Future Health Systems
Innovations for equity

WORKING PAPER 8

Innovations to improve provider performance

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July 2009

www.futurehealthsystems.org

Preface

This report is part of a series of Future Health Systems working papers on health markets. The authors acknowledge the scientific support extended by Future Health Systems: Innovations for Equity (a research program consortium of researchers from Johns Hopkins University Bloomberg School of Public Health, USA); IDS, UK; ICDDR,B, Bangladesh; Indian Institute of Health Management Research, India; Chinese Health Economics Institute, China; The Institute of Public Health, Makerere University, Uganda; and University of Ibadan, College of Medicine, Faculty of Public Health, Nigeria. www.futurehealthsystems.org

This report has also been published by the Results for Development Institute in October 2008 as part of the Rockefeller Foundation-sponsored initiative on the role of the private sector in health systems in developing countries. http://resultsfordevelopment.org/index.php

The authors express their appreciation for the financial support provided by the UK Department for International Development (DFID) for the Future Health Systems research program consortium. This document is a product of a project funded by DFID for the benefit of developing countries. The views expressed are not necessarily those of DFID.

Summary

This paper identifies innovations shown to affect the performance of providers in meeting the needs of the poor and likely to have a major impact on health-related markets in the future. The authors faced major challenges in putting this information together. There are no definitive inventories of innovations in health-related markets and there is relatively little scientific literature on the performance of these providers. Much activity takes place outside a formal regulatory structure and is not subject to reporting requirements. Some of the most populous countries are experiencing very rapid increases in the demand for goods and services and in the growth of local companies. It is difficult to obtain information on these companies and the strategies they are formulating to capture market shares. Finally, it is impossible to generalize about a wide spectrum of low- and middle-income countries which differ in almost every way.

Informal sector

This section builds on the review by Bloom and Standing (2001) of the growing role of unorganized markets in the provision of health-related services to the poor and the reviews[1] by Shah, Brieger, and Peters (2008) and Cross and MacGregor (2008) of current knowledge on informal providers. It is difficult to draw a boundary around these markets. Informal providers include traditional practitioners, relatively untrained sellers of drugs, and providers of medical services and categories of health worker who provide expert services in the public sector but are not entitled to private practice, such as nurses and midwives, in some countries.

Shah and colleagues (2008) undertook a systematic review of the published evidence on interventions to address problems with dangerous practices, ineffective treatment, and unnecessary costs. The analysis is not complete and the full findings will be presented in the final draft of this report. One striking finding is the small number (88) of distinct interventions on which evidence has been published over the past 15 year, of which 49 percent were in Africa. These interventions targeted a variety of providers, including commercial medicine vendors (30 percent), traditional birth attendants (26 percent), and community health workers (30 percent). The majority of the interventions were direct training (70 percent), and a small number employed other primary strategies such as supply provision, franchise creation, branding, regulation, and so forth. Many interventions combined training and other strategies. The review of the evidence

[1] These reviews were co-financed by the DFID-funded Future Health Systems Consortium, and three will be published as Future Health Systems Working Papers.

on the impact of these interventions is still under way and will be reported in the final draft of this report. Their preliminary conclusions are that training of lay health workers to play a role in the formal health system can be effective in extending access to health services. Also, measures to improve the knowledge of drug sellers can improve the quality of prescriptions. However, training alone seems not to be adequate to ensure appropriate use of drugs, if not combined with measures to design incentives that do not encourage overuse of inappropriate drugs.

Cross and Macgregor (2008) point out the wide variety of people offering health-related goods and services and the difficulty in defining who is an informal provider. They emphasize the degree to which they work within a social context that influences their relationship with clients. They also emphasize the need to understand their livelihood strategies and their need to attract and retain clients. They draw attention to the role of a variety of informal arrangements that influence the performance of informal providers, including associations. They point out that associations often play a dual role of excluding competitors and maximizing the benefits of members, as well as protecting the reputations of members. They also argue that the growth of markets for pharmaceuticals and the aggressive efforts of the manufacturers and distributors of these products to increase their markets strongly influence the performance of informal providers. Interventions aimed at influencing the performance of these providers that do not take these contextual factors into account are likely to have unintended consequences.

One particularly important area of concern is the interaction between the markets for health services and for pharmaceuticals. A study in Chakaria District in Bangladesh, for example, found dangerous use of certain drugs, ineffective treatment of many conditions, and substantial amounts of unnecessary drugs. The study explored a number of reasons for these outcomes. One important finding was the role of the wholesalers of drugs. The study team found that there had been a very large increase in the number of people selling drugs to informal providers. These people had powerful incentives to promote the use of expensive products and may have influenced prescription behavior. A similar study in Nigeria also emphasized the importance of the flows of information on appropriate use of drugs as well as the structure and incentives associated with the wholesale network.

Innovations in the organized sector

This section presents the findings of an inventory of innovations in the organized sector compiled by Claire Champion. It is largely based on several years of participating in networking meetings and undertaking field work with social entrepreneurs and international organizations that provide technical assistance to the private health sector, supplemented with information

from the Web sites of umbrella and implementing organizations.[2] Although every effort has been made to be comprehensive, the inventory is biased in favor of interventions supported by donor agencies, those inspired by developed country experiences and imported by developing markets, and models initiated by well-established local organizations. Those undertaken by private companies and local actors are likely to be greatly underrepresented. It is difficult to assess the relative importance of these different sources of institutional innovation.

The models presented in the inventory show common trends, but they differ greatly in their missions, forms, funding sources, and implementing mechanisms. It can be misleading to use an ideal-type categorization, such as "social franchising" adapted from advanced market economies, to describe an organizational arrangement in a very different context. We have tried to avoid misleading simplification.

