Non State Providers of Health Services

Briefing paper for DFID policy division

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1. Introduction

This paper on Non-State Providers (NSPs) of health services in developing countries is one of a series of papers that include sanitation, water, education and health services. These papers were commissioned by the Policy Division of DFID in London. Each paper considers the following key issues:

- The scale, importance and comparative advantage of non state provider (NSP) activity in each of the sectors;
- The limits and potential for expanding state purchase of services through contracting of NSPs;
- The limits and potential for different forms of regulatory approach

This paper builds on a previous multi-sectoral DFID funded study on Non-State Providers of Basic Services conducted in 2004 by IDD, Birmingham University, WEDC, Loughborough University, CIE, Sussex University and the LSHTM, that included three case studies from Africa and three from South Asia.

2. Nature, Scale and Importance of NSPs

2.1 Defining NSPs

Non state providers of health are 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. They include large and small commercial companies, groups of professionals such as doctors, national and international non governmental organisations, and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses, midwives and paramedical workers, diagnostic facilities e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores\(^1\).

Government employed health workers may also constitute part of the non state provider category. In practice there is often a sizeable overlap between the public and private sectors. Staff employed in the public sector may practice privately within or outside of a public sector facility. They may do this on their own account or working for owners of private facilities. This may or may not be legal. Public hospitals may operate their own private wards and manage the income
from them, or may allow work for private gain on their premises, as when doctors admit private
patients and are paid directly by them.

In many of the poorest countries health workers are working de facto within the private sector, as
they have to charge full cost for the services they deliver to patients due to the lack of any
functioning government system of subsidy\(^2\). If public services become heavily dependent on fee
income, as for example in China, there may be little to distinguish them from private
entreprises\(^1\). Finally health workers within the public sector may institute their own forms of
informal charging (McPake 1999) – further blurring the boundaries between public and private
sectors.

Bhat\(^3\) suggests a useful typology of the vast range of NSPs that may operate a low income
country. The table below builds on this typology to give a sense of different types of NSP to
consider. The context of different countries and health systems will clearly influence which are
most relevant. For instance in India the informal private sector plays a far more important role in
service delivery than it appears to in South Africa.

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Public</th>
<th>Not for Profit</th>
<th>Organised For Profit</th>
<th>Informal Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Organisation</td>
<td>Hospitals Clinics Dispensaries</td>
<td>Mission Hospitals Clinics Some TBAs</td>
<td>Hospitals Clinics General Practitioners</td>
<td>Faith healers Herbalists Some TBAs</td>
</tr>
<tr>
<td>Systems of Medicine</td>
<td>Allopathic</td>
<td>Allopathic Traditional</td>
<td>Allopathic Traditional</td>
<td>Mostly traditional</td>
</tr>
</tbody>
</table>

However, even such distinctions are not easy to make. It is difficult to always distinguish
between “profit” and “not for profit” organisations – many “not for profit” are still keen to
maximise the budgets that they receive. The “not for profit” sector also includes a vast range of
differences in organization and training - types of providers range from individuals with limited
training such as traditional birth attendants and community volunteers to groups of individuals
such as locally created, community based NGOs. There are also NGOs that are attached to, or
spin offs from, large international NGOs, and the international NGO sector itself.
2.2 Scale and utilisation of NSPs

In the six case study countries, the availability of data on the size and activities of NSPs was generally poor. In some this was true even of very basic information such as how many providers of each type were registered or operating. However, in all countries, with the possible exception of South Africa, there was some evidence that NSPs provided the majority of primary contacts with the health system. In South Africa 53-73% of GPs, 40% of nurses and 75-77% of specialists work in the private sector⁴. In Nigeria private and traditional medicine are estimated to deliver at least 60% of health service provision.⁵ The Pakistan Medical Association reports that about one half of registered medical doctors in Pakistan practise predominantly in the private sector (ibid). It is commonly quoted that the for-profit and not-for profit non-state providers deliver approximately 80% of services (personal communication).

The following table reports World Health Organisation estimates on private sector expenditure on health (payment by companies and households) and out of pocket payments (payment by households at point of use) for the six case study countries. Whilst there are some differences, the pattern of dominant private sector expenditure and very high out of pocket payments is clear.

<table>
<thead>
<tr>
<th>Country</th>
<th>Private sector expenditure as a % of total expenditure on health</th>
<th>Out of pocket payments by households as a % of private sector expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>74.8</td>
<td>85.9</td>
</tr>
<tr>
<td>India</td>
<td>78.7</td>
<td>98.5</td>
</tr>
<tr>
<td>Malawi</td>
<td>58.9</td>
<td>42.6</td>
</tr>
<tr>
<td>Nigeria</td>
<td>74.4</td>
<td>90.4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>65.1</td>
<td>98.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>59.4</td>
<td>20.9</td>
</tr>
</tbody>
</table>


This pattern is repeated in many other poor countries, results of some studies are highlighted below.
• An eight country study found that the private sector played a key role in service delivery (Makinen et al 2000). It was estimated to deliver between 50%-60% of services in Guatemala, South Africa and Paraguay.

• Goodman et al cite a series of studies showing that over 50% of febrile illness episodes in many African settings are treated through retailers (pharmacists, drug shop staff with minimum qualifications, shopkeepers and street vendors). In previous work, McCombie suggested that self treatment of malaria with cosmopolitan drugs from shops is common – with rates estimated from 4% to 87% in the early 1990s.

• Prata, Montague and Jeffreys study showed that over 70% of children in 22 African countries brought to see a medical practitioner with diarrhoea were taken to an NSP.

• Of 801 people interviewed at a public TB unit in Vietnam, 39% had attended a private pharmacy or private provider as their first attempt to seek care (Lonnroth et al 2001). This is likely to be an underestimate of the real rate, given that these were people interviewed at a public facility.

• In Egypt a study found that a preference for private sector providers was so strong that 58% of those with insurance coverage in the public sector still paid out of pocket to use private providers (2005 PHR plus).

