

Oxfam's response to World Bank critique of 'Blind Optimism' **10 March 2009**

World Bank

Oxfam's Briefing Paper No. 125 "Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries"¹ argues that "international donors are promoting an expansion of private-sector health care delivery" to meet global health goals and sharply criticizes the conceptual and practical arguments for working more with the private sector. Oxfam argues that "the evidence is indisputable... that to achieve universal and equitable access to decent health care ... the public sector must be made to work as the main provider. There is no short cut and no other way." In several important respects, this paper misrepresents the evidence on private health care in poor countries and the work of donors, including the World Bank, and draws conclusions more reflective of dogma than science. The following are some key points of disagreement.

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Oxfam's Briefing Paper No. 125, "Blind Optimism" was written with many contributions from academics across the world and was reviewed by a number of different actors who both sympathized and disagreed with the stance we are taking. The evidence comes from Demographic Health Surveys; from peer-reviewed literature; from academics in research institutes globally; from our partner organizations; and from reports published by the World Bank, the World Health Organization and donor agencies. In particular it draws heavily on the work of the WHO's Commission on Social Determinants of Health, which concluded that reforms driven by international agencies and commercial actors that introduce market behavior into public health systems and encourage a greater role for the private sector have further undermined the performance and ability of public health systems to redress inequity. Above all the message of Oxfam's paper is to call on the World Bank and other donors supportive of private provision to return to the evidence and themselves step away from 'conclusions more reflective of dogma than science'.

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1. [Oxfam states \(p.2\) "For over two decades the World Bank advocated a solution based on investment and growth of the private health-care sector."](#)

World Bank lending and non-lending work in the health sector is overwhelmingly focused on strengthening public sector health delivery. Lending is almost entirely to governments. The World Bank has repeatedly

¹ <http://www.oxfam.org/en/policy/bp125-blind-optimism>

argued that, given the large presence of non-state actors in health, more could and should be done to leverage their potential contributions. This does not necessarily mean “growth” of the private health-care sector. Indeed in many countries the private sector in health may be too large, or parts of it that have poor quality, inefficiency, or impose a high payment burden may be too large. Improving the private sector can have a variety of different elements

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Oxfam welcomes the World Bank recognition that in many countries the private sector in health may be too large, that scaling up ‘does not necessarily mean “growth” of the private health care sector, and that ‘parts of it [the private sector] have poor quality, inefficiency, or impose a high payment burden that may be too large.’ This is exactly the kind of reasonable assessment of private provision that has been lacking to date, and that our paper calls for. Whilst criticism of the public sector is elaborate and detailed, our research identified no realistic assessments of both the positives and the negatives of private provision by the World Bank or any other major donor. This makes a proper assessment based on evidence difficult. As our paper demonstrates, the reality of private care in developing countries is that it is often either inaccessible to the poorest due to its prohibitive costs, or is of such a poor quality as to be in many instances dangerous to health.

Oxfam recognizes that the World Bank does indeed contribute to public sector health delivery through lending and non-lending (technical advice) to governments, and that World Bank health lending is predominantly through the public sector. Indeed the conditions and technical advice attached to lending to governments gives the World Bank its unrivalled position in shaping the development policy of developing country governments in ways that have sometimes been damaging. The introduction of health user fees in many instances, the systematic disinvestments in public services in favor of economic adjustment and debt servicing, and the hugely inefficient proliferation of vertical disease specific initiatives at the expense of investment in primary health and health systems have resulted in part from this influence.

The fact that most World Bank lending goes through the public sector does not mean that it is not used to promote private provision. In fact, as we outline in the paper, much of this lending and ‘non-lending’ (technical advice) is increasingly also being used to promote an approach which seeks to separate out the purchaser and provider roles, looking to the state increasingly as only a regulator and steward of the health sector while contracting out services to private providers. In this approach, World Bank lending to governments is used to encourage governments themselves to contract out provision to private providers. Our view is that this is a risky and largely unproven way to organize health systems and public services in developing countries, is not supported by the evidence, and can prove a dangerous distraction from the urgent need to scale up quality public provision.

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2. Oxfam states (p.2) "...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."

We agree that most high health-performing developing countries have strong public sector delivery systems. However, we know of none that rely "solely" on tax-funded public delivery and are not sure what "predominantly" means. But we question the implied causality and the conclusions. Does tax-funded public delivery cause a country to become high performing, or are those countries with better governance able to make public sector health care delivery systems work (as well as other systems)? We believe the latter is the correct conclusion and note that the number of developing countries able to do so is small and that there are far more examples of developing countries where public systems still do not give satisfactory results despite decades of investment in such systems, often strongly supported by the World Bank and other donors.

