id21 health insights

research findings for development policymakers and practitioners

March 2009 issue 76

In Sierra Leone, street vendors have a number of different medicines in stock (prescription and non-prescription) but many are not in their original box or are out of date
Rob Huibers, Panos Pictures, 2002

Making health markets work for poor people

People use a variety of market-based providers of health-related goods and services ranging from highly organised and regulated hospitals and specialist doctors to informal health workers and drug sellers operating outside the legal framework. Many encounters with health workers and suppliers of pharmaceuticals involve a cash payment.

The boundary between public and private sectors is often very porous, with people either paying government health workers informally or consulting them outside their official hours. Unregulated markets, in particular, raise problems with safety, efficacy and cost. This issue of *id21 insights* explores some of the responses to these problems.

Almost everyone agrees that governments are responsible for making markets perform better, particularly in meeting the needs of poor people. However, serious weaknesses in public sector management and in governance arrangements have contributed to problems with safety, efficacy and cost, and the same factors affect efforts to strengthen regulation.

Successful strategies for constructing more effective regulation increasingly involve partnerships between government, civil society organisations and the private sector. Health sector initiatives can learn from experience in managing other types of market relationships, while taking the special characteristics of health into account.

A growing body of research and experience is addressing ways to improve the performance of markets that poor people use. One example is the 'markets for the poor' approach. This Asian Development Bank and DFID-funded regional technical assistance project has carried out research on the relationship between providers and users of goods and services in a number of sectors. → p2

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Barbara McPake, a health economist specialising in health policy and health systems research, provided academic advice for this issue of *id21 insights*. She is Director of the Institute of International Health and Development, Queen Margaret University, Edinburgh.

The evidence demonstrates the influence of both formal and informal rules on this relationship and the multiple agencies that undertake supporting functions.

Strategies for change thus need to go beyond improving the management of a single organisation or intervention to include measures that consider the diversity of contexts and how to influence them. They also need to acknowledge the importance of conflicts of interest and the degree to which power relationships influence the organisation and functioning of markets. For example, many health-related markets are segmented, with well-regulated components used mostly by the better off and un-regulated ones used by poor people.

An important aspect of the relationship between health providers and users is the transfer of the benefits of medical expert knowledge to the latter. As in other specialised sectors, this transaction is characterised by varying degrees of asymmetry of information and a consequent imbalance in power, which possessors of expertise can use to their advantage.

Societies have mechanisms to address this problem through a combination of regulation by the state, different forms of self-regulation and organisations that build and maintain a reputation for competent and ethical behaviour. The relevant organisations include the regulatory arms of central and local government, professional and trade associations, large service provision organisations and civil society organisations and consumer associations. Different configurations for managing information asymmetries are likely to emerge to manage poorly regulated health markets.

In the health sector, there is consensus on the desirability of governments using public funds and their regulatory powers to ensure access to certain services as a right. This can take the form of insurance and/or government subsidies for services used by poor people. In highly marketised health systems, one of the most pressing issues for equity is "who pays".

This issue of *id21 insights* addresses different aspects of the characteristics of the markets for health-related goods and services and emerging approaches for improving their performance. **Wim van Damme** and **Kristof Decoster** show how the growing burden of chronic disease is creating new needs and new markets for health-related goods and services.

Dominic Montagu and **Richard Lowe** discuss the factors behind the development of retail pharmacy chains and the potential role of this kind of private sector arrangement for exerting positive influence over quality and price. **Arunesh Singh** shows how a social entrepreneur has developed a simple model for making eyeglasses widely available to people in India, raising interesting questions about possibilities for adapting the model to other countries and other health-related problems. **Rowen Aziz**, **Meenakshi Gautham**, **Oladimeji Oladepo** and **Kate Hawkins** discuss examples of strategies from Bangladesh, India and Nigeria to improve provider performance, including the potential roles of associations of providers and citizen groups for health monitoring on the performance of informal providers of health services.

