

WORKING PAPER No. 2

WORKING WITH THE NON-STATE SECTOR TO ACHIEVE PUBLIC HEALTH GOALS



**World Health
Organization**

Working Group on the Non-State Sector
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Making health systems work

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MAKING HEALTH SYSTEMS WORK: WORKING PAPER No. 2

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**WORKING WITH THE
NON-STATE SECTOR TO
ACHIEVE PUBLIC
HEALTH GOALS**

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ABOUT THE 'MAKING HEALTH SYSTEMS WORK' WORKING PAPER SERIES

In April 2005, WHO hosted a meeting called 'The Montreux Challenge: Making Health Systems Work'. A set of background documents known as 'core technical frameworks' were prepared for that meeting. Their purpose was to begin to develop consensus about the key challenges and effective strategies for building capacity in some critical areas of health systems in low-income countries. These papers have been revised based on the comments and directions for action agreed in Montreux, and they now form part of this 'Making Health System Work' working paper series. As working papers, these documents will be periodically revised as new knowledge and experience becomes available.

Working paper 2: Working with the non-state sector to achieve public health goals

The purpose of the paper is to begin to develop consensus about key challenges and effective strategies in working with the non-state sector to achieve public health goals. This paper has been prepared by: Sara Bennett (*Abt Associates, Bethesda, MD, USA*), Kara Hanson (*Health Policy Unit, London School of Hygiene & Tropical Medicine, UK*), Patrick Kadama (*Evidence and Information for Policy, WHO*), Dominic Montagu (*University of California, Berkeley*). This paper has been reviewed by Karen Cavanaugh, Venkatraman Chandramouli, Knut Lonroth, Sara Sulzbach, Alex Ross, Phyllida Travis, Mukund Uplekar and Hugh Waters as well as by other participants at the Montreux meeting. As agreed at the Montreux meeting, a working group on the Non-State Sector is also being established.

Further comments and information

Those wishing to give comments, or interested in finding out more about activities outlined in this paper should contact Sara Bennett (Sara_Bennett@abtassoc.com) or Dominic Montagu (dmontagu@berkeley.edu or montagud@who.int). For more information on the work of WHO on health systems, please go to: www.who.int/healthsystems

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1. CRITICAL CHALLENGES FOR LOW-INCOME COUNTRIES

The non-state sector plays a very significant role in the delivery of health services, and the provision of health and health related commodities in developing countries (see Box 1). In both urban and rural settings, private for-profit and non-profit health care providers and suppliers of health-related commodities serve both the rich and the poor. Clients often perceive non-state sector health care providers to be more responsive to consumer preferences (in terms of privacy, hotel characteristics and speed of service) and they are often also more geographically accessible than public sector providers. On the part of governments, and others working to achieve global health goals, there is interest in how to take advantage of the opportunities presented by the large number of existing contacts between target populations and the non-state health sector.

Box 1. Evidence on role played by non-state sector in providing services related to global health goals¹

- A review of Demographic and Health Survey (DHS) data from 38 countries showed that for children in the poorest income quintile, 34% to 96% of children seeking treatment for diarrhea, received that treatment in the non-state sector, while 37% to 99% of children seeking care for acute respiratory tract infection received that care in the non-state sector.
 - In India, the non-state sector distributes 65-70% of Oral Rehydration Salts (ORS) used in the country.
 - In Sub-Saharan Africa the majority of malaria episodes are initially treated by private providers, mainly through the purchase of drugs from shops and peddlers.
-

A very broad range of actors make up the non-state health sector, thus it is difficult to generalize about the for-profit or non-profit non-state sector or develop “one-size-fits-all” solutions. For clinical care services in particular there appears to be great variability in the technical quality of care provided by the non-state sector which may have significant public health repercussions. Moreover its composition varies across countries, and so it is difficult to identify challenges that are equally relevant in all contexts.

a. Priority challenges

The most important challenges in government and non-state collaborations are those that directly relate to improved prospects of achieving immediate public health goals:

- Taking advantage of the untapped potential associated with the non-state sector to expand coverage of products and services, including preventive services, which are known to have a public health benefit
- Promoting a higher quality of care in the non-state sector, at a minimum to protect the health of patients and broader society, but more broadly to improve quality of care (see Box 2).