What then is the guidance for donors and countries with poor governance in the public sector? Should they focus exclusively on tax-funded public delivery and hope for the best? Or should they seek more pragmatic approaches that build on what is available and what works in both the government and non-government sector to expand access and quality? Clearly we feel the latter is the right strategy. It is also worth noting as well that very few high performing developed countries rely solely or even primarily on government delivered services. (In the U.K. for example, GPs are not civil servants but private contractors to the NHS and hospitals are mainly non-profit trusts. Other rich countries have a wide mix of government and private roles in service delivery.) Why then be so dogmatic in prescribing only this approach for developing countries?

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Oxfam welcomes the recognition by the World Bank that 'most high health- performing developing countries have strong public sector delivery systems'. Our starting point in developing the paper was predominantly empirical; a survey of those countries that have been successful, and an analysis of the policies they have chosen to pursue.

Oxfam agrees with the World Bank that good governance and political commitment are indeed an essential pre-requisite for delivering health care to the entire population of any country. Part of our work in over 100 countries around the world is supporting vocal citizen and civil society action to demand better governance.

However, the evidence is that good governance is not enough to fully explain the success of high health-performing developing countries.

The policies they have chosen to pursue in health also make a major difference. It is reasonable to suggest that given that most of them have chosen substantial public delivery of health services, that this method has the best chance of working in other developing countries. This does not mean that those countries have no private sector – they all do, and in many cases the private sector is comparably as large as neighboring countries without strong public services. The difference is that those countries with strong and sustained investment in public provision are successfully delivering services for poor people, while those that don't are not. The fact that no successful developing country has chosen to rely predominantly on private provision instead of public provision certainly would suggest that the burden of proof lies very much with those who are advocating this route.

Oxfam is clear that many developing countries have not managed to deliver the success of the few that have. However, where we differ from the World Bank is that we do not feel that this means that there is some inherent or intractable weakness in public provision in these countries that means the private route is preferable. The evidence does not show that the public route has failed, 'despite decades of investment', leaving no choice but to pursue private provision instead. Instead the public sector in many poor countries has been decimated by years of under-investment and sapping of government revenues through debt servicing and low levels of very poor quality aid. This was compounded by pressure to adopt now largely discredited policies such as the imposition of user fees (fees that remain in place in the majority of poor countries).

None of this is to suggest that working with the public sector is not without many problems in developing countries, or that these services are not in a terrible state in many instances. Neither do we suggest anywhere in our paper that donors and governments should 'focus exclusively on public delivery' - this is an inaccurate representation. But as the increasing number of successful sector-wide approaches and initiatives such as the International Health Partnership show, it is possible in a wide variety of developing countries to get behind one government plan to expand access to health, and that the opportunities for scaling up quality free public provision are greater now than they have been for many years. It is for this reason we have released this paper now, to encourage donors to support the policies that have the best chance of working for a successful scaling up of health care in developing countries.

World Bank

3. [Oxfam's arguments about the not-for-profit private sector](#) ("civil society providers") are inconsistent and confused. Oxfam praises CSOs for "not being motivated by profit" and for being "a lifeline for many." Yet Oxfam criticizes evidence from recent impact evaluations that CSOs sometimes provide better access and quality at lower cost than government services.

This growing body of evidence that governments can effectively contract out services to improve results is largely dismissed and we believe Oxfam ignores high quality evidence to reach this conclusion. According to Oxfam “CSOs must only ever be a complement to and not an alternative to, public health systems.” We are unsure what Oxfam means by this. If it means that public and private (including non-profit) provision should co-exist in systems – we agree. But if it means that CSOs can only provide services as an adjunct to in-place public sector delivery capacity, we disagree. Experience shows that CSOs have enabled governments to finance alternative strategies of service delivery where governments themselves may be unable to deliver services. Most of the relatively modest financing from the World Bank for working with private providers has been of this type (not primarily support the private for profit sector as Oxfam implies) – assisting governments to contract out service delivery to accelerate health gains when government provision has not been able to meet the needs – and we anticipate doing more of this. Governments often recognize the advantages of this approach of using non-government providers as an alternative vehicle of health care delivery.

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Oxfam is clear that non-profit or civil society providers are a lifeline for millions of people and are not subject to many of the market failures that disadvantage for-profit providers. But we also recognize that performance, capacity and cost-effectiveness vary across civil society organizations. In some countries the rapid growth of NGOs providing services has undermined the co-ordination of the health care system and has left some regions without any services at all. Non-profit organizations can still compete with the government for already limited numbers of health workers. That is why we are encouraging non-profit health care providers to sign up to the NGO Code of Conduct for Health Systems Strengthening to ensure their services do not undermine but support government health care provision. Existing non-profit provision where appropriate should be integrated into the national health system to ensure co-ordination and avoid duplication.