Henry Lucas highlights the opportunities and challenges associated with developments in information and communication technologies and the proliferation of channels of information and organisations producing health-related content. He suggests that the growing access to expert knowledge creates the possibility of major changes to the existing provider-patient paradigm. Finally, **Gina Lagomarsino** and **Sapna Singh Kundra** explore how health insurance can catalyse improvements in provider behaviour by establishing a secure source of funding and exercising the powers associated with strategic purchasing.

These articles focus on the influence of civil society and market arrangements on providers of health-related goods and services. These types of initiatives are more likely to be scaled up when complemented by strong political leadership and effective support from government systems.

Governments have a special responsibility for making markets perform better, particularly in meeting the needs of poor people

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Useful weblinks

Centre for Global Development Private Sector Advisory Facility
www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/psaf

Making Markets Work for the Poor Network
www.m4pnetwork.org

Private Health Care in Developing Countries
http://ps4h.org

Private Sector Partnerships for Better Health
www.psp-one.com/section/project

Private Sector Programme in Health
www.psp.ki.se

World Health Organization Working with the Non-State Sector
www.who.int/management/nss/en/index.html

World Bank Private Sector Development Blog
http://psdblog.worldbank.org/psdblog/healthcare

World Bank Knowledge Resources for Financial and Private Sector Development
http://rru.worldbank.org

Oxford Health Alliance Chronic Disease
www.oxha.org/initiatives/economics/chronic-disease-an-economic-perspective

Have your say

What do you think about this issue of *id21 insights*? Write, text or email us your views and comments.

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The consortium aims to ensure real health gains for poor people by addressing the design of developing country health systems and working closely with researchers, policymakers and innovators leading the transformation of health systems in their own countries. FHS is funded by the UK Department for International Development. See **www.futurehealthsystems.org**

Future Health Systems
Innovations for equity

Improving provider performance

Poor quality and high costs are associated with the informal provision of health care. New research in Bangladesh, India and Nigeria offers innovative strategies to improve performance.

Poor people often use informal providers for health care. In Bangladesh formally trained workers account for only five percent of providers. The private sector comprises around 180,000 informal providers practising as village doctors and/or drug vendors.

Over 70 percent of India's population is rural yet more than 70 percent of its medical professionals practice in the urban, affluent private sector or have migrated overseas. Fewer than 50,000 doctors work in rural primary and secondary health care facilities; health care is delivered mainly by under-trained staff, often referred to as rural medical practitioners or the informal private health sector.

In Nigeria, self-treatment of common illnesses using drugs purchased from patent medicine vendors (PMVs) is widespread and the most common source of malaria treatment in Nigeria (See Figure 1).

An International Centre for Diarrhoeal Disease Research, Bangladesh study found that villagers, social leaders, health care providers and drug vendors see village doctors as an essential source of health care. But there is concern about the quality of care: village doctors need up-to-date medical information and training opportunities. A new intervention is testing a manual and a training programme to improve informal providers' treatment of common illnesses. ICDDR, B is also creating a network of informal providers - Shaysthya Sena, or Health Force - whose members must adhere to agreed quality standards for:

- appropriateness of treatment
- reduction in prescriptions of harmful drugs
- timely and appropriate referrals.

Compliance will be monitored by a local health watch group, composed of members of the Shastya Sena network, government administration, civil society, peers and experts.

Recognising the potential of the informal sector, India's National Rural Health Mission and the Eleventh Plan Approach Paper have called for innovative partnerships with informal providers to improve quality of care at the frontline. First Care Health is a social enterprise with rural medical practitioners currently being piloted by the Indian Institute of Technology's Rural Technology and Business Incubator in Tamil Nadu. They have given rural practitioners computers and internet technology, distance learning and other support.

Pharmacy in Chakaria
Shahidul Hoque

Researchers from the University of Ibadan in Nigeria found that most PMVs would like stronger government regulation to reduce the availability of fake drugs, while nearly a quarter called for self-regulation through professional associations.

Over 90 percent of vendors thought it would be good to involve community members in monitoring the quality of drugs – a view echoed by government. The University of Ibadan is trying to increase consumer knowledge and expectations for consumer rights, including the creation of effective regulatory partnerships to ensure the quality and affordability of drug supplies. The university's research in Oyo State has drawn interest from the government which would like to strengthen the communication of drug policy and regulation to PMVs and understand the mechanisms by which they can work together to identify and remove substandard and counterfeit drugs from the market.

