EXECUTIVE SUMMARY

Health care reforms in the 1990s promoted government collaboration with the private sector. This was in response to deficiencies in public sector provision, and in the light of the perceived private sector strengths of quality and efficiency. A diverse set of interactions evolved between the public and private sectors across the developing world. This was on the basis of very little information on the nature of the private sector, its services and impact on health. Recent experience suggests that, contrary to dominant opinion, public-private interactions (PPIs) can worsen inequity, provide poor quality care, create inefficiencies and undermine the coherence and sustainability of the health system, especially in the realm of sexual and reproductive health (SRH). This means that PPIs should be approached in a cautious and planned manner. Governments should be guided by clear principles for engagement, and supported by strong regulatory frameworks and contractual arrangements. Governments need to be capacitated to implement and monitor PPIs appropriately. Above all, the strengthening of the public sector must not be compromised by parallel efforts to extend private sector involvement.

WHAT IS THE ISSUE?

How can government best draw on private resources to support the achievement of sexual and reproductive health service objectives?

BACKGROUND

INTERACTIONS BETWEEN THE PUBLIC AND PRIVATE SECTORS

In some instances, the private sector exists alongside the public sector, working completely independently or even in direct competition. In many other instances, however, there are complex interrelationships between the two sectors, involving the financing, management and provision of health care services which traditionally were seen as the preserve of government.

Reforms in the 1990s sought to expand such ‘public-private interactions’. This was in response to the decline of the public health sector due to unfavourable macroeconomic conditions, structural adjustment, declining donor support, inefficiencies and popular disaffection. The nature of these reforms was diverse, ranging from the introduction of mandatory health insurance, to the contracting of private providers for clinical and non-clinical services, to the use of private distribution networks for the marketing of public health care interventions and the manufacture of drugs and supplies.
Why is the private sector useful to government?

Certain assumptions about the private sector make it appear an attractive option for addressing the crisis in health care provision:

- It represents additional financial, human and other resources that can be utilised to expand coverage;
- It has the reputation of efficiency, and promotes competition;
- It is perceived to provide high quality care, and is therefore often more popular with patients, even those from low-income groups; and
- Where patients are able to pay for private care, this alleviates the burden on the public sector which can concentrate more resources on the indigent and focus on the tasks of policy-making and regulation.

These pragmatic considerations are underpinned in some cases by an ideological position which holds that government expenditure should be reduced, and that market-style reforms are the key to development. Some commentators believe that this position reflects the growing power and influence of business following globalisation in the 1990s.

Are sexual and reproductive health services well-suited to private sector involvement?

The demand for sexual and reproductive health services is rising. This is partly because international mandates have committed governments to providing an expanding array of high quality services, partly because there are increasing numbers of people in the reproductive age, and partly because of the HIV/AIDS epidemic. In this context, private sector resources are much needed. In addition, the private sector has proved popular for the treatment of sexually transmitted infections because of the privacy that it affords. The failure of the public sector to meet many of women's health care needs, drives them to use the private sector, in many countries illegally (for example, for abortion, sterilisation and certain types of contraception).

On the other hand, the for-profit private sector has little incentive to provide inexpensive services, like certain contraceptives. Even not-for-profit organisations may be selective in the care they are willing to provide (for example, abortion services may not be provided by certain Christian groups). At the conceptual level, then, there is some question as to whether sexual and reproductive services are ideally suited to delivery through the vehicle of PPIs.

Lessons from recent experience

An examination of developing country experience reveals that some of the assumptions made about the ability of the private sector – and of PPIs – to contribute to the achievement of health care objectives are questionable, particularly in relation to sexual and reproductive health services.

While PPIs may expand coverage and improve services for some, there is evidence that they may contribute to worsening inequity, for example:

- PPIs tend to be based in commercial centres, and do not reach remote communities. This is even true of social marketing projects, and means that public and donor subsidies are ‘captured’ by more urban people in higher income groups.
- Many forms of PPI, including some that involve not-for-profit providers, only serve those who are able to pay. Out-of-pocket payments are particularly inequitable in that they require lower-income groups to pay proportionately more than high-income earners. Because of the financial burden they place on poor families, they also delay visits to health services.
- Even health insurance premiums can be inequitable when there are insufficient cross-subsidies between income and risk profile groups: there is some evidence from Latin America, for example, that women are charged higher premiums (because of the costs associated with reproduction).
- PPIs can reduce – rather than free up – resources available for providing essential care to the indigent. At the national level, this is evident when donor funds are diverted to PPIs. At the international level, it is evident with the current focus on infectious disease programmes, rather than other components of sexual and reproductive health services.
- Differentials in care are experienced between paying and non-paying patients, such as in hospitals with private wards and in cases where
fees are charged for diagnostic services and drugs.