We do not agree with the World Bank that the evidence on contracting out provision to private providers is of a high quality. In fact we have very serious concerns about the quality and reliability of the data, especially in countries such as Cambodia and Bangladesh, and the way some World Bank advisors have used this data to promote contracting elsewhere. There are no fair comparisons we have found where donor agencies and government dedicate the same level of expertise and resources to strengthen public provision as compared to contracted private provision. Existing World Bank research has also avoided calculating the significant transaction costs associated with contracting. There is a need for more transparency in the analysis. Furthermore, any attempts to simply apply the findings of contracting with non-profit providers to promote contracting with very differently motivated and resourced for-profit providers is a serious mistake.

The World Bank's focus on contracting is to the detriment of exploring other ways in which not-for-profit organizations can support and expand health care provision. In Timor-Leste for example, NGOs played a critical but temporary role in rehabilitating the public health system and working in partnership with the government to build its capacity to manage and deliver services itself. The World Bank played a leading role in co-ordinating donors in support of this successful approach, and it would be great if this could be disseminated more widely.

World Bank

4. [Oxfam emphasizes a polemic approach to the insufficient and highly mixed evidence about the performance of both the public and private sectors, emphasizing only mainly negative findings about the private sector.](#)

We feel that overall the evidence is inadequate for such strong generalizations. Evidence on quality in general and evidence that properly compares public and private sector providers is particularly lacking. Rather than sterile and inadequate debates about which system is better, we prefer a more pragmatic approach especially in countries with weak public sector systems. We need to gain more understanding not only of how different strategies for service delivery perform but of why they perform the way they do and the relative benefits and costs of different strategies for increasing effective coverage with priority services. If working with the private sector will improve outcomes more than dogmatic strategies to expand poorly performing public sector delivery, we think it merits support.

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Oxfam welcomes the fact that the World Bank recognizes that 'evidence on quality in general and evidence that properly compares public and private sector providers is particularly lacking'. It is for this reason that we researched and wrote this paper, and hope that it will contribute to the process of addressing this research deficit and enable a much more evidence based debate.

The World Bank itself has contributed to this research gap. Research by the World Bank into the failures of the public sector, for example into its capture by the middle classes, or absenteeism of nurses and doctors, has been elaborate and detailed. At the same time documentation or analysis by the World Bank or any other donor of public sector success stories and of private sector failings is sorely lacking, as are comparative studies. Until we see this evidence deficit addressed, we believe that a truly 'pragmatic' approach is not possible, and any pretence to pragmatism is unfairly biased against public provision. Given finite resources, the risk of pursuing the wrong policies in this evidence vacuum is deeply concerning. We look forward to the World Bank working with others to address this research deficit rapidly in the coming period, so that the debate can be more evidence based.

World Bank

5. **Oxfam argues that the public sector is the key to equity in access to health care.**

However there is very mixed evidence about the equity performance of the public and private sectors. Recent work by the World Bank in its “Reaching the Poor” program, including extensive analysis of the Demographic and Health Surveys, shows a large disparity between the poor and the better-off in coverage with priority services including from public sources. For a number of priority health problems – treatment of children’s acute infections for example, private providers may deliver a larger share than public in reaching the poor. Public sector services may be captured by the non-poor and private providers may be the main source of service to the poor where public systems fail. This does not mean there are not significant problems with private provision. We feel it is useful to think in terms of both access and quality and ask whether creating new access (say to public provision) is necessarily or always better than improving quality of existing access (say to non-government provision).

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The issue of equity of access is addressed in our paper at length, and also extensively by the IMF and in the recent report on the Social Determinants of Health. The IMF is clear that even in situations where the middle classes capture more of the benefits of health provision, the fact that they pay more taxes means that the overall impact on society in most instances is still to increase equity. In the majority of developing countries public health care still has to be paid for and user fees are still in place; it is no real surprise then that the better-off capture more of the services available. This is why Oxfam, along with many others is calling for the World Bank to help eliminate user fees in all developing countries.

Oxfam’s paper does not suggest that there should be no attempt to make private provision work better for the poor. In Malawi for example, we support the negotiation of agreements between governments and mission hospitals to make their services free. We support pragmatic approaches that build on equitable foundations. We also think that regulating and organizing the multiplicity of private providers is in many instances a Herculean task that even developed country governments struggle with.

At the same time the rapid expansion of public provision is not even being discussed in most country contexts. This is despite empirical cross-country evidence from Asia that equity in health care access is determined by what the government does or doesn’t finance and deliver, whilst the role of the private sector has negligible impact. We need to urgently redress the balance of emphasis if we are going to successfully scale up, and that is the main message of this paper.