In India, health care in rural areas is delivered mainly by under-trained staff

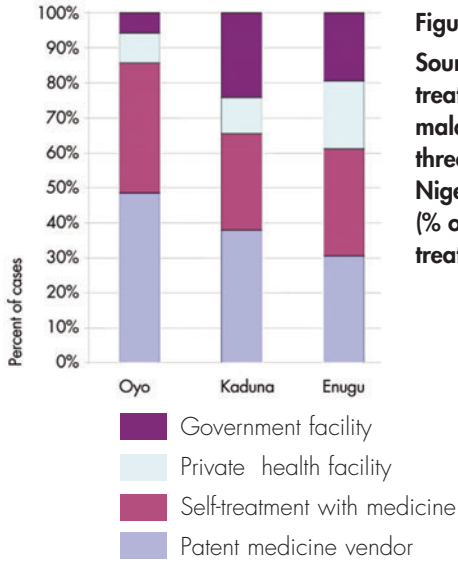

Figure 1
Sources of treatment for malaria in three states in Nigeria (% of first treatment)

All these interventions aim to understand better the potential benefits of linking informal providers, communities, knowledge brokers, researchers and policymakers. Possible outcomes include:

- more empowered informal providers
- better informed government actors
- more locally-devised and -owned educational tools
- stronger formal links between civil society, government and the informal sector.

Interventions and policies to strengthen health systems that fail to acknowledge informal providers as a potentially key source of services are less likely to succeed. Mechanisms will differ depending on context, capacity and technology. They will, however, provide evidence on the potential of non-state actors to improve access to quality health care.

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See also

Malaria Treatment in Nigeria: The Role of Patent Medicine Vendors, Future Health Systems Policy Brief, by O. Oladepo *et al*, March 2009
www.futurehealthsystems.org/docs/Policy%20Brief%20%20NIGERIA%20March08.pdf

Health Workforce in Bangladesh: Who Constitutes the Healthcare System? Bangladesh Health Watch, 2007
http://sph.bracu.ac.bd/publications/reports.bhw.htm

Health Seeking Behaviour in Chakaria, Future Health Systems Research Brief, ICDDR,B, 2008
www.futurehealthsystems.org/publications/policy%20briefs/Bangladeshinformalproviderbrief.pdf

First Care Health
www.firstcarehealth.in

Not Enough Here…Too Many There… Health Workforce in India, WHO Country Office for India, 2007
www.whoindia.org/LinkFiles/Human_Resources_Health_Workforce_in_India_-_Apr07.pdf

The benefits of health insurance

A catalyst to improve provider performance

Well-implemented public or private health insurance programmes create a platform for pooled strategic purchasing that can drive improvements in quality of care and increase availability of services for poor people (see Figure 2).

Health insurance can lessen some of the traditional problems of quality caused by market failures. Insurance programmes can:

- develop a network of preferred providers for insured patients to choose from
- proactively provide clinical protocols, training, and quality-assured products
- collect information and monitor the quality of providers in the network and, if quality is not up to standards, the insurer can withhold payments or remove the provider from its network—both strong incentives for performance.

Health insurance can also increase the availability of quality services for poor people. It provides a steady stream of revenues to providers, a major incentive for the entry and scale-up of organisations that can meet network quality standards set by health insurers. Steady revenue streams make health care businesses more attractive to investors, allowing them to attract capital for growth and investments that yield greater quality and efficiency.

Importantly, health insurance also provides a mechanism to funnel demand-side subsidies to poor people, which can encourage providers to serve poor populations and allow for more comprehensive benefits packages.

However, there are a number of hurdles to the successful implementation of health insurance in low-income countries, including:

- earning the trust of communities
- constructing benefits that are attractive to the population and aligned with the existing supply of services
- ensuring a quality delivery system
- pricing benefits soundly, within the constraints of customer affordability and available subsidies
- mitigating insurance-related risks, such as the tendency for only the sickest community members to enrol, driving up costs and deterring participation from the healthier people
- building institutional capacity to manage the administration of a scheme.