Box 2. Quality of care issues in the non-state sector²

- Unnecessary use of antibiotics for treatment of diarrhoeal diseases and non complicated acute infections (Egypt, Pakistan)
 - Insufficient use of ORS for treatment of dehydration (Bangladesh, Nigeria, Pakistan, Sri Lanka and Yemen)
 - Under-dosing of antimalarials (Viet Nam)
 - Inconsistent and non-standardized prescribing of antiretrovirals (ARVs) (Zimbabwe, Senegal)
 - Over-the-counter sales of non-prescribed ARVs (Viet Nam)
 - Non-adherence to treatment guidelines in TB care (India)
-

b. Root cause challenges

Underlying these challenges are a number of root causes that relate less directly to the achievement of health goals but need to be addressed in order to respond to the higher level challenges identified above. Root causes reflect the lack of country-specific information about the non-state sector, and the problems that have been identified with respect to the public sector “doing business” with the non-state sector, including lack of skills and mistrust between the two sectors, specifically:

- Tailoring responses to individual contexts and providers so as to take account of the heterogeneity in the non-state sector;
- Overcoming mistrust between public and private sectors^{2 3};
- Improving information availability and reliability about the number and nature of non-state sector providers (clinics and hospitals), the range and quality of services which they offer, and treatment outcomes;
- Developing public sector management capacity to deal with non-state sector actors, and learning new skills in the non-state sector way of “doing business”;
- Promoting a more organized non-state sector, so as to reduce the transaction costs of working with a large number of small, disparate groups;
- Strengthening government’s ability to manage vested interests in powerful parts of the non-state sector (including potentially medical associations, private hospital complexes, private health insurance industry) during reform processes – particularly in countries where the private sector is more organized.

2. SCOPE, DEFINITIONS AND CONCEPTUAL FRAMEWORK

Unlike some of the other templates prepared for the Montreux meeting⁴, the non-state sector topic does not address a discrete health system function. Rather, the performance of the non-state sector and relations between state and non-state actors permeate multiple other functions addressed (health financing, human resources, health information).

The non-state sector is typically defined to comprise “all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease”⁵. This would include private for-profit (commercial) and private non-profit formal health care providers (private hospitals, health centers, clinics, diagnostic centers etc), as well as traditional and informal practitioners.

Another way to classify and define the non-state health sector which allows the range of actors to be expanded beyond health service providers is to focus on activities that private actors in the health sector may engage in. There are a broad range of such activities (see Table 1), encompassing private for-profit and private non-profit hospitals, health centers, clinics, and diagnostic centers, as well as traditional and informal practitioners, medical commodity retailers, civil society organizations, and private financing agents.

Table 1. Health sector activities which may engage non-state sector actors

Activity	Non-state sector actors likely to be engaged
Provision of clinical services (including laboratory and other diagnostic services).	Private for-profit and private non-profit health care providers (including private hospitals, health centres and clinics). Traditional healers and midwives. Unqualified doctors (quacks). Diagnostic centers. VCT (Voluntary Counseling and Testing) centers. Workplace clinics.
Distribution of health and health related commodities (e.g., ITNs (Insecticide Treated Nets), ORS, condoms, drugs).	General retail outlets (shops and stores), drug sellers and pharmacies.
Provision of preventive and psycho-social support services	Community groups involved in providing support to HIV+ patients. Behavior change communication through employers and youth groups.
Provision of auxiliary (non-clinical) support services (such as laundry, transport, management, cleaning services) in health facilities.	Private for-profit firms.
Financing of care.	Employers (through employer based medical benefit schemes). Private health insurers. Community based health insurance schemes.
Pharmaceutical production, importation, distribution.	Pharmaceutical manufacturers and companies importing or wholesaling pharmaceuticals.
Medical provider training.	Privately established medical and nursing colleges.

