Oxfam International

Blind Optimism

Challenging the myths about private health care in poor countries

An Executive Summary

The realisation of the right to health for millions of people in poor countries depends upon a massive increase in health services to achieve universal and equitable access. A growing number of international donors are promoting an expansion of private-sector health-care delivery to fulfil this goal. The private sector can play a role in health care. But this paper shows there is an urgent need to reassess the arguments used in favour of scaling-up private-sector provision in poor countries. The evidence shows that prioritising this approach is extremely unlikely to deliver health for poor people. Governments and rich country donors must strengthen state capacities to regulate and focus on the rapid expansion of free publicly provided health care, a proven way to save millions of lives worldwide.

The stakes could not be higher. Every minute a woman dies in pregnancy or childbirth for want of simple medical care; every hour 300 people die of AIDS-related illnesses; and every day 5,000 children are killed by pneumonia. The world is badly off-course to achieve the internationally agreed health Millennium Development Goals (MDGs). To get back on-course and achieve universal and equitable health care for all requires a massive expansion of health services. To fail in this endeavour will be to abandon hundreds of millions of people to an early death and a life blighted by sickness. The critical question is how can such a massive scale up be achieved?

For over two decades, the World Bank advocated a solution based on investment and growth of the private health-care sector. Decrying the failure of public health services in poor countries, failure in which the Bank's enforced public sector spending cuts and widescale restructuring have played a significant role, the argument was that the private sector could do a better job. Although in recent years the World Bank has acknowledged the key role of the government in health care, this is largely as a regulator and 'steward' rather than as a provider of services.

Despite the poor performance of private sector-led solutions, there has been a noticeable increase in efforts in recent months by a number of donors and influential organisations, to encourage and fund an expansion of health care by the private sector. The idea is that those who can afford it should buy their own health care in the private sector and governments should contract private providers to serve those who can't. The approach is promoted not only as a matter of 'common sense' but as essential to reverse the lack of progress in health care and to save the lives of poor people.

This paper examines the arguments made in favour of increased private for-profit provision of health services as a means of scaling-up to achieve health care for all. It finds the evidence in favour of private-sector solutions is weak. On the contrary, there is considerable and increasing evidence that there are serious failings inherent in private provision which make it a very risky and costly path to take. All too often these risks are not taken into account.

At the same time, a growing body of international research reaffirms that despite their serious problems in many countries, publicly financed and delivered services continue to dominate in higher performing, more equitable health systems. No low- or middle-income country in Asia has achieved universal or near-universal access to health care without relying solely or predominantly on tax-funded public delivery. Scaling-up public provision has led to massive progress despite low incomes. A Sri Lankan woman, for example, can expect to live almost as long as a German woman, despite an income ten times smaller. If she gives birth she has a 96 per cent chance of being attended by a skilled health worker.

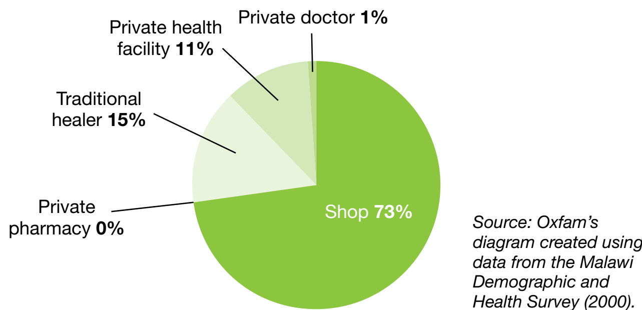
Stallholders in Freetown, Sierra Leone sell an assortment of prescription and non-prescription medicines at a street market. Many are not in their original boxes or are out-of-date. Rob Huibers / Panos Pictures

Examining six common arguments made in support of private-for-profit health-care provision:

Argument 1: The private sector is already a significant provider of services in the poorest countries, so must therefore be central to any scaling-up strategy.

A recent report by the International Finance Corporation (IFC), the private-sector investment arm of the World Bank, claims that over half the health-care provision in Africa comes from the private sector. In fact, Oxfam's analysis of the data used by the IFC finds that nearly 40 per cent of the 'private provision' it identifies is just small shops selling drugs of unknown quality (see photo). In some countries such as Malawi, these shops constitute over 70 per cent of private providers.

Figure 1: Private health-care providers for the poorest fifth of the population in Malawi

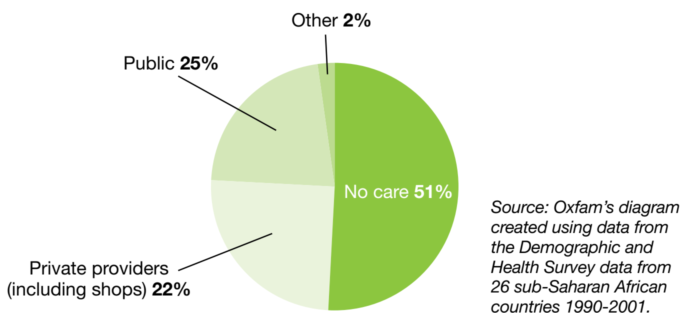


Source: Oxfam's diagram created using data from the Malawi Demographic and Health Survey (2000).