2.3 Utilisation of non state providers by the poor

Poorer groups also use non state providers as their principal source of care. It is likely there is a tendency to use less qualified and hence cheaper cadres of providers such as general stores and traditional healers. For instance in Nigeria Onwujekwe found a statistically significant likelihood that poorest households were more likely to patronise patent medicine dealers, community based health workers and traditional healers. Wealthier households used a higher cadre of provider such as primary health care centres, pharmacy shops and hospitals. However other studies find little difference in care seeking behaviour by socio-economic quintile in the private sector – meaning that the poor are likely to be spending more, as a proportion of their income, on private sector care. A recent household survey in Tanzania found that of those having fever in the previous two weeks, 57% went to drug stores or general shops, with no statistically significant difference across socioeconomic groups. (Njau et al in press). In Vietnam it was estimated that the private sector provided 60% of all out patient contacts and the difference in use of private sector between low and high socioeconomic quintiles was not significant (Thi Hong Ha 2002).
The Bangladesh case study from the previous work\textsuperscript{10} found that in Bangladesh the National Health Accounts (NHA) study (MOHFW 2003) indicated that the poor make use of both for profit and non-for profit NSPs. A Service Delivery Survey (SDS) conducted by CIET Canada found that, in 2003, 88% of households seeking health care went to non-state providers\textsuperscript{11}. The single most important provider was the village doctor, who served 43% of the households who sought treatment. Another survey found whilst there was no significant difference between poor and non-poor households as regards utilisation of non-state services (83% compared to 81%), a higher proportion of the poor (74%) went to Alternative Private Practitioners compared to non-poor households (62\%)\textsuperscript{12}.

2.4 Why do people use NSPs?

A number of reasons why people chose NSPs are cited consistently across diverse settings:

1) Interpersonal quality of care- Non state providers give care in a way that clients prefer. Dimensions of this are described as greater politeness, a belief that the providers are more knowledgeable, better qualified, give a better examination, or in some countries have stronger, more effective drugs.

2) Accessibility – non state providers, in particular drug and general shops, tend to be open longer hours and more geographically accessible. Goodman\textsuperscript{19} demonstrates this with figures from Tanzania – where there is one retailer stocking drugs for every 310 people, one antimalarial retailer for every 834 people and one health facility for every 4368 people. A survey in Zambia found that half of respondents lived within a 30 minute walk of a traditional healer – only 34\% could get to a hospital in that time. In addition 48\% felt that they had to wait a long time at the hospital, versus 28\% feeling this about a traditional healer\textsuperscript{13}

3) Affordability – curiously, the private sector may sometimes be the cheaper option. In the private sector people may purchase a partial dose of drugs. They also may not have to travel so far – saving on time and travel costs which make attending non state providers relatively cheaper than the public sector (which may entail travel costs, time and informal charges).

4) Lack of a functioning public sector alternative – many people do not live within the catchment area of a government funded health care provider which is functioning at an acceptable level of quality (e.g. drugs and staff).
2.5 Quality of care by NSPs

What do we know about the quality of care provided by NSPs? Non state providers are so varied that it is difficult to make any generalisations on this point. The quality of care provided across different providers and in different countries is highly variable. It is important to distinguish between for-profit and not for profit providers also, due to the incentives that they face in providing care.

- Poor treatment practices within the private sector have been reported that usually stem from financial incentives or lack of training. Worryingly however, they have been recorded for diseases of great public health importance such as TB and sexually transmitted infections\(^\text{14, 15}\).
- Causes of this have been identified as lack of access to up to date knowledge and a low profit environment creating powerful economic incentives to minimise expenditure on care.
- However on the other side of the scale, international NGOs have been at the forefront of demonstrating ways of managing HIV treatment in resource poor settings\(^\text{16, 17}\).
- A study in South Africa\(^\text{18}\) that compared a range of public sector and non state providers (all for profit) found that there was no consistent picture, but that for profit non state providers tend to emphasise curative care. Overall the quality of care delivered by the private sector was not superior to that available in the public, with the exception of the greater acceptability to clients mentioned above.
- For the ubiquitous drug vendors, questions are raised over the quality of drugs, confusion over dosage and brand names, uncontrolled use of drugs that can fuel the development of resistance [such as antimalarials], and the availability of components of combination therapies as monotherapies\(^\text{19}\).

2.6 What quality of care do the poor receive from NSPs?

Quality of care provided to different income groups in the private sector has received some scrutiny in Tanzania. A number of studies suggest that the rich will access a higher quality of care.

- Schellenberg et al (2003) studied children under five in rural Tanzania who had had an illness episode in the previous two weeks. It was less likely that the poorer children would access appropriate care and the rate of hospital admissions in the lowest socioeconomic quintile was almost half that of the highest. The wealthier children were...
more likely to get antimalarials and antibiotics for pneumonia and were more frequently admitted to hospital.

- Njau et al\textsuperscript{20} found individuals who were in the top third of the population based on asset ownership were more likely to receive antimalarials, and this differential was even more pronounced when effective antimalarials were considered.
- Also in Tanzania, Goodman et al (2004) found that general retailers were much less likely to stock antimalarials, but that when they did, it nearly always included chloroquine which is no longer on the treatment regimen in Tanzania. If poorer groups are more likely to use lower levels of private provision such as general shops versus drug shops (the evidence is currently ambiguous) then this would also imply that they were receiving a poorer quality of care.

3. Using NSPs to scale up service delivery: what are the issues?

The current drive and enthusiasm for scaling up service delivery and reaching the millennium development goals has focussed attention on the potential role of non state providers in achieving this aim. There are a number of different ways of engaging with NSPs to influence or expand service delivery. These include training, regulation, use of vouchers, franchising, social marketing, accreditation and contracting out. These can be divided into two broad themes:

1) \textit{Improving access} by purchasing services from NSPs. This has the advantage of reducing the financial barrier to the service recipient. (xx) Examples include contracting-out the management of public facilities e.g. in Cambodia, Afghanistan, Pakistan and Bangladesh; contracting community nutrition or health workers e.g. in Senegal and Madagascar (Marek et al 1999); and contracting-out a variety of preventive and palliative services related to HIV/AIDS, such as targeted services for high risk groups in Pakistan and India, and home-based care in South Africa. More traditionally, there have also been contracts for non clinical services such as catering and laundry, and with church hospitals in rural areas of many African countries e.g. Uganda, Malawi, Nigeria, Lesotho.

2) \textit{Improving quality} by regulating the activities of NSPs. Regulating quality can be done using penalties or incentives. Increasingly there are attempts to engage with NSPs and work cooperatively with them to reach joint goals of expanded, good quality service delivery. These
attempts include social marketing, franchising, accreditation and the use of vouchers. Social marketing includes a wide range of interventions which usually encourage consumers to use effective services and products. It advertises and promotes subsidized products and services usually distributed by private for-profit providers. Franchising uses commercial techniques to improve the provision of health services through a shared-brand network of standardized service providers. The use of vouchers differs from social marketing in that the subsidy accrues to the consumer who then has a choice of where to spend it. Accreditation is similar to franchising but has less of a formal network or brand identity, being a more straightforward quality signal. All these more innovative attempts at regulation are resource intensive and are currently only rarely operating at a national scale in any country.