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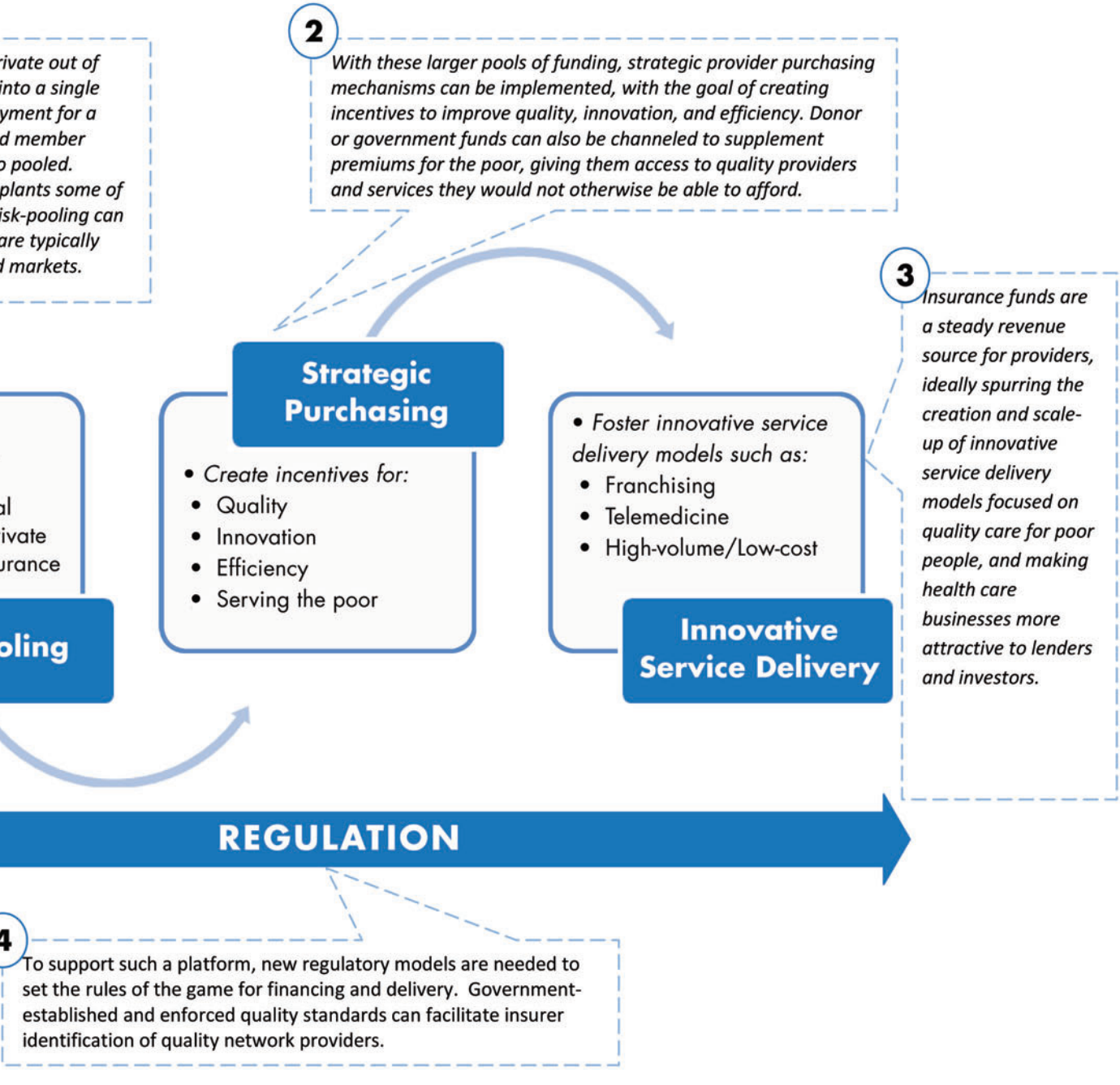
See also