If the shops are removed from the data, and only the clinics staffed by trained health workers – what most would think of as 'health services' – are included then the share of services in the private sector falls dramatically, especially for poor people. Comparable data across 15 sub-Saharan African countries reveals that only 3 per cent of the poorest fifth of the population who sought care when sick actually saw a private doctor.

Even if the private sector is a significant provider of some services this does not mean it is filling the health-care gap. In India, 82 per cent of outpatient care is provided by the private sector. The number of first class private hospitals is rapidly increasing. Yet this same system denies half the mothers in India any medical assistance during childbirth. The reality is that most people in poor countries have no health care at all. Over half of the poorest children in Africa have no medical help when sick.

Figure 2: Use of health-care providers among the poorest fifth of the population when a child is sick in sub-Saharan Africa



Source: Oxfam's diagram created using data from the Demographic and Health Survey data from 26 sub-Saharan African countries 1990-2001.

To take the failing status quo in health care, in which the private sector, in some cases, plays a significant role, and see this as indicative of the way that successful expansion should be organised is illogical. It is comparable to looking at the huge rise in private armed bodyguards in failed states and concluding that the private sector is best placed to take over national policing. The case for greater private provision must be made on the basis of its merits in comparison to public provision and not simply on the basis that, on some measures, it is currently a significant provider in some poor countries.

Argument 2: The private sector can provide additional investment to cash starved public health systems.

But attracting private providers to low-income risky health markets requires significant public subsidy. In South Africa the majority of private medical scheme members receive a higher subsidy from the government through tax exemption than is spent per person dependent on publicly provided health services. Private providers also directly compete for the small number of trained health workers in many poor countries.

Argument 3: The private sector can achieve better results at lower costs.

In fact, private participation in health care is associated with higher (not lower) expenditure. Lebanon has one of the most privatised health systems in the developing world. It spends more than twice as much as Sri Lanka on health care yet its infant and maternal mortality rates are two and a half and three times higher respectively. Costs increase as private providers pursue profitable treatments rather than those dictated by medical need. Chile's health-care system has wide-scale private-sector participation and as a result has one of the world's highest rates of births by more costly and often unnecessary Caesarean sections. Commercialisation has led to a decline of less-profitable preventative health care in China: immunisation coverage dropped by half in the five years following reforms. Prevalance rates of tuberculosis (TB), measles, and polio are now rising and could cost the economy millions in lost productivity and unnecessary treatment in addition to unnecessary suffering.

The difficulty of managing and regulating private providers also creates inefficiencies, especially where government capacity is weak and there are too few private providers to ensure price competition. In Cambodia, the low number of technically acceptable bids received in one of the largest contracting-out health-care schemes meant that in many cases contracts were awarded without competition and the overall size of the programme had to be reduced by 40 per cent. Private providers were found to have lower operating costs in only 20 per cent of contracting programmes for which data is available. Even then the full transaction costs to government of managing private providers are not counted: these can divert as much as 20 per cent of spending from health budgets.

Argument 4: The private sector can help raise the quality and effectiveness of health services.

There is a lack of evidence to support claims for the superior quality of the private health-care sector. The World Bank reports that the private sector generally performs worse on technical quality than the public sector. In Lesotho, only 37 per cent of sexually transmissible infections were treated correctly by contracted private providers compared with 57 and 96 per cent of cases treated in 'large' and 'small' public health facilities respectively. Poor quality in the unregulated majority private sector puts millions of people's lives at risk every day.

Argument 5: The private sector can help reduce health inequity and reach the poor.

In reality private provision can increase inequity of access because it naturally favours those who can afford treatment. Data from 44 middle-and low-income countries suggests that higher levels of private-sector participation in primary health care are associated with higher overall levels of exclusion of poor people from treatment and care. Women and girls suffer most. To make a return whilst serving the poor, the IFC recommends doctors see over 100 patients a day, or one every four minutes, while those who can afford it can receive a much greater level of care.

Argument 6: The private sector can improve accountability.

There is no evidence that private health-care providers are any more responsive or any less corrupt than the public sector. Regulating private providers is exceptionally difficult even in rich countries. Fraud in the US health-care system is estimated to cost between $12 and $23 billion per year.

What will deliver health care for all?

The private sector provides no escape route for the problems facing public health systems in poor countries. Instead these problems must be tackled head on because the evidence available shows that making public health services work is the only proven route to achieving universal and equitable health care. Committed action by governments in organising and providing health services was responsible for cutting child deaths by between 40 and 70 per cent in just ten years in Botswana, Mauritius, Sri Lanka, South Korea, Malaysia, Barbados, Costa Rica, Cuba, and the Indian state of Kerala. More recently countries such as Uganda and Timor-Leste have used co-ordinated donor funding to massively expand public provision. In Uganda, the proportion of people living within 5 km of a clinic increased from 49 to 72 per cent in just five years. In only three years, the Timor-Leste Government increased skilled birth attendance from 26 to 41 per cent.