In light of the range of options above, considering the appropriate strategy, limits and potential of using NSPs to scale up service delivery should include consideration of:

1) contextual factors, in light of the risks and opportunities that NSPs present
2) the motives of different stakeholders for/ in such arrangements

3.1 Contextual factors and risks or opportunities

Non state providers pose a number of risks and opportunities for health systems. Clearly these will differ according to the context, type of NSPs and level of government capacity. Patterns of NSP provision vary from country to country.

A range of risks and opportunities that may be presented by NSPs is suggested below:

<table>
<thead>
<tr>
<th>Risks</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• They may compete with the public sector for scarce human resources &amp; encourage dual practice.</td>
<td></td>
</tr>
<tr>
<td>• The quality of care they offer may be poor and may contribute to the development of drug resistance in important conditions such as AIDs and malaria.</td>
<td></td>
</tr>
<tr>
<td>• If there is no public subsidy, accessing care from non state providers may impoverish households and cause catastrophic health</td>
<td></td>
</tr>
<tr>
<td>• Non state providers may have considerable expertise and training. Most trained health professionals may be in the non state sector.</td>
<td></td>
</tr>
<tr>
<td>• Non state providers are often present in remote areas and are numerous. They may provide effective treatment and drug distribution channels to remote areas.</td>
<td></td>
</tr>
<tr>
<td>• Non state providers often have strong traditions of service delivery in some areas</td>
<td></td>
</tr>
</tbody>
</table>
expenditure

- Interaction with government or donors tends to be on a pilot project or piecemeal type basis - they may fragment the existing health system rather than consolidate it.
- Regulating NSPs may overwhelm limited government capacity.

such as prevention of HIV, home based care, community based distribution (TB Dots). They may be better trained and equipped to deliver some services appropriately.
- People find quality of care and accessibility of non state providers to be better than the public sector.
- They respond to financial and humanitarian incentives quickly. They may show greater degrees of flexibility and innovation than the public sector.

Aspects to consider in mapping the context of NSP/ government relations should include:

- Importance of public sector as provider of health care currently and any urban /rural differentials in this. Is provision currently dominantly for profit/ NGO or public sector?
- % of donor contribution to the recurrent health sector budget
- What is the nature of NSP provision?
  - Size, number and role of drug shops and general shops as sources of drugs and information
  - Size, number and role of traditional healers / equivalent unqualified providers
  - NGOs / CBOs – what sort are there? Mainly national/ international? Do they have a history of advocacy or service delivery?
- Is the setting post conflict or fragile in some other way?
- How strong is the government and how well established? What mechanisms of regulation exist? What capacity to implement them?
- Where are the health workers? Are they currently in the public or private sectors or both? Is dual practice highly prevalent? Is health worker retention an issue?
- What is the history of the relationship between different NSPs and government? One of cooperation or hostility? Was private practice banned at any stage? Does government spend any of its own budget through NSPs for service delivery currently?
- Who uses NSPs? Are they providers who reach the poor or the rich? Are they more universally used? Are they actually the providers who service the rich whilst the poor uses the state sector or has no access to care?
3.2 The motives of the stakeholders

In order to design interaction with NSPs effectively, it is important to understand the different motivations and perspective of stakeholders. Three main ‘players’ in this can be identified: donors, governments and NSPs themselves. It is interesting to note that typically donors fund most purchasing of services from NSPs and interaction with NSPs on behalf of government.

Donors

Global attention has been focused on public sector failings by the establishment in 2000 of the UN Millennium Development Goals (MDGs), including such targets as reduction of under-five mortality by two thirds, and by the rapidly increasing international funding available to tackle diseases such as HIV/AIDS and malaria. Interventions exist which can help achieve the MDG targets, but coverage is low. For example, if use of proven effective childhood services rose from current levels to 99%, under-five deaths could fall by 63% (Jones et al 2003). Multilateral and bilateral agencies tasked with a goal of poverty eradication are thus seeking ways of rapidly ‘scaling up’ health services in a context of limited government capacity (Wagstaff and Claeson 2004). Contracting-out offers a means of getting round limited government absorptive capacity and resistance to changing resource allocation patterns.

The motives of donors are

1. to see effective service delivery expended as quickly and efficiently as possible and
2. to attempt to regulate the activities of NSPs that have negative externalities.

They see NSPs as one possible way to bypass the constraints of government’s absorptive capacity. They hope that NSPs are also effective at “reaching the poor” and there is some evidence to back up this hope (Schwartz and Bhushan 2005).

Government/ Ministry of Health.

The position of the MOH / MOPH in relation to the non state sector is always complex. They may share the donor agenda to scale up service provision and constrain the negative activities of the private sector. However they face the following constraints which will shape their behaviour:

1. They are responsible for the existing, albeit non functional, public sector. Resources that go to NSPs by definition can not be given to their natural constituency, the public sector hierarchy. This is likely to lead to some conflict within the ministry.
2. They may not trust NSPs or wish to see their activities scaled up. They may see NSPs as threatening their power base.

3. They may feel that they have insufficient information or knowledge to be able to control the activities of NSPs.

**Non state providers**

They provide a vast array of perspectives. They are characterised below into three, potentially overlapping, forms – mercantile, dependent and altruistic.

"Mercantile" NSPs are searching for profit either to expand or to survive. A good example would be general stores or drug shops. They will be keen to work with governments/donors if they are going to make a profit from doing so. In South Africa and some other middle income countries there are for profit companies now working within clinical service delivery\(^{21}\). They may behave opportunistically in terms of seeking profits.

"Altruist" NSPs may be national or international NGOs or CBOs. Whilst they may be in need of funds their primary motivation is service delivery/altruism rather than profit or survival (?). Examples would be community based organisations or large humanitarian NGOs that have their own resources (medicines sans frontiers).

"Dependent" NSPs might be mercantile or altruistic. But their key feature has become their dependence on an income from the state or a donor to survive. They may have been used to receiving money either in grants from elsewhere or from government, or face a decline in their private sector business. They need an income from the state to continue to provider services. Examples of this are Part time district surgeons in South Africa\(^ {22}\) or mission hospitals/clinics in Malawi, Uganda, Nigeria, Lesotho and other African countries. Over the past two decades such facilities have been in increasing need of funds from government to make up for the shortfall in contributions from their traditional overseas supporters (European and American churches). New types of dependent NSPs are being created by the current trend to contract out HIV/AIDS related activity or general health service delivery. These are NGOs/CBOs that are created with the purpose of winning government contracts. For instance, a recent report looking at NGOs that would be involved in home based care in South Africa found that they sources 64% of recurrent funding from government\(^ {23}\). Such NSPs are highly dependent on government/donor sources of income. Issues to consider with these NSPs is that entering into a relationship of support for them
means that you can not easily exit that again. They are unable to stay operational without government support.