Risk Pooling: Challenges and Opportunities, Results for Development Institute: Washington, DC, by Gina Lagomarsino and Sapna Singh Kundra, 2008
www.hifund.nl/library/documents/HIFCO_SAPNA.pdf

MicroInsurance Focus Resource Centre, CGAP Working Group on MicroInsurance, Microfinance Gateway
www.microfinancegateway.org/resource_centers/insurance

A traditional healer, or *curandeiro* in Maputo, Mozambique. *Curandeiros* are well respected, especially in rural areas where access to public hospitals is limited
Alfredo d'Amato, Panos Pictures, 2007

Figure 2 How health insurance can influence provider behaviour



The Hygeia Community Health Plan

There have been numerous attempts to implement health insurance in low-income countries. Many of these have failed to achieve the benefits theoretically available because of the hurdles identified above. However, one example of a programme that uses a number of strategies to improve care quality and availability for poor people is the Hygeia Community Health Plan. Hygeia incorporates risk-pooling, strategic purchasing and demand-side subsidies for poor people. With support from its partner organisations, the Dutch Health Insurance Fund and PharmAccess, Hygeia offers health coverage in Kwara State, Nigeria, providing care through a network of contracted private and public sector clinics and hospitals. Hygeia provides clinical protocols, training, and quality monitoring and directly funds the physical and information technology infrastructure of many facilities. Hygeia is able to offer a more comprehensive benefits package and ensures that providers serve poor patients by supplementing patient premiums with HIF funds.

Retail pharmacy chains

Setting standards for quality and price

Retail pharmacy chains and franchise networks have the potential to change the way drug markets work in low and middle-income countries, standardising quality, lowering prices, and increasing access to medicines for people across all income levels.

Most low and middle-income countries (LMICs) have pharmaceutical retail markets consisting of formal and informal independent retail outlets, but the emergence of chains or franchises is limited, due to both legislative barriers and a mix of secondary factors.

The experiences of India, South Africa and other countries suggests that where chain retailers do develop, the resulting standardisation and advantages of scale can lead to increased availability of services and lower prices for consumers.

More than 50 percent of total health expenditure in Africa, and more than 70 percent in Asia, comes from private sources; nearly all of this is out-of-pocket expenditure by individuals and households. The World Health Organization's 2004 World Medicine Situation Report found that between a quarter and a half of all out-of-pocket expenditure in LMICs is on medicine.

Of the countries in Africa and Asia studied by the University of California, San Francisco (UCSF), almost all have pharmacy markets which are exclusively made up of single outlet stores. The study used key informant interviews, secondary data, and analysis of published materials from a range of sources to document the current status of private sector retail pharmacy legislation and regulation in 25 LMICs.

In only two of the countries surveyed - South Africa and India - has there been recent growth in pharmacy chains and franchises over the past five years. In South Africa this consolidation appears to have been initiated by a change in legislation regulating ownership which was implemented in 2003.

In India the legal framework governing ownership changed earlier, and it appears that the availability of financing (mostly from private sources) and private companies' growth in confidence regarding regulatory intentions were the critical factors which led to multiple chains developing beginning around 2003/2004.

Nigeria, Uganda, and other countries with ownership laws which would theoretically permit chain and franchise creation have not seen similar market changes, despite growing demand for pharmaceuticals.

UCSF findings suggest that legislative restrictions on shared ownership or multi-outlet ownership is a barrier to retail market consolidation, as one would expect, but that this alone is unlikely to fully explain the level of consolidation. Access to financial inputs also appears to be critical: limited personal savings and weak capital markets leave potential entrepreneurs in Nigeria and elsewhere unable to raise funding which would permit them to expand successful pharmacies.

Whilst more research is needed, particularly from middle-income countries, this article suggests that facilitating consolidated ownership of retail pharmacies can lead to an overall increase in their number and distribution, and a decrease in retail prices.