This paper focuses primarily on the provision of clinical services and commodities. It does not consider efforts to introduce private sector management techniques into the government sector, or global level public/private partnerships.

The complexity of engaging non-state sector actors depends substantially on the nature of the task in which they are to be involved. For example, selling condoms or ITNs is not dissimilar to the sale of other non-health commodities, and therefore private retailers (without medical training) may be well placed to do this. Working with non-state actors on services which are relatively straightforward to specify in advance and to gather information about how well the job is done, is likely to be easier than

for more complex and difficult-to-measure tasks⁶ - so for example it is likely to be easier to contract vector control services than clinical services.

In recent years there has been a greater recognition of the blurred boundaries between public and non-state sectors⁷. So drugs and other commodities purchased by the public sector may leak into informal drug markets, government health workers may moonlight in the non-state sector⁸, or alternatively may impose private charges when they see patients in public health facilities⁹, or even refer their government patients to their private practices¹⁰. These boundary issues and the regulatory responses available are central to this framework.

3. TACKLING THE TRACTABLE PROBLEMS IN COUNTRIES: WHAT IS EFFECTIVE AND FEASIBLE?

a. Identifying mechanisms to improve service coverage and quality

Table 2 presents a range of interventions which have been used to promote greater **coverage** of services through the non-state sector. The table documents the mechanism underpinning the intervention, as well as summarizing evidence on effectiveness.

Table 2. Summary evidence on interventions to expand coverage

Intervention	Mechanism underpinning intervention	Evidence on effectiveness
Social Marketing	Increased coverage by non-state sector actors via information provision to consumers, subsidy of products and expanded distribution chain.	Tends to increase uptake of marketed commodity; impact on other brands of the same commodity retailed through other outlets less clear, hence concerns about crowding out existing private sector. ¹¹
Vouchers and business-targeted subsidies	Promotes consumer choice and ability to afford to seek care from non-state sector actors, through subsidy of goods or services, either to consumers (vouchers) or purchasers (eg: employers who would add services to on-site clinics).	Vouchers appear to have positive impacts on uptake of a service or commodity, but relatively limited experience with this mechanism, and administratively complex to target. ¹² Non-consumer purchaser targeting has positive record (South Africa), and anecdotal successes in expanding HIV/AIDS care (cf. PharmAccess).
Contracting out	Expands non-state sector coverage of particular services via government finance, and may (through contract specification) improve quality of care. Sometimes said to improve efficiency and quality through competition.	Larger evidence base on this intervention with mixed findings, leaning towards the positive. ¹³ Contracting out, under certain circumstances may lower costs, expand coverage, but effectiveness requires appropriately structured and administered contracts. One rigorous study shows greater improvement in immunization coverage among poorest groups ¹⁴ . Also evidence of contracts not achieving, or partially achieving goals.

Public/private co-investment (build own transfer/build own operate)	Joint public/private investment in new facilities reduces costs and extends coverage by leveraging private sector resources.	Only anecdotal evidence regarding the effectiveness of this intervention in low-income country contexts.
Franchising	Increases supply of quality health care services via encouraging franchisees to follow protocols and guidelines.	May increase uptake of services, may increase quality of services. Very limited data on either.

Many of the interventions (such as social marketing, vouchers and franchising) have been used predominantly by disease or service specific programmes. In some instances (as is commonly the case with franchising) the range of interventions provided are broadened out from this disease or service-specific base. There is considerable variation in the scale with which interventions have been implemented, for example, while there are many countries where social marketing of condoms and insecticide treated nets is widespread, there are fewer countries where franchising has taken root and been scaled-up nationwide, experience with vouchers is still more limited. Although there is a growing body of experience with mechanisms such as those listed in Tables 2 and 3, there are relatively few rigorous evaluations of their effectiveness.

Table 3 below presents potential interventions that focus primarily upon improving **quality**, although note there is a degree of overlap between Tables 2 and 3. Again, with the exception of regulation, and perhaps training, most interventions have only been implemented on a relatively small scale in the developing world.