4. Purchasing services

Whether espoused by donor or government, the rationale for contracting-out service provision to the private sector is varied, ranging from the theoretical to the pragmatic. Theoretically, the arguments are broadly similar to those put forward within the approach known as ‘New Public Management’ in developed countries (Walsh 1995). The main objective is to improve efficiency of service provision and it is argued that either making clinics and hospitals residual claimants on revenues (Milgrom and Roberts 1992; Gauri, Cercone & Briceno 2004), or exposing them to competitive markets through the establishment of renewable and competitive contracts, will achieve this aim. The idea of giving incentives to providers by making them more autonomous is less relevant in resource-poor settings, where providers are often private and autonomous. These private providers are commonly thought to be more efficient than public providers, though evidence on this, certainly at primary care level, is equivocal (Mills, Palmer, Gilson et al 2004).

Pragmatically, a number of arguments have favoured contracting-out policies. One key argument is that in many settings, public provision has failed altogether, has never arrived, or has widespread technical inefficiencies. For example poor drug supply systems result in health facilities lacking drugs for a good part of the year; poor human resource management and remuneration systems result in high rates of health worker absenteeism and poor service quality (Hanson et al 2003). Allocative efficiency is also judged to be poor: expenditure is skewed to hospitals, with low levels of coverage of highly cost-effective interventions such as immunisation and treatment of under-fives. There are also widespread inequalities: resource allocation (both funding and staff) favours urban areas. Thus there is scepticism on the willingness and ability of the public sector to improve technical and allocative efficiency through direct provision and hierarchical management.

Another pragmatic argument is that resources already exist in the private sector both locally and globally and can be rapidly mobilised through contracts. Such resources include solo private practitioners, drug sellers, private hospitals, and NGOs such as church providers. The latter may already receive government subsidies, but without a formal contract. Evidence abounds that the majority of care-seeking, even for an important public health issue such as TB, is within the
private sector (Uplekar, Pathania & Raviglione 2001), so these providers are widely acceptable to the population – usually more so than public providers.

Finally, it is argued that NGOs are better suited to delivering certain types of services, notably socially and politically sensitive ones such as those related to HIV/AIDS. This is rooted in the belief that NGOs are more experienced and appropriate for working at community level, dealing with marginalised or at-risk populations, and addressing topics sensitive for the government, such as illegal drug use.

4.1 Features of purchasing environment in low income countries and fragile states

Whilst the ‘make or buy’? question is a direct echo of debates in developed countries such as the UK, the different motivations and context of such a policy in countries which are both resource- and information-poor suggest that the approach, outcomes and implications are likely to diverge from those in wealthier settings. Three key features of such settings affect the landscape for policy implementation, with implications for the type of contracts that can feasibly be used, and the manner in which they are likely to operate.

- First, whilst in many developed countries contracts are used as a mechanism to reshape service delivery, usually between existing parts of a public sector bureaucracy, resource-poor settings often employ them as a way of expanding service provision and bringing in new providers. Such providers are independent private entities, in contrast to the developed country providers who are not necessarily privately owned or profit-maximising (Bartlett and Le Grand 1993).

- Second, the public sector bureaucracy is usually weak and overstretched (Bennett and Mills 1998), with implications for its capacity both to provide services and to fulfil a stewardship role and act as informed purchaser (WHO 2000). Lack of government capacity also implies that the problem of “hidden information”, where uncertainty affects the performance of a task, will be considerable for resource-poor governments who lack information on the cost and quality of public and private service provision.

- Third, most low income country governments are dependent to a considerable degree on external finance, and this means that the agenda of the donor community can play a role in determining national policy: in effect the donor may be the purchaser, at least during the period of project funding. Indeed, contracting-out service delivery to the private sector appears to be primarily favoured by the donor community rather than by countries. Research undertaken for the previous stage of NSP work suggested that many governments actively
distrust the for-profit private sector (Palmer 2005). A further implication of the involvement of international funding agencies is that it often leads to greater involvement of international contractors such as international non-government organisations (NGOs).

### 4.2 Types of purchasing arrangements

A formal contracting framework is a good place to start in looking at state purchase of services, but the varying nature of contractual relationship has been highlighted\(^{24,25}\). In some cases the contract is little more than the formalisation of a subsidy from government to ensure that private providers continue to provide services in underserved areas. In others, requirements may be more extensively specified, and payment may contain a performance-based element.

In the previous NSP work we identified a number of types of contracting relationships

1) Long standing contracts/ payment of subsidies between government and for profit providers or faith based organisations. These contracts tended to be related to service delivery in rural areas and were characterised by a strong degree of dependence between the contracting parties.

2) Newer contracts between government and NGOs, typically funded by donors. These were common for HIV related services such as preventive education or home based care or areas in which NGOs were argued to have an efficiency advantage. In addition, the use of contracts to scale up service delivery in fragile states e.g. DRC, Afghanistan, Rwanda is expanding rapidly.

3) No contract per se, but “co-production” between NGOs and government facilities

#### 4.2.1 Indefinite contracts in rural areas

One relatively long standing model appears to be “indigenous” contracts/ subsidies between government and providers of rural health care. Here governments are using their own budgets to purchase services. The contracts tend to be long standing and indefinite in duration. The part time district surgeon (PDS) system of South Africa has provided one case study of this type of government contracting with for profit providers. Another form, which is prevalent in a number of countries is the payment of recurrent expenses to mission run hospitals. This is happening in many countries including Lesotho, Malawi, Nigeria, and Uganda.
**The South African PDS**

Here the government paid private GPs on a fee for service basis to treat public sector patients in some rural areas.

*Motive:* The system was effective in providing access for populations that would otherwise have no access to a health care professional at the level of doctor.