- The presence of an active private sector contributes to the ‘brain drain’ of personnel from the public sector.

It is difficult to monitor the private sector, even when it is involved in PPIs, but there is emerging evidence of practices that lead to poor quality services.

- PPIs tend not to provide good screening and follow-up services, that is a particular problem when oral or injectible contraceptives are prescribed (as these may have side effects).

- Private providers have a lesser likelihood of following national guidelines such as, for example, those for the management of STIs.

- There is an array of problems around the misuse of pharmaceuticals, such as inappropriate choice of drugs, over-prescribing, and failure to inform the patient of side-effects. Decisions around drug prescription seem to be influenced by the patient's ability to pay and opportunities for profit.

- Social marketing and franchising programmes can skew the uptake of contraceptives towards oral and injectible contraceptives, rather than to condoms which are more appropriate for the treatment of STIs. This may relate to profit-making, and reflects the wider tendency of the private sector to under-provide preventive services and to 'medicalise' health-related issues.

- In the case of illegal services, there is no control of the quality of care provided, and women are vulnerable to being charged high prices.

PPIs seldom provide comprehensive care and tend to take a selective approach which affects the coherence of the health system.

- Private sector services are often driven by profit motive (or, in the case of not-for-profit organisations, by particular belief systems). This can lead to the neglect of certain services. Very few PPIs render pregnancy and child birth services, and very few deal with STIs in general (as opposed to high risk) population. While some types of PPIs specifically focus on family planning services, many others are particularly bad at providing this sort of service.

- PPIs tend to fragment preventive, diagnostic and curative services, which increases 'lost opportunities' for the provision of integrated care. Diagnostic services appear to be over-provided (especially in the area of HIV/AIDS), while the prospects for appropriate care (following diagnosis), remains slim for many.

- PPIs tend to transform the patient from a citizen with rights into a consumer who participates according to the ability to pay. Community participation in priority-setting tends to be severely compromised in the case of PPIs.

Policy Options

In most developing countries, the public sector is underfunded and understaffed. In this context, the private sector remains a potential source of additional resources. Mounting evidence suggests, however, that it is difficult to deploy these resources optimally in the service of social objectives. PPIs should thus be embarked upon with caution and in a planned and strategic manner. This requires:

- Development of over-arching government policies on engagement with the private health sector, based on a set of clear principles. PPIs
should only be embarked upon, or continued, if they unequivocally meet the requirements of these principles (which could include equity, quality, efficiency, coherence and sustainability).

- **Strengthening of government’s ability to develop, implement and monitor regulatory frameworks and contractual arrangements in relation to the private sector.** This is critical to the development of PPIs that benefit society as a whole, and is an area where governments tend to be particularly weak. Frequently private providers benefit disproportionately from their relationship with government, are not monitored sufficiently stringently, and are not sanctioned for failure to meet government objectives.

- **Investment in research to better understand all aspects of private sector provision and its impact on the achievement of health care objectives.** The private sector is not known for its transparency, nor does it have very good health information systems. This has meant that engagement with PPIs has been embraced in the absence of detailed knowledge of the sector.

These strategies require sustained efforts from governments, as well as considerable capacity development. This is difficult within the context of the current public health sector crisis, and in the face of sustained pressure from international agencies and donors to increase private sector involvement. In addition, the private sector is very diverse, even amongst not-for-profit providers, which increases the complexity of interaction. However, the responsibility for the achievement of the Millennium Development Goals, not to mention the more comprehensive International Conference on Population and Development’s Programme of Action (ICPD POA), lies firmly in the hands of the public sector. In this light, government and donor resources must not be squandered on PPIs which do not meet social objectives. In addition, there is a clear imperative to strengthen the public health system in order to achieve competent stewardship as well as support the provision of essential, integrated services.

**References**


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This policy brief was prepared by **Jane Doherty.** It is based on Ravindran TKS, Weller S, Moorman J, Alonso V. Public-private interactions in health. In: Ravindran TKS, de Pinho H (editors). The **Right Reforms? Health Sector Reform and Sexual and Reproductive Health.** Johannesburg, Women’s Health Project, School of Public Health, University of the Witwatersrand, 2005.

The full text of the book can be found at www.wits.ac.za/whp/rightsandreforms/globalvolume.htm

Other policy briefs in this series include Health sector reforms in the 1990s: Implications for sexual and reproductive health services; Financial health sector reforms and sexual and reproductive health; Priority Setting in the context of health sector reforms: Implications for sexual and reproductive health services; Decentralisation and implications for sexual and reproductive health services; Integration, health sector reforms and sexual and reproductive health; Strengthening service accountability and community participation in health sector reforms. They can be found at www.wits.ac.za/whp/rightsandreforms/policy.htm

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