Public provision is definitely lacking or is very weak in many countries, but the problems are not intractable. Public provision of health care is not doomed to fail as some suggest, but making it work requires determined political leadership, adequate investment, evidence-based policies, and popular support. When these conditions exist, public health systems can take advantage of economies of scale, standardised systems for regulation and improving quality, and most importantly, the legitimacy and capacity to redistribute resources and reduce inequality. Policies of universal access in Sri Lanka, Malaysia, and Hong Kong benefit the poor more than the rich. Indian states that invest more in public health services have been more successful at reducing rural-urban inequalities. In fact the overall benefit of government health spending was found to have reduced inequality in 30 studies of developing countries reviewed by the International Monetary Fund (IMF).

Civil-society organisations (CSOs) must be considered as distinct actors from the for-profit private sector. CSOs have a key role to play in helping to strengthen and expand viable, accountable public health-care services. As providers of health care, they are a lifeline for millions in many countries, especially for some of the most marginalised and stigmatised populations. Because they are not seeking to make a profit, they are not subject to some of the negative incentives of for-profit providers. But CSOs also have limitations in capacity and scale and cannot reach all those in need of treatment and care, including those infected with HIV, TB, and malaria. CSOs should only ever be a complement, and not a substitute, for the state. They work best in collaboration with the public system, as in Uganda where the government operates in partnership with mission hospitals. CSOs also play a critical role in holding governments and international actors to account, creating the political pressure to make governments act to provide free health care for all.

Existing private providers must be integrated into public health systems where possible, and in some contexts that role could be partly extended. However, to look to the private sector for the substantial expansion needed to achieve universal access would be to ignore the significant and proven risks of this approach and the evidence of what has worked in successful developing countries. In particular, in most low-income countries the high-end and expensive formal private sector is irrelevant for the majority of citizens. Its growth can come at a direct cost to public health systems and undermine their capacity to deliver to those most in need. Subsidising this sector with tax or aid dollars cannot be justified.

At the same time, **governments** must make an effort to improve the standards of the enormous number of informal private health-care providers including through training and public education. But the task is enormous, and experiences from more successful countries suggest the most effective way to regulate is to invest in scaling-up free public provision using competition to drive up quality. In the Indian state of Kerala the quality of the public hospitals, whilst far from perfect, still appears to put an effective quality 'floor' under the health services provided by the private sector. Any direct attempts to improve the performance of the myriad informal providers

must therefore always be in addition to the longer-term more sustainable strategy to scale-up and strengthen the public health system as the main provider.

The available evidence should not be used to mask the scale of the challenge facing public health systems. Nor does the evidence suggest there can be no role for the private sector – it will continue to exist in many different forms and involves both costs that must be eliminated or controlled and potential benefits that need to be better understood and capitalised upon. But where the evidence is indisputable is that to achieve universal and equitable access to health care, the public sector must be made to work as the majority provider. Governments and rich country donors must act now to bring real change and prioritise the rapid scaling-up of free public health care for all.

Recommendations

For donors

- Rapidly increase funding for the expansion of free universal public health-care provision in low-income countries, including through the International Health Partnership. Ensure that aid is co-ordinated, predictable, and long-term, and where possible, is provided as health sector or general budget support.
- Support research into successes in scaling-up public provision, and share these lessons with governments.
- Consider the evidence and risks, instead of promoting and diverting aid money to unproven and risky policies based on introducing market reforms to public health systems and scaling-up private provision of health care.
- Support developing-country governments to strengthen their capacity to regulate existing private health-care providers.

For developing-country governments

- Resist donor pressure to implement unproven and unworkable market reforms to public health systems and an expansion of private-sector health-service delivery.
- Put resources and expertise into evidence-based strategies to expand public provision of primary and secondary services, including spending at least 15 per cent of government budgets on health, and removing user fees.
- Ensure citizen representation and oversight in planning, budget processes, and monitoring public health-care delivery.
- Work collaboratively with civil society to maximise access and improve quality of public health-care provision.
- Strive to regulate private for-profit health-care providers to ensure their positive contribution and minimise their risks to public health.
- Exclude health care from bilateral, regional or international trade and investment agreements, including the General Agreement on Trade in Services negotiations in the World Trade Organisation (WTO).

For civil society

- Act together to hold governments to account by engaging in policy development, monitoring health spending and service delivery, and exposing corruption.
- Resist pressure to commercialise operations and call on rich country donors and government to strengthen universal public health services.
- Ensure health services provided by CSOs complement and support the expansion of public health systems, including by signing on to the NGO Code of Conduct for Health Systems Strengthening.

This executive summary is drawn from Oxfam International's Briefing Paper No. 125, *Blind Optimism: Challenging the myths about private health care in poor countries* (February 2009). It was written by Anna Marriott with the support of many colleagues and external advisers. The text of the full paper can be downloaded from: www.oxfam.org

Oxfam International is a confederation of thirteen organizations working together in more than 100 countries to find lasting solutions to poverty and injustice. Visit www.oxfam.org for more information.