*Purchasing arrangements:* Fee for service based on monthly reported figures

*Advantages/ Disadvantages:* Concerns over the quality of care delivered and the possibility of fraudulent activity by some doctors. These issues arose due to weak monitoring – the state did not have the resources to perform this role adequately in so many rural locations. Quality and appropriateness of care delivered were argued to be eventually at the discretion of each provider with little recourse for the state purchaser to monitor events\(^{25}\)\(^{26}\) Palmer and Mills 2003) This system raises questions about the ability of public sector bodies to adequately manage contracts with for profit providers who may behave opportunistically\(^{26}\) Palmer and Mills cerdi paper)

**Subsidies to Christian Health Missions in Africa**

*Motive:* to maintain existing primary care clinics and district hospitals which are run by faith based NGOs. Since 1980s these organisations have seen remittances from overseas (European and US) churches dwindle. In some rural locations they are the sole provider of services so it is important for the government to try to maintain their viability.

*Purchasing arrangement:* Exact details of all not known. Our previous studies included the Christian Health Associations of Nigeria (CHAN) and Malawi (CHAM). Contracts are being initiated as an attempt by government to formalise the subsidies which they have increasingly been called upon to make. In the case of Malawi, in December 2002 a Memorandum of Understanding was signed between CHAM and the Ministry of Health to formalise an existing arrangement where the MOH was paying salaries of CHAM personnel. The government pays the subsidy in an attempt to keep facilities open and user fees relatively low. In other cases also tends to be a subsidy that is aimed to provide for salaries of some or all staff. Little monitoring of activity.

*Advantages/ Disadvantages:* Good example of mutual collaboration to achieve service delivery goals. As with PDS above, similar issues of dependence but unclear accountability are present. (Rightly or wrongly there is less concern that providers may behave opportunistically or fraudulently when dealing with faith based groups?) As with the PDS above, a feature of this type of contract is the quite high mutual dependency underlying the contract and restricting either
parties ability or willingness to exit from the relationship. This is demonstrated by the fact that in the absence of a Memorandum of Understanding in Malawi, payments were already being made.

4.2.2 Service Delivery Contracts
A different form of purchasing which is becoming more common is contracting of specific services or packages of care to non state providers, typically NGOs. In the previously commissioned case studies NGOs had been or were being contracted to deliver nutrition services and a package of primary health care to the urban poor (Bangladesh) HIV/AIDs preventive services and district health services (Pakistan), and home based care for HIV/AIDs (South Africa). Most of the contracting has been undertaken using donor funds.

In other countries there are notable initiatives which are also described briefly in table 1. Many of these are in fragile states – (Cambodia, Haiti, Afghanistan, Rwanda and Democratic Republic of Congo (DRC)) or involve the contracting of HIV prevention and treatment services. Again this form of contracting raises issues of dependence. Governments are likely to become reliant on these service delivery organizations, and the organizations are already in many cases heavily reliant on the government for their operating budgets. Many NGOs are being rapidly established to act as service deliverers. A recent report looking at NGOs that would be involved in home based care in South Africa found that they sourced 64% of recurrent funding from government.  

4.2.3 NGO/government “co-production”
The final model of contracting was mutual collaboration, where rather than a principal agent type model where there was a purchaser and a provider, both NSP and government were involved in funding and providing services. In some case NGOs were providing quite substantial resources themselves.

Pakistan- AJK
In Pakistan several examples of co-production by NGOs and government had emerged out of a World Bank funded health project in Azad Jammu Kashmir in the late 1990s. The Family Planning Association of Pakistan (FPAP) used government provided staff, commodities and facilities to deliver services, but also contributes their own resources. Similarly the Marie Adelaide Leprosy Centre worked closely with government and delivered services on government’s behalf, but brought considerable resources themselves, in particular providing about 50% of TB drugs. Both FPAP and MALC are large, well established and specialised
NGOs. They both have international affiliations and can bring financial resources and technical strength to their partnership with government. They were also connected to influential individuals in Pakistan, and appeared to have taken the initiative to persuade government to allow them to become involved in government facilities and service delivery. One NGO manager commented: 
“we had to work hard to make the government understand that collaboration could work”\(^\text{28}\).

**Malawi**

Malawi provided a similar and quite illuminating case. Here an NGO involved in reproductive health services had traditionally enjoyed considerable donor support. Attempts were made by the donor to encourage closer working between government and this NGO with mixed consequences. The NGO was given access to government facilities in rural areas, and encouraged to channel its drug procurement through government channels. The contrast between the NGO and government performance was stark – sometimes government facilities were so run down that the NGO had to refurbish them before they could be used, and the channelling of drug procurement through the government system was abandoned as the process was so slow. This case raised the question of how an underfunded and underresourced government can co-operate with NGOs which have traditionally benefited from external sources of funding and are technically and financially stronger.

### 4.3 Key issues in contract design

a) **Specification of package of services** – in some countries a basic package of services has been defined and this forms the basis for the contract. In others the form of service delivery is less specified leaving the possibility that different providers offer quite different types of service. Some types of service lend themselves more easily to specification than others. Our research has indicated that the broader and more primary care type services are very difficult to specify accurately\(^\text{22,24}\) unless the whole basic package is contracted out, as in the case of Afghanistan. This is then dependent on the skill with which the basic package has been formulated. Areas likely to suffer in specification of services are those less easy to forecast, for instance appropriate referrals, social issues and preventive care. Again, our research has indicated that some NSPs tend to focus on curative care as performance in this field is easier to measure and report

b) **Methods of payment** Contracts tend to be funded on a fee for service basis or using some form of per capita payment. Fee for service has the limitation of creating incentives to over service the
population. Per capita payments create better incentives, but care needs to be exercised that they don’t create inequities. In some areas providers bid competitively for different contracts and may receive quite different per capita payments. In the long run variations in per capita allocations may help to indicate what the true level should be in different areas, but care needs to be exercised that different regions are financed according to some objective resource allocation criteria.

c) **Performance based financing (P4P)** – is becoming a growing trend in contracting out and attracting increasing attention.\(^1\) P4P can operate at the contract or health facility level. For instance donors such as the World Bank issue contracts with P4P based element to NGOs in several countries. Several NGOs (notably CordAid and HealthNet as international NGOs) use P4P designs to subcontract to either their health workers or different providers in a district/region\(^2\). Here health workers or providers in sub-facilities are paid according to their performance against a similar range of indicators (utilization, assisted deliveries, immunization).