Table 3. Summary evidence on interventions to improve quality

Intervention	Mechanism underpinning intervention	Evidence on effectiveness
Information management: collection of information on non-state providers & dissemination of information to consumers	Tracks patterns of service provision in the non-state sector which may help to identify quality issues. Creates greater consumer knowledge that enables consumers to use private providers wisely and detect poor quality care.	Limited evidence on how this affects user choice of provider and decision to seek care in the non-state sector.
Providing resources to private providers	Improves quality of care through better or more appropriate resources e.g., subsidized provision of key equipment, or provision of drugs pre-packaged in complete dosage.	Only anecdotal evidence regarding the effectiveness of this intervention.
Franchising	Increases supply of quality health care services via encouraging franchisees to follow protocols and guidelines.	May increase uptake of services, but requires consumer willingness to pay for services. Quality increases shown in one multi-country study. ¹⁵

<p>Accreditation</p>	<p>Creates incentives for providers to improve quality of care by signaling higher quality providers to health care purchasers.</p>	<p>Well demonstrated effectiveness at ratcheting quality in developed and medium income countries. Mixed success record in low-income countries. Increasingly government initiated. May be more effective when initiated in conjunction with a powerful purchaser (eg. social health insurance scheme), not common in low- income countries.</p>
<p>Certification</p>	<p>Creates similar quality incentives to accreditation, with less intensive measurement, and limited or no comparison between provider sites due to the pass/fail nature of process. Has been used with individual providers, pharmacies as well as clinics, labs, and hospitals.</p>	<p>Limited empirical evidence regarding effectiveness, but a priori likely to be more effective when implemented in connection with powerful purchaser (eg. social health insurance scheme or voucher scheme) which is not common in low-income countries.</p>
<p>Regulation</p>	<p>Promotes quality of care (and potentially efficiency, equity etc) via legislation and/or the enforcement of stipulated standards.</p>	<p>Substantial evidence of health sector regulations remaining unimplemented or only weakly implemented due to lack of regulatory capacity, or being perverted by powerful vested interests. Regulatory strategy should probably focus on discrete high priority issues, and be backed up by strengthening of (appropriate) regulatory capacity.</p>
<p>Training, continuous education for private providers</p>	<p>Increases private provider skills and therefore quality of care. Could take form of continuous medical education for formal private providers or training for shopkeepers in appropriate prescribing.</p>	<p>Larger evidence base, but again somewhat mixed findings. In particular findings vary as to the extent to which training alone will solve quality problems, versus the need for a package of interventions which also create better incentives for private providers to offer good quality care.</p>

b. Identifying appropriate roles and capacity of government and non-state sector stakeholders

In many developing countries the relationship between government and non-state sector actors has historically been fraught with tension, and a degree of mistrust. Sometimes prevalent political ideologies have led to government policies which attempt to limit the role of non-state sector actors. Conversely, in other countries, powerful corporate interests are sometimes viewed to wield too much power over the government's health agenda. While in many contexts, government policies towards the non-state sector have become more open, or are in the process of doing so, the historical legacy of mistrust and the lack of prior experience with effective collaboration can still be a significant barrier to working with the non-state health sector. Moreover, in contexts where the non-state health sector has previously not been seen as a critical partner in the achievement of health objectives, it is frequently weak and poorly organized. Without private practitioner associations, or non-governmental organization umbrella organizations, there may be very high transaction costs for government in working with the non-state sector. In the opposite situation, where the non-state sector is large, powerful and sophisticated, the challenge is likely to lie more in creating sufficient capacity within government to negotiate with non-state sector actors, and create agreements and understandings which are in the interests of public health. While there is increasing agreement at national and international levels that countries cannot afford to ignore the non-state sector in developing and implementing strategies to achieve health goals, it is helpful to understand and appreciate the broader political context.