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Where chain retailers do develop, the resulting standardisation and advantages of scale can lead to increased availability of services and lower prices for consumers

People relaxing outside a pharmacy in a shopping centre arcade in Trivandrum, Kerala, India
Qilai Shen, Panos Pictures, 2007

Limited evidence from South Africa and India suggests that where market consolidation has occurred it has resulted in an increase in pharmacy outlets and a decrease in consumer prices. Competition has led Indian independent pharmacist associations to explore group purchasing in order to be able to match the lowered prices.

In South Africa while some independent pharmacies have closed, the large supermarket chains have opened as many or more new pharmacy outlets within their existing groceries and accessibility appears to have increased.

See also

'Franchising of Health Services in Developing Countries', *Health Policy and Planning*, 17(2), pages 121-130, by Dominic Montagu, 2002
www.psp-one.com/files/1034_file_Franchising_of_Health_Servies_in_Developing_Countries.pdf

World Medicine Situation Report, World Health Organization: Geneva, 2004
www.cdf.sld.cu/World_Medicines_Situation.pdf

Life-long burden

Chronic disease, health markets and poverty

The rise of chronic diseases, such as diabetes or heart disease, is strongly related to ageing populations, increased smoking, less physical exercise, and increased consumption of processed and fatty foods.

Chronic diseases are complex and expensive for patients, households, and health care providers to manage. A mix of behaviour change, self-care and medical treatment is required. Diabetes, for example, requires a continuous balance in terms of diet, physical effort and medication.

However, health services in low-income countries are mainly designed to deal with problems facing mothers and young children, and with curable infections. Most health workers do not have the skills or resources to treat chronic illnesses.

Recent surveys by the POVILL Consortium in China and Cambodia show that dealing with chronic disease places a high financial burden on households. Much of household expenditure is spent on sub-standard or unnecessary care. Households pay mostly out-of-pocket, and frequently sell assets or take loans, often with high interest rates. Based on cost-effectiveness analysis alone it is easy to conclude that curative care for chronic diseases is not a priority, as long-term treatment tends to be expensive and relatively ineffective.

However, without intervention, the demand for the treatment of chronic diseases is escalating rapidly, especially in Asia and Latin America. Where government run-health services do not provide care for chronic diseases, private markets step in.

In Bangladesh, private pharmacies market lab tests and medicines for diabetes and other diseases. Accepting that chronic disease care is not cost-effective and consequently leaving it to unregulated health and credit markets, will continue to undermine the health of ageing populations, people's livelihoods and poverty reduction efforts.

However, some demand-side interventions, such as those to inform and empower patients and communities, seem to yield promising results. Indeed, the challenge of life-long coping with a chronic disease also creates new opportunities, for example through peer support and expert patients who become key decision-makers and advisers in their own and others' treatment. Many HIV and AIDS support networks around the world, including The AIDS Support Organisation (TASO) in Uganda, have led the way. MoPoTsyo, an NGO in Cambodia, provides advice and information on diabetes and other non-communicable diseases. To date it has trained 18 educators who support 800 patients.

Whilst these empowerment initiatives offer promising results, they need links with reliable, affordable medical services to be fully effective and sustainable. Much can be done to stimulate such provision, through appropriate incentives and regulation, including public financing. There is a need to explore which bundle of demand-side, supply-side and social protection initiatives have the greatest promise in which contexts.

Until solutions are found, the burden of chronic disease will continue to fall largely on households, local communities and societies.

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A medicine vendor selling pills and tablets in the market in Bangassou, Mbomou, Central African Republic
Juan Vrijdag, Panos Pictures, 2007

Chronic diseases are complex and expensive for patients, households, and health care providers to manage

Vision entrepreneurs

The packaging of health services as commodities to be distributed through the private sector has been used in the likes of family planning, the treatment of sexually transmitted disease and for insecticide-treated bednets. This approach aims to standardise and assure quality of care while minimising costs and creating incentives to providers to make cost-effective services available.

VisionSpring is an organisation which empowers local entrepreneurs to provide eye care services to poor rural communities, and creates a source of livelihoods for these individuals. VisionSpring launched its first pilot in India in 2001. Today it supports local entrepreneurs to provide eye care services to thousands of people in Africa, Latin America and South Asia.