Performance-based contracting has been suggested as one way of better aligning incentives so that problems of ‘hidden information’ are lessened, and the need for costly and difficult monitoring of performance reduced. Eichler, Auxila and Pollock (2001) reported the findings of a pilot scheme in Haiti (funded by USAID) which introduced performance-based contracts for NGOs providing basic health services. Under the new system, which replaced a system of straightforward reimbursement for NGO expenditure, a portion (5%) of the NGOs’ historical budget was withheld but the opportunity was offered to earn that plus an additional 5% if performance targets were met. A one-year pilot showed marked improvements in performance, however it is difficult to attribute these directly to the P4P as there is no control. (It is also argued that the elasticities of response to the small incentive of 5% extra payment were so great as to suggest that there were other motivations at play). This type of P4P approach is also being used in a pilot scheme for contracting with Ugandan NGO hospitals (funded by the World Bank), and in extensive contracting with NGOs to deliver a basic health service package in Afghanistan (funded by the World Bank). In these settings, providers either chose or are allocated targets for service delivery. Monitoring is done by record review or household survey. The extent to which the incentive of a performance bonus will alter the behaviour of providers is not yet clear.

\(^1\) The Centre for Global Development has recently established a working group to examine the advantages and disadvantages of this approach.

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Concerns over P4P are that it does not really cure problems of “hidden information” but may increase incentives to game the system. It may create an overly strong focus on certain targets at the expense of general systems strengthening. It may discourage efforts to reach poorer groups by diverting resources to achieving targets by servicing easier to access populations. There is some discussion over formulating targets that include access by socio-economic groups but that is difficult and costly to monitor. Another innovative approach (used in Haiti example) is to offer various sets of indicators that must be achieved and then only monitor a randomly selected subset of these, so that the provider is not clear which ones they need to meet and has to meet all.

d) Monitoring - Theories relating to contracts suggest that the nature of the contract will be largely determined by the ability of the purchaser to monitor process and outcome. In the case of health this is notoriously difficult to do. In the case of NSPs in developing countries monitoring is a huge challenge. Approaches to monitoring service delivery under contract are usually:

- Providers report on paper or electronically. With or without random visits/ checks by purchaser or third party employed by purchaser. Challenges to this approach include distance to different providers, accessibility by road and how to verify records. It has the advantage of being cheap.

- Household surveys are used to assess access to services in the population. This was used to evaluate contracting in Cambodia, and is being used in Rwanda and Afghanistan. It is a more objective and reliable measure of provider activity, but it very expensive and fraught with logistic difficulties.

Concerns are expressed in all social sectors about the use of target or indicators to track performance. Monitoring of contracts is bedeviled by the problems of the incentives that it creates.

e) Degree of competition - Theories relating to contracts suggest that their advantages in terms of enhancing efficiency in providers depend on a degree of competition or contestability within the market. There is little evidence that many contracts for basic health services, especially in rural areas, are awarded competitively. This means that the purchaser’s power to exercise control over the activity of the provider is limited by the lack of an alternative. Termination of the contract is not a viable option, as there is a reluctance to endanger whatever basic service delivery exists. In such settings consideration must be given to how to manage contracts where both parties are dependent on the contract continuing.
f) **Contracting channel** – Some contracts are let directly by donor to NSP. Others are managed through the Ministry of Health, possibly in a government unit such as the Grants and Contracts Management Unit in Afghanistan. Scope for governments to try and align the different funders of contracts and maintain processes that are workable for health system strengthening is increased if they are put in the position of being the purchaser. In some fragile states or those where politically the government cannot be involved, donors will contract directly.

### 4.4 Evaluating the effects of state purchase of services

Are any or all of these types of contract a good idea? This question is difficult to answer, and remarkably few attempts have been made to address it comprehensively. Contracts can be evaluated both directly and indirectly. Direct evaluation can attempt to look at the performance of providers, or results achieved in terms of volume, efficiency and equity of service provision. These studies are difficult to conduct rigorously and few have been done. They are often hindered by the need to have similar data on the ‘counterfactual’, or the efficiency and equity of service provision by any alternative provider, who may not actually operate in the same setting. This means that there needs to be careful assessment of the study context in order to understand whether findings are more widely relevant.

A further issue facing evaluation is what is feasible in terms of data collection or data availability. Many contracts in resource-poor countries have not been in place for very long, or the lack of data on service delivery can make it impossible to evaluate.

### 4.5 Recent evaluations of state purchase of services

This section summarises the evidence base on contracting-out, selecting the most comprehensive recent attempts to evaluate the performance of providers and the nature of contractual relationships.

Two models of contracting for the delivery of district health services were piloted in rural Cambodia during 1998-2001 as part of a project funded by the Asian Development Bank. Districts were selected randomly and assigned either to “contracting-out” (2 districts), “contracting-in” (3 districts), or controls (4 districts). Under contracting-out, NGOs were given full responsibility for the delivery of specified services in a district, including drug procurement and hiring and firing of staff. Under contracting-in, NGOs worked within the existing system to
strengthen district administrative structures. Control districts received no external support except a small subsidy towards service delivery. Equity as well as coverage targets for primary health care services were explicitly included in contracts. Pre- and post intervention household and facility survey data are available for evaluation of service delivery. Coverage of primary care services in all districts substantially increased over the study period. Based on the household and facility survey 2.5 years after contracts started, all contracted districts outperformed control districts in terms of pre-defined coverage indicators such as immunization and attended deliveries. Contracted-out models outperformed contracted-in. Much of the increase in health care utilisation in contracted districts was attributed to increased use by households of low socioeconomic status – children in the poorest 50% of households in the contracted districts were more likely to be fully immunized than those living in similar households in districts served by the government model of service provision (Schwartz and Bhushan 2004b). However, there may have been different resource flows to the different districts and the differences observed could be attributed to this. In addition it is unclear to what extent the NGOs that held these few contracts would be able to replicate this performance over a larger scale, or could be substituted by other NGOs.

A similar comparison between NGO and public sector service delivery has been attempted in Bangladesh (Mercer et al 2004). During 1998-2003, the Bangladesh Population and Health Consortium, supported by DFID, funded NGOs to deliver an essential package of services through their own clinics. NGOs reported their activities quarterly and their performance was evaluated using indicators such as the vaccination status of children and deliveries attended by a qualified person. Similarly compiled data from public sector clinics were not available, so to evaluate the performance of the NGOs, the authors compared selected health indicators with the latest estimates for Bangladesh, some of which covered earlier time periods. NGO data indicated high coverage of reproductive and child health services, and low levels of child mortality, in comparison to the rest of Bangladesh. Given the absence of any baseline data, it is not clear whether this was inherent to the areas where the NGOs were operating, although the authors attempted to control for this by tracking mortality rates: these demonstrated a clear drop since the commencement of contracts.