Government, given its stewardship function¹⁶, has a fundamental responsibility to set “the rules of engagement”, that is, it must provide non-state actors with overall policy direction, define clear roles for government and non-state actors, and help develop a predictable and transparent environment within which non-state sector actors can operate. Two further, specific critical roles for government as part of its stewardship function are (i) the ongoing collection and analysis of information about the non-state sector, and (ii) regulation. In order to develop appropriate policy with regard to the non-state sector government needs to have reliable information about the number and type of non-state sector health care providers, the type of services which they are offering, and basic service utilization and financial data. To the extent possible, non-state sector providers should be integrated into routine health information systems. Regulation can be broadly defined as imposing external constraints upon the behavior of individuals or organizations with the aim of countering market failures (such as protecting consumers who are relatively less informed than providers) or achieving social goals (such as promoting more equitable access to care). While government has a responsibility to ensure that such a regulatory framework exists and is enforced, the authority to implement regulation may be delegated to other actors (such as professional associations).

With the exceptions of information management and regulation, the other interventions defined in Tables 2 and 3 above are optional for government – in the sense that they may choose whether or not to pursue them. The extent to which governments do undertake to encourage, oversee, or manage interventions of this sort depend upon their assessment of the benefits of pursuing such strategies versus the opportunity costs, as well as their capacity to support such interventions.

Non-state sector actors also have important roles to play in ensuring accountability and promoting trust between government and the non-state sector. Civil society organizations can help hold government and other health sector actors to account. For example, coalitions such as the “People’s Health Movement” are gaining voice at the local, national and international policy levels to advocate

for equitable access to effective health services. The Global Fund has tried to build upon this notion by establishing Country Coordinating Mechanisms (CCMs) (that are required to include civil society actors, notably representatives from affected communities) as part of its governance mechanisms. Evaluations of this mechanism suggest that despite the requirements set out by the Global Fund, CCMs are often government dominated and civil society organizations have weak voice¹⁷.

While there are a large number of civil society organizations which already play an advocacy role or are actively engaged in policy discussions, many may benefit from enhanced capacity and improved information upon which to base their efforts.

4. PRIORITIES FOR ACTION

a. Government role and basic regulation

- **Priority 1 - Define and establish a clear role for Government with respect to the non-state sector** - Governments need to set clear policy frameworks and plans for engagement with the non-state sector, and then play a stewardship role, including both information collection and regulation, in ensuring that this vision is fulfilled.
- **Priority 2 - Strengthen basic regulatory functions** through building a clearer understanding and greater consensus about what are core minimum regulatory functions (eg. consumer protection, licensing of private providers, drug prescribing regulations etc) while acknowledging that they may well differ between countries. In addition:
 - Build a role for self-regulation by NGOs and for-profit entities
 - Give specific consideration to how basic regulatory functions can be accomplished in failed and fragile states
 - Establish criteria for prioritizing regulatory interventions
 - Develop common standards for public and non-state sectors
 - Promote the role of professional associations, particularly in setting and enforcing standards.

b. Capacity building

- **Priority 3 - Building institutional capacity in the currently unorganized and disparate non-state health sector** – the transaction costs of working with the non-state sector may be reduced if the non-state sector were to be more organized, through the establishment of private physicians associations etc. Such a development may also promote a stronger sense of professional ethics (although note that a possible downside might be that it creates stronger vested interests which may oppose specific sorts of reforms);
- **Priority 4 - Build public sector capacity to work with the non-state sector; develop skills and attitudes amongst public sector managers conducive to dealing with private providers.**
 - Public sector managers need improved skills and understanding conducive to dealing with private providers. This might include training in and exposure to new skills such as how to negotiate and agree contracts with private health providers¹⁸. Such training could build upon existing training modules but also more innovative strategies such as exchanges

with private sector executives could be considered. Exchange strategies, as well as other interventions (e.g., joint training) may also help build trust between public and non-state sectors.