VisionSpring's 'Business in a Bag' model features a sales kit containing the products and materials needed to market and sell eyeglasses. It also trains local people to conduct eye care marketing and awareness-raising campaigns; host one-day "vision campaigns" in underserved villages; sell a selection of affordable eyeglasses supplied by VisionSpring; and refer those in need of advanced eye care to partner clinics.

The 'Vision Entrepreneurs' model has proven to be sustainable and replicable. It is now being replicated in partnership with NGOs in other countries, including Nicaragua and Paraguay.

Key factors necessary for the success of the 'Vision Entrepreneurs' model are:

- The service provided does not rely heavily on clinical skill for diagnosis or management of treatment.
- The managerial staff and local people recruited to become Vision Entrepreneurs have the appropriate skills and profile required.
- An appropriate sales format was adopted through regular 'eye camps' in villages and door-to-door selling to convert pending sales or to follow up.

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The impact of ICTs on health care

There is growing consensus that the impact of information and communications technologies (ICTs) on health systems could be substantial or even revolutionary.

Though the precise nature of the impact is much more difficult to predict, it seems that the health sector will benefit from advances in mobile telephony and internet services. For example:

- Patients and informal providers in Bangladesh routinely seek advice from doctors supporting HealthLine, a subscriber service implemented by the Grameen mobile telephone company.
- Health information systems for HIV and AIDS services in Rwanda – including TRACNet, a mobile phone-based system that allows tracking the use of anti-AIDS drugs through text messaging – are widely regarded to have been improved by the introduction of data transfer via mobile phones and personal data assistants.
- Medical staff world-wide have many opportunities to update their skills through internet-based advice and training initiatives. For example, Moorfields Eye Hospital in London provides an internet-based consultancy service for ophthalmology patients in a number of African countries.

More speculative issues arise for innovations that might shift the existing provider-patient paradigm. Take the use of 'expert-systems' (software using databases of 'best-practice' clinical protocols) to guide diagnosis, recommend treatment and monitor implementation. This was recently piloted by a chain of private clinics in South Africa and a pharmacy franchise in Mexico (a 'social-entrepreneur' - a private company aiming to be economically successful and to improve social welfare). It could transform existing power relations within the health sector by circumscribing the behaviour of professional staff.

Private dentists advertise their skills in Karachi, Pakistan
Piers Benatar, Panos Pictures 2002

Where patients struggle to find competent and honest providers either in the public or private sectors, new types of institutions, able to demonstrate that ICT-based 'self-regulatory' mechanisms can deliver quality care at reasonable cost, may prove attractive.

ICTs could also transform informal regulation by providing people with the knowledge they require to challenge existing practices and make more rational health care choices. Communications networks that allow those facing health problems to share information, identify trustworthy providers, seek advice or campaign for improved treatment are central to such forms of empowerment. As clearly evidenced by those organisations campaigning for better care for those with HIV and AIDS, such as the World AIDS Campaign, ICTs can extend these networks beyond family, community and national boundaries.

Medical staff worldwide have many opportunities to update their skills through internet-based advice and training initiatives

These developments may prove beneficial for many but it would be naïve to ignore the risks. Becoming a 'trusted intermediary' in one of these networks, able to mediate debates and influence activities, could provide an attractive power base for those wishing to use them to gain financial advantage, prestige or support for their religious or other convictions.

Experience of the internet does not encourage us to believe that the most trustworthy individuals or institutions necessarily become the most popular or influential communicators. Even leaving aside such concerns, there would also seem to be an inherent risk of biasing the allocation of health resources towards the most high profile health conditions and advocates.

Those working on health systems have traditionally encouraged 'evidence-based planning and priority setting' in order to address both equity and efficiency concerns. A world in which multiple disease-specific networks, possibly funded by international drug companies, use ICTs to compete for the attention of governments, donor agencies and private enterprises, may undermine that approach.

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See also
The E-Health Connection, *Health Affairs*, 27 (6), pages 1665 to 1667, by Susan Dentzer, 2008
http://content.healthaffairs.org/cgi/content/full/27/6/1665

Keywords: Health markets, informal sector, health insurance, service delivery, disease, ICT, non-state providers

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