In the late 1980s, the Costa Rican government introduced a number of market-like mechanisms including the contracting of provision to health care co-operatives, which are founded by employees of primary care clinics. Co-operatives are autonomous legal entities which receive a
yearly capitation fee based on the local population size. A recent analysis compared health outputs amongst the cooperatives with traditional and comparable public sector facilities (Gauri, Cercone and Briceno 2004) using panel data from 1990-1999. They found that cooperative clinics had significantly more generalist visits per capita and significantly fewer specialist visits per capita than traditional clinics; they also performed fewer lab tests and prescribed fewer drugs. This suggests that cooperatives were reducing costs, and the authors concluded that overall they were not under-servicing according to tracers of the per capita rate of emergency visits and first time patients, which were similar to those in traditional clinics. The authors pointed out that the differences could be due to unobserved variables that systematically differed between the cooperative areas and areas of public provision, differences in the population, or differences in the organisational culture of those facilities which converted to cooperatives.

5. Regulating NSPs

5.1 Forms of regulation

Alternative approaches to regulation are often characterised as the carrot (incentives) and the stick (a more legalistic, command and control approach). This captures the basic idea of incentive based regulation versus legally sanctioned regulation.

More extensive classifications include:

<table>
<thead>
<tr>
<th>Regulatory approach</th>
<th>Example</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Command and control</td>
<td>Using force of law to impose fixed standards e.g. Health and Safety regulations</td>
<td>Unambiguous use of state’s power to protect its citizens</td>
<td>Complex, expensive, tendency to regulatory capture. May not be effectively enforced.</td>
</tr>
<tr>
<td>Self regulation</td>
<td>Medical Associations – an organisation develops a set of rules that it monitors and enforces against its own members</td>
<td>Well informed rule – making and low cost of enforcement</td>
<td>Lacks openness- the rules written by self regulators may be self serving</td>
</tr>
<tr>
<td>Incentive based</td>
<td>Use of grants of subsidies to encourage appropriate behaviour</td>
<td>Low levels of discretion reduce costs and risks of capture</td>
<td>Difficult to predict their effect on the ground. Only relevant for certain types of</td>
</tr>
<tr>
<td>Market harnessing controls</td>
<td>Competition laws, franchising (e.g. competition for a market rather than in a market), tradeable permits</td>
<td>Low levels of intrusion, allows flexibility for firms</td>
<td>Still need to regulate this form of regulation! E.g Ofsted, OfRail</td>
</tr>
</tbody>
</table>

Source: Baldwin and Cave 1999

It is also useful to consider the distinction of supply and demand side regulation. Demand side measures typically provide subsidies to service users to increase access to NSPs and regulate quality e.g. vouchers for maternity care in Bangladesh described below.

Legally sanctioned regulation, or the command and control type approach described above is the most common form of regulation in low income countries and also notoriously ineffective. In the case study work done in the prior phase of this project this form of regulation was not looked at in any great depth, as there were few cases that appeared to be interesting or successful and insufficient data to judge how widespread they were.

What did appear from the previous case studies was a category of regulation which aimed to increase the knowledge of private providers and the quality of their service. In our previous cases this was dubbed “regulation by facilitation”. As a concept it is examined in greater detail in the next section.

5.2 Facilitation

These approaches tried to use incentives – either payment or inputs such as training and equipment, to improve accessibility and regulate quality. In our case study work we found a number of examples which tended to be smaller scale and often at the “pilot” stage. This may signify the relative complexity of the approaches and the greater resources and management skills required for them to operate effectively.

Such approaches to improve quality included demand side financing of birth attendants in Bangladesh, and the training and provision of equipment to Traditional Birth Attendants (TBAs)
in Malawi\textsuperscript{33} and Nigeria\textsuperscript{34}. Data on their impact in terms of effect on quality of care was not available.

The Bangladesh scheme of demand side financing aimed to give vouchers for antenatal care and delivery to pregnant women. These vouchers would give them access to a range of accredited providers. The providers were predicted to self-regulate on quality in order to gain accreditation and compete for these vouchers.

Pakistan provided an example of how quality could be improved by franchising. The Green Star franchise was facilitated by donor funds to establish partnerships with providers of basic reproductive health care services. These providers agreed to integrate a defined package of reproductive health services into their practice in return for training and the right to use the franchise brand – the Green Star of quality - above their door. A drawback of this successful scheme is its size and questions arise over the resource intensity of the monitoring and operation of the accreditation system. In Pakistan, Green Star was only operating in urban and peri-urban areas and quality was monitored using supervisory visits and mystery client surveys. It is unclear to what extent such pilot projects or urban-based initiatives can be cost effectively scaled up. Adequate decentralisation of responsibility for monitoring would be required for this to operate effectively across a country. However, an evaluation of Green Star noted that:

\textit{“the Green Star network shows that good family planning services can be delivered effectively and efficiently to low income populations through the private sector if health providers are equipped and motivated to do so”}\textsuperscript{35}

The training of TBAs has been a theme of public health policy in many countries for decades. Since the 1970s, Malawi had a UNFPA funded programme to support TBAs by providing training, delivery kits, drugs and supervision. However a shortage of human resources means that the supervisory task fell to district nurses who were already overloaded with other tasks. As a result, supervision has been very minimal. Since 1982 only 40\% of TBAs have been trained. Controversy over whether this has improved performance, especially in light of a recent doubling of Malawi’s maternal mortality rate has further hindered the programme’s progress.

Other examples, not in our study, of innovative approaches to regulating the quality of care in the private sector include a project with shopkeepers in Kenya and one with GPs in South Africa. In Kenya\textsuperscript{36} an educational programme for general shopkeepers and communities in Kilifi District, rural Kenya was associated with major improvements in the use of over-the-counter anti-malarial
drugs for childhood fevers. In South Africa Schneider et al.\textsuperscript{14} describe results of an evaluation of an intervention to improve quality of sexually transmitted infections (STI) care among 64 private general practitioners (GPs) working in two urban districts in Gauteng Province, South Africa. They implemented a multifaceted intervention, the core of which were four interactive continuing medical education seminars. Changes in STI treatment practices were evaluated through record reviews before and after the continuing medical education intervention. There were statistically significant improvements in the quality of drug treatment for urethral discharge but not pelvic inflammatory disease among both intervention and reference GPs. Although improvements in treatment quality were possibly the result of a background secular trend rather than the intervention itself. They observe that further research is needed on financial and other incentives to improved quality of STI care in the private sector environment.

**Discussion**

The case study work highlighted a number of themes, from which some tentative conclusions are drawn below.

