Supporting non-state providers (NSPs) in basic health service delivery

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.

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. If public services become heavily dependent on fee income, as for example in China, there may be little to distinguish them from private enterprises. Finally health workers within the public sector may institute their own forms of informal charging—further blurring the boundaries between public and private sectors.

Who uses NSPs?

Various studies have highlighted the central role played by private sector providers in basic health care delivery. The private sector delivers between 50%-60% of services in Guatemala, South Africa and Paraguay. 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). Over 70% of children in 22 African countries brought to see a medical practitioner with diarrhoea were taken to an private provider. In Egypt, the preference for private sector providers is so pronounced that even 50% of those with insurance coverage still paid out of pocket to use private providers (2005) PHR plus.

NSPs and 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 e.g. general stores and traditional healers. For instance in Nigeria it was found that poorest households were more likely to patronise patent medicine dealers, community based health workers and traditional healers. 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.
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 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.

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).

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 helping to achieve 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) Improving access by purchasing services from NSPs. This has the advantage of reducing the financial barrier to the service recipient. 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) 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

This paper was commissioned by DFID Policy Division, London as part of a study on non-state providers in the water, sanitation, education and health sectors. The full report on which it is based is available from DFID, or WELL well@Lboro.ac.uk
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

Non state providers pose a number of risks and opportunities for health system development. Clearly these will differ according to the context, type of NSPs and level of government capacity.

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

<table>
<thead>
<tr>
<th>Risks</th>
<th>Opportunities</th>
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<td>• They may compete with the public sector for scarce human resources &amp; encourage dual practice.</td>
<td>• Non state providers may have considerable expertise and training. Most trained health professionals may be in the non state sector.</td>
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<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>• 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>
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<tr>
<td>• If there is no public subsidy, accessing care from non state providers may impoverish households and cause catastrophic health expenditure</td>
<td>• Non state providers often have strong traditions of service delivery in some areas 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.</td>
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<td>• 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.</td>
<td>• People find quality of care and accessibility of non state providers to be better than the public sector.</td>
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<td>• Regulating NSPs may overwhelm limited government capacity.</td>
<td>• They respond to financial and humanitarian incentives quickly. They may show greater degrees of flexibility and innovation than the public sector.</td>
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**Contextual Factors**

Three key features of settings in low and middle income countries 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. 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).

Purchasing Arrangements
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

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.

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<tr>
<th>Regulatory approach</th>
<th>Example</th>
<th>Strengths</th>
<th>Weaknesses</th>
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<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>
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<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>
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Traditionally the health sector has relied on command and control type of regulation which has not been implemented very effectively. Recent initiatives such as vouchers for ante natal care in the private sector and training for Traditional Birth Attendants seek to focus more on the incentive based or market harnessing side of regulation.

**Lessons for governments and donors**

Recent work has shown that 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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Access to health care in Burundi: results of three epidemiological surveys  April 2004  Medicins Sans Frontieres