World Bank

6. [Oxfam raises some difficult questions about the role of the private formal and informal sector providers and specifically criticizes the recently established AMFm.](#)

As in other places in the paper, Oxfam holds to the idealistic notion of free, universal, and good quality public provision and capable government regulation as the remedy to the problems of pluralistic health care delivery and lack of quality control in the non-government sector. Unfortunately, the evidence to assure us about the feasibility of this remedy in many countries is not there. Despite free public provision, people, including the poor, in many settings use a mix of government and non-government health care providers. Specifically with regard to artemisinin, our last effective drug against malaria, should we wager its efficacy solely on the hope that public systems will be effective and preferred in many difficult settings? Or should we seek a range of strategies to try to sustain effectiveness?

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Our paper does not shy away from the many difficulties and problems with public provision in many developing countries. However, there is already a substantial and detailed body of evidence detailing public sector failings, but almost no assessment of the public sector successes that we identify in our paper, or what can be learned from them. At the same time there is virtually no research undertaken by the World Bank or others looking at the failings of private provision, or a realistic assessment of the ability of governments to regulate or control private providers. In our paper we have tried to redress this balance, by looking in more detail at the available evidence in favor of private provision.

Regarding the AMFm (the proposed scheme to subsidize private provision of Malaria drugs), we are particularly worried about repeating the mistakes of the past, where over and under-prescriptions of Chloroquine led to widespread drug resistance. Already resistance to Artemisinin has been found in Cambodia. Given this is, as you rightly point out, 'the last effective drug we have against Malaria', risking its distribution by unqualified shop-keepers with minimal safeguards we feel is a mistake. The AMFm also ignores research by organizations such as Médecins Sans Frontières showing how subsidization of Artemisinin is not enough to significantly increase access to treatment for the poor. Their direct experience in countries across Africa has shown that it is only when completely free care (medicines, consultations and other related costs) was introduced that access rates dramatically increased.

This does not mean the private sector should have no role in the provision of this medicine, particularly the faith sector and not-for-profits, in the same way the public and private sectors are working closely together to enable access to ART for those with HIV. However, once again we feel the option of strengthening public sector channels

of delivery, including the use of community health workers and mobile clinics is being neglected in the rush to pursue private sector strategies, in this instance as a result of research that is weak.

World Bank

7. [The informal private health care providers pose some particularly difficult problems.](#)

They are widespread, easily accessible, and popular. They are often of very poor quality. We think they have a role to play, but more evidence is needed on how to help governments work with them to improve access, quality, and coverage.

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Oxfam remains concerned that the World Bank retains such an upbeat assessment of the informal private sector, especially in contrast to its damning assessments of public provision. The informal private sector, is too often a shop-keeper, selling out-of-date drugs or an otherwise unqualified individual. Too many informal private providers are a danger to public health in too many instances and cause untold misery to millions with false diagnosis and mistreatment every day.

This does not mean that regulating or working with these providers is impossible, but there is no doubt that it is an enormous task, and should be realistically weighed up with the costs of expanded public provision, and the competitive pressure this will put on private providers to improve their standards, as has been the case in countries such as Sri Lanka. Improving the standards of the informal private sector will also necessarily involve limiting services to only those that can be delivered safely by unqualified practitioners. Informal sector interventions therefore cannot substitute for building and expanding comprehensive primary health care provision backed by an effective referral system for more complex treatment and care. This is critical if we are to reverse the appalling progress made to date on reducing maternal mortality rates.

World Bank

8. [Oxfam states \(p. 27\) “The World Bank and IMF, as well as some rich country donors have, through their aid and policy prescriptions, significantly hampered the ability of government to provide health for all” and that “ ...failed policies, were a significant cause of government failure to deliver in recent decades.”](#)

We are at a moment of increasing and unprecedented consensus amongst partners in global health about how to accelerate health gains towards achieving the MDGs. We doubt that the Oxfam paper, with its weak analysis, is a helpful contribution.

Oxfam

Oxfam would agree with the World Bank that there is indeed an unprecedented consensus amongst partners in global health about the need to scale up services fast to meet the MDGs. We would also agree that there is consensus on a number of policy areas, for example the need to invest in health systems and rationalise the hugely inefficient and Byzantine proliferation of vertical health initiatives. However, there are also very fundamental differences of opinion as to what policies will work best to rapidly scale up health in developing countries, both in terms of financing and in terms of provision. Private financing and private provision have not been scrutinised or researched nearly enough to warrant the level of support they receive.

With countries as diverse as the US and China planning significant scaling up of public financing and provision in health, and a fundamental recognition globally of the failure of the market in delivering equity, there is a need for the World Bank to move with the times. Given finite resources and a worsening economic picture we cannot afford to waste a single dollar pursuing policies that are risky and largely unproven. Instead we need advice and support on policies that have a track record of success at reaching poor people with systems that work for all.