- There was a trend towards increasing dialogue between governments and NSPs and an attempt to involve them more in strategic planning for the sector. However, in all cases these initiatives were still at very preliminary stages, and there was some evidence of the difficulty of maintaining an ongoing dialogue with NSPs.
- Command and control approaches to regulation suffered from incomplete regulatory frameworks and a lack of compliance by providers. There were also questions over the objectivity of some professional bodies.
- Incentive-based approaches to regulation promised to be better at encouraging self regulation, but only if the resources existed to provide a credible threat to those who tried to game the system. Currently they tended to be run on a relatively small scale, leaving the question of how effectively they could be expanded, especially in rural areas, still to be answered. The resource intensity of monitoring via visits and quality checks was a central problem both for incentive regulation and also different forms of contracting out.
- Some collaboration took place on a co-production basis.
- Finally, increasingly formal contracts with NGOs, using donor funds, were a fast increasing trend. These offered the potential to scale up service delivery rapidly. It was not possible to judge whether the services delivered under such schemes were of better quality or more cost effective than a public sector alternative. However NGOs did work
effectively to get system delivery moving in a way that was not mirrored by the public sector in most case study countries.

- With the exception of donor initiated projects of contracting out, the health cases suggested that much government activity towards NSPs in health was rather piecemeal. A glaring omission was any comprehensive attempt to work with small scale, informal NSPs. The cases also suggested that NSPs and donors were more pro-active at initiating partnerships than governments themselves.

- This raises the issue of the motivations for the interactions that we studied. On the government side, it was important to distinguish between NSP interactions which they take on independently and those which were fostered and encouraged by a donor. Some government players appeared to be reluctant or ambivalent partners in NSP collaborations. There were few examples where governments were using their own funds to purchase services from NSPs. A further symptom of this possible ambivalence was how governments retained a separate focus on developing public sector systems of delivery, often in parallel with NSP initiatives. The case studies of dialogue demonstrated how only limited attention and strategic thought was given to how to deal with the private sector, and this was often heavily donor driven.

- Several case study reports comment on hostility or suspicion by government and policymakers of the NSP sector, in particular to for-profit providers. Governments appeared to be more willing or more comfortable engaging with NGOs, which do not represent the bulk of NSP service delivery in most countries. This may be because governments perceive a greater alignment of motivation and shared goals, finding the prospect of managing a relationship with NGOs less daunting. This implies that government can work with NGOs in a co-production arrangement where both have shared concerns for public action, although it would also mean that governments and NGOs may clash where they have different public action concerns.

- NGOs, on their side, were motivated to fill gaps in inadequate public sector provision but also were keen to access resources from donors and/or government to sustain or develop their organisations. Increasing numbers of NGOs acting as service delivery mechanisms (for example in Bangladesh, Pakistan, South Africa) probably reflect this increasing financial incentive for NGOs. In some cases NGOs described how their traditional
funding sources had declined in recent years; their willingness to take part in contracts with government may be a result of this general trend.

- Another dimension to consider was the stage of maturity at which we witnessed these interactions. Most initiatives were at a very early stage and the feasibility of scaling them up to have an impact at national level was still unclear. Furthermore, many of the collaborations that we studied appeared unique and rooted in some historical setting that might further limit their replicability (for example, CHAM and CHAN, and NGO collaborations in Northern Pakistan). On the other hand, some initiatives were new, in particular large scale contracting with NGOs. It is yet to be seen whether these latter initiatives become well-established and sustainable.

Four lessons emerge from the cases and themes discussed above. The first is that to achieve successful and sustainable collaboration between governments and NSPs, there is a need to foster trust between them. Donors may find a useful investment in establishing fora which allow interaction and discussion between these groups. Engagement should be planned at both national and local level, with umbrella groups which represent specific types of NSPs but also in the form of local NSP / Government groups. Here issues could be raised and debated and interventions developed. Such local groups would help to give a sense of the appropriate interventions at national level as well as allowing greater familiarity to develop trust. Local level interaction between different NSP groups and government may be a useful first step in defining a national regulatory framework.

The second lesson is that governments and donors tend to focus most on NGOs when they attempt to approach NSPs. However, the smaller scale for-profit providers may be the ones that are most widespread in reaching the poor. A second investment that may be useful would be in encouraging means for these smaller scale providers to come together and interact with governments and donors. Again, the establishment of local level fora would be an important factor in achieving this. Schneider et al (2005) describe an initiative in South Africa to work with private GPs to improve the quality of care for sexually transmitted infections by implementing continuing medical education seminars. Here all GPs in a defined area were contacted and invited to be part of the process. Channels of communication were developed through which attempts to improve quality of care could then be transmitted. An important first step in that
process is that government must begin to map the nature and scale of providers in different areas, again possibly a useful area for donor involvement.

A third, related, lesson is the difficulty of engaging with scattered small scale providers (legal and illegal practitioners and drug sellers). This is compounded by the difficulty of monitoring their activities. A clear lesson from these cases is that to tackle these issues adequately would require sustained investment of resources and expertise to develop human resources, transport and technical capacity to monitor adequately. Any system based on incentives or punitive regulation will still require a credible commitment to monitoring by the implementing body. Ways of decentralising this responsibility to local government or increasing the capacity and expertise of the stewardship function of Ministries of Health need to be further explored. Useful research into the cost effectiveness of different monitoring and stewardship strategies is called for.

This leads to the final lesson – that a myriad of pilot projects has done little to solve any of these complex challenges. With the exception of the larger contracting initiatives, the approaches demonstrated in the cases we examined were ad hoc, small scale and without any clear agenda either for comprehensive evaluation or for subsequent scaling up.

To formulate and manage a comprehensive policy towards NSPs, governments and donors will need to devote considerable resources, in terms of policy formulation, management and research. The data on use of the private sector suggest that it is bigger than the public sector in most countries, even ‘stewarding’ such a masse of varied actors is a large scale undertaking. This presents governments with a series of strategic choices how best to use resources. An initial range of choices, each established on a different view of the most likely nature of successful NSP regulation, could include:

a) Developing a specialist unit for monitoring and regulating private sector activity at national and regional levels.

b) Investing in the establishment of incentive regulation approaches on a large scale and the specific monitoring needs of these approaches

c)Investing in the fostering of better relationships between government and NSPs in the belief that such activity will better align their incentives

d) Using the resources to improve government service delivery, thereby potentially reducing the use of NSPs
An understanding of the culture and history of government and NSP provision of health in varied contexts will help to establish which approach may be most successful. Ultimately however it is only on a large scale that the success or otherwise of any of these approaches can be measured. Appropriate arrangements for evaluation using robust study designs are a final consideration for both governments and donors.

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