay. Moreover, people report the perception that they are treated with greater respect and confidentiality. Poor people are especially likely to go to unlicensed retailers of medicines or informal practitioners. Surveys in 42 low- and middle-income countries show that, for children with respiratory tract infections, around 50% (in some countries up to 95%) of those who seek care are taken to private health-care providers.<sup>2</sup>

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<sup>1</sup> *The Business of Health in Africa*, International Finance Corporation, Washington, DC, 2007.

<sup>2</sup> The Demographic and Health Survey programme conducts surveys of population, health, HIV infection and nutrition in more than 75 countries. See [www.measuredhs.com](http://www.measuredhs.com).

5. In many countries the boundary between public and private sector is not clear: for instance, public-sector staff offer private out-of-hours services in government facilities, whereas conversely, in Malaysia for example, a state government owns the country's largest health-care corporate group, accounting for 1500 hospital beds and specialist consultants, as part of a for-profit corporation listed on the stock exchange.

6. The structure of the private health sector is changing in many low-income countries, which have seen a significant increase in the number of registered nongovernmental organizations, due in part to the influx of funds for work related to HIV and AIDS. At the same time, funding for faith-based organizations has declined, and some countries report movement of staff away from missions to the public sector where pay and conditions are improving. Some large companies have become more involved in health-care provision; notable examples include mining corporations in Papua New Guinea and South Africa. In Asia especially the number of health-care corporations that own and operate chains of hospitals has grown.

7. Health-care provision can be influenced by either the profit motive or the need to generate income (a problem not exclusive to the private sector). Overprovision of medicines (sometimes counterfeit products) and overuse of diagnostic tests and even surgical procedures are not uncommon. Quality also depends on the nature of the intervention and client demand. A case study of private pharmacies in one Asian country, where more than 80% of retailers treated sexually transmitted infections without being licensed to do so, suggested that they worked as typical for-profit retailers, not as agents to improve their clients' health.

8. Given the wide range of private-sector providers, cost and quality of care vary considerably; practices also may range from the most sophisticated to the frankly dangerous. The main concerns for health-policy makers are malpractice in private provision, threatening health and contributing to impoverishment because of cost, and diversion of public resources for private gain.

## **INVOLVING PRIVATE HEALTH-CARE PROVIDERS IN ESSENTIAL HEALTH SERVICES**

9. Government policies on the role of the private sector in providing essential health services range from active and positive encouragement to excluding it from public-health planning. The text below focuses on building capacity in the State sector in order to work with private providers in achieving public health goals.

10. For governments in rich and poor countries alike, the challenge is to strike a balance between harnessing the potential of different types of private providers, while managing concerns about equity of access, cost and quality of care. Experience suggests that, when relations are well-managed, private providers can play a significant role in providing essential health services.

11. Work on tuberculosis has demonstrated that initiatives involving private providers contribute to detecting between 10% and 50% of cases in different settings. Other important examples can be found in the areas of increasing access to reproductive health services, increasing the uptake of insecticide-treated mosquito nets against malaria, and prevention and treatment of AIDS.

12. Some general lessons emerge from practical experience. It is crucial to build trust between public-sector officials and private providers, and in particular to overcome the perception that collaboration with the private sector will weaken, or be at the expense of, public institutions.

Collaboration must be seen as beneficial to both parties. A task-mix approach, which identifies main tasks and matches them to appropriate providers, is important, as are clear aims, good channels of communication and sharing practical examples of how results were achieved.

13. The institutional arrangements for working with private health-care providers will vary according to country and type of provider. For instance, many faith-based organizations have well-established umbrella associations through which negotiations can be conducted. Unlicensed and unqualified retailers or health practitioners, however, do not have similar representative bodies.

14. Strategies and interventions must take into account the fact that demand for services from private providers can be influenced by informing clients (about cost, quality or services available), exemption from fees (usually for the poorest), or provision of vouchers or cash. On the supply side, a range of contractual arrangements with providers can be used in order to specify type, quantity and quality of services to be provided. Similarly, for accreditation, a third party assures the quality of services. Self-regulation depends on professionals accepting responsibility for maintaining standards, usually through membership arrangements. Governments can call on laws, regulations and rules to encourage or restrict providers or protect clients.

15. The various organizations responsible for implementing such strategies and interventions include statutory bodies for licensing and registration of facilities; financing and health-insurance organizations; health-professional councils; voluntary accreditation agencies and professional associations; umbrella organizations; and consumer watchdog and protection agencies. In many low- and middle-income countries many of these institutions are considered to be poorly resourced and under-staffed.

16. International agencies have been focusing on promoting the role of private providers in expanding access to care. Less attention has gone to enhancing the role and capacity of government in providing policy guidance, exercising oversight, and defining and enforcing the mix of incentives and regulation needed.

17. WHO's ongoing work on the renewal of primary health care aims to consolidate experience, document best practice and plan the way ahead, particularly regarding the role of private providers. Several data-collection and research activities are under way through international cooperation. Bodies such as the Africa Health Workforce Observatory are working to complete country information on health-care personnel in the public and private sectors. The Alliance for Health Policy and Systems Research is defining non-state-sector research priorities in low- and middle-income countries. The Secretariat annually reports on national health expenditures, and is working with Member States to apply tools for mapping the range of services offered in public and private facilities. Other international institutions and partnerships are also actively experimenting with and documenting different approaches.

## **ACTION BY THE EXECUTIVE BOARD**

18. The Board is invited to note the report.

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