- Create appropriate structures for engagement between government and the non-state sector at local and national levels.
- **Priority 5 - Build capacity at the district level, including for government health staff, to support and nurture NGOs and other non-state sector actors.** Much of the interface between government and non-state sectors takes place at the district or local level. Approaches to capacity building with respect to non-state sector roles, need to explicitly address this level.
- **Priority 6 - Build capacity amongst civil society actors to play an advocacy role, and hold public and private providers, and decision makers to account.**

c. Generation and synthesis of information

- **Priority 7 - Strengthen the empirical information base on effective interventions to promote access through the non-state sector, or raise quality in the non-state sector – particularly for interventions which have been scaled-up.** New initiatives promoting interventions such as those listed in tables 2 and 3 should be strongly encouraged to include a robust evaluative element (preferably with evidence on changes over time and with control groups). Evaluations are particularly important with respect to interventions that have been scaled up, and which therefore may have different costs and benefits. Evaluative frameworks also need to address how elements of context (such as state of economic development, or degree of organization in the non-state sector) influence the effectiveness of the mechanism.
- **Priority 8 - Strengthen the collection, analysis and interpretation of information about the characteristics and services provided by non-state health providers.** Non-state actors are frequently only weakly linked into existing information systems. Efforts to better integrate them into information systems could be pursued in partnership with the Health Metrics Network. One-off investigations or mapping of the non-state sector may also be useful in order to generate basic data for country policy makers on the relative characteristics of public and non-state health sector actors. While there is currently no commonly accepted and codified manner in which to describe and analyse the role that non-state sector actors play in a particular country context – parts of such an analytical framework do exist¹⁹, and could be elaborated to develop a basic, and commonly agreed tool for conducting assessments of the role of public and non-state sectors.

5. ADDRESSING THE GAPS AT THE INTERNATIONAL LEVEL: WHAT ELSE SHOULD BE DONE AND BY WHOM?

What is already being done

Many global health initiatives explicitly recognize the importance of the non-state health sector, have extensive experience of working with the non-state sector, and in recent years have been at the cutting edge of work related to the non-state sector. Some global health initiatives (such as the Global Fund) have underlying principles which emphasize the role of the non-state sector. There is currently

no consolidated attempt to address the non-state sector challenges laid out here. Action to-date is scattered and there is not always exchange and learning between initiatives specific to different services or diseases.

With respect to the priorities identified above, the World Bank, through its flagship course on health sector reform has provided some limited training to government officials on working with the public sector and has plans to expand this into a new course on public/private collaboration which will focus on how to create an enabling environment for both sectors to help contribute towards improved health outcomes (this course has already been piloted in Asia).

The Public/Private Mix Network undertook a significant amount of research²⁰ in this area but is no longer functional. USAID-supported initiatives have added greatly to the overall knowledge base of non-state health issues, but in specifically restricted areas (notably quality, financing, and reproductive health).

6. MOVING FORWARD

A small working group will be established in Autumn 2005 with the secretariat provided by WHO. It will encompass participants from health systems strengthening and disease/service-specific programmes, developing and developed countries, and government and non-state sectors, to respond to the priorities identified in this paper. Specifically, the objectives of the working group will be to:

- **Review evidence, and draw lessons**, about how best to engage non-state sector actors in the provision of preventive and curative services and health-related commodities, with respect to definition of standards, monitoring of non-state sector practice and regulation;
- **Provide guidance and recommendations** to government about how best to work with, and relate to, the non-state sector;
- **Develop tools** to enable governments and other actors (such as medical associations) to reach out to and work with non-state sector actors.

Addressing service coverage and quality of care by non-state sector providers inevitably involves health workforce and health financing policy issues. The new non-state sector working group will liaise closely with the emerging international Health Workforce Alliance and the working group established on health financing.²¹

It is anticipated that a revised version of this paper will be produced in March 2006, and that subsequent products will include:

- Development of guidance for governments (May 2006)
- Development of tools to help government implement new roles (December 2006)
- Development and implementation of additional studies (April 2006 – October 2007)

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- ¹⁶ Stewardship refers to the oversight role of the state in monitoring, shaping, regulating and managing the health system.
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- ²¹ For example participants in the Montreux Challenge meeting identified three specific topics on human resources for health and the non-state sector which they wished to see addressed, namely: (i) dual practice and improved understanding of policy options to govern dual practice (ii) the role of the non-state sector in medical education and (iii) balancing incentives for health workers across public and private sectors, and between services and disease specific programmes.