Innovations are taking place at all levels of care from community-based services[3] to specialty hospital care.[4] Some organizations focus on one level of care and refer patients to the public or private sectors. Others provide two or more levels of care with referral mechanisms.[5] These organizations cover a large spectrum of health services. Some address family planning or HIV/AIDS and TB needs, whereas others offer a broader approach such as meeting essential drugs needs. Innovations have also taken place in the laboratories and diagnostic services industry.[6]

The self-defined mission of organizations include nonprofit, commercial, and faith-based. Whereas the commercial for-profit model has a clear mandate for financial sustainability, nonprofit status is not a clear indication of the mission or financial objectives of the organization. Some nonprofit organizations have introduced an up-front objective to reach financial sustainability within the first few years of their activities, and others anticipate a need for

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[2] The Nextbillion.net platform (www.nextbillion.net/blogs/topic/health) brings together social entrepreneurs, business leaders, NGOs, policymakers, and academics to exchange information about innovative business models. It has published a number of case studies in health. Dominic Montagu, of the Global Health Group at UCSF, has developed a list of private sector initiatives (www.ps4h.org/Private_Sector_Health/Resources.html). The IFC, in collaboration with the Gates Foundation, commissioned an overview of health care markets in Africa (IFC 2007). Ashoka is one of the leading networks of social entrepreneurs. Finally, USAID has funded PSP-One, a program for private sector development in health that focuses on reproductive health services (www.psp-one.com).

[3] E.g., Business for Health in Ghana, Living Goods in Uganda, Janani in India, or BRAC in Bangladesh.

[4] E.g., Aravind and Narayana Hrudayala in India.

[5] For example, ProSalud provides primary, secondary, and tertiary services to its patients, ranging from community outreach activities to services provided through their referral hospitals. The CFWshops franchise has two levels of care: the outlets run by a trained community health worker and the small clinics run by a nurse. Referral mechanisms have been put in place from the outlets to the clinics.

[6] E.g., Bio24 in Senegal and Radmed Diagnostic Center in Nigeria.

subsidies for a very long time.[7] Little is known about the degree to which different sources of finance affect the values and management of an organization.

There is a proliferation of bottom-up and commercial models in Asia. This is most likely due to the better entrepreneurship environment of the region as well as growing and recognized market opportunities. Africa seems to favor imported models such as franchises as well as faith-based initiatives. However, this is not the case in all countries (e.g., Nigeria or South Africa). In addition, the inventory might not provide adequate representation of volume and types of initiatives per country and per continent. One noticeable trend, however, is that most for-profit ventures target an urban market.[8] A few recent initiatives have tried to target rural areas with full cost-recovery targets,[9] but many recognize the challenge of working in rural areas because of lower population density and the higher cost of monitoring and controlling quality.

Innovations have a number of sources. Some are the results of local or international entrepreneurs spotting a commercial and social opportunity.[10] Existing companies have also looked into opportunities to extend their outreach to lower income populations and create their own distribution systems.[11] Some health franchising models are a direct extension of previous social marketing activities, in which a franchising agreement has been signed with distribution outlets to increase incentives for quality.[12] Other initiatives are the result of independent health providers looking at improving their work efficiency and quality and deciding to create their own association or network.[13] Lastly, the faith-based organizations provide services out of their religious mandate and fill the needs unmet by the public sector.

We identified three types of quality control mechanism: a mix of management incentives and strict monitoring, a contractual approach with a branded franchise, and an accreditation

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[7] This is the case, for example, for Business for Health, Living Goods, or CareShops. ProSalud has a cost recovery of 98 percent (Discussion with Carlos Cuellar, Abt Associates).

[8] E.g., Farmacias Similares pharmacies and ProSalud are located in poor neighborhoods in urban and peri-urban areas.

[9] Business for Health in Ghana, Living Goods in Uganda, and the Shatki entrepreneurs in India.

[10] The CFWshops franchise was started by the Health Store Foundation, funded by a U.S. lawyer.

[11] In India, Hindustan Liver Ltd. partnered with self-help groups to start a network of women entrepreneurs to distribute their products in rural areas. Farmacias Similares was set up by a generic drug manufacturer to expand sales coverage to low-income areas through quality services. The network now comprises 3,000 pharmacies throughout Mexico.

[12] This has led the Ghana Social Marketing Foundation, after years of successful family planning and social marketing activities, to create the CareShop franchise, a network of 270 licensed chemical sellers recruited. Population Services International (PSI) and Marie Stopes International started several franchise initiatives for the same reasons (e.g., PSI Top Réseau Network and PSI Sun Quality Health).

[13] K-MET started as an association of for-profit medical practitioners from peri-urban and rural areas in Kenya.

mechanism. In the accreditation model, quality control is outsourced to the local authority,[14] while franchises internalize quality control. Franchisees are motivated to abide by the law of the franchise so that they can remain part of the franchise and benefit from its advantages (e.g., brand recognition, quality and affordable drugs, training, and professional network). In some franchises, franchisees are allowed to provide additional services that do not fall under the franchise rules,[15] while in others the franchisees are only authorized to provide a limited list of services and products.[16] Other organizations use a mix of management incentives and strict monitoring and quality control activities. They set up standardized procedures and guidelines and create a strong corporate culture for quality improvement.[17]

Brand and reputation are generally of prime importance. The asymmetry of information between the providers and their patients creates the need for patients to base their decision on reputation and signs they can recognize. Many of the organizations have developed large marketing and community outreach activities in order to enhance trust between the patients and the organization.[18]

There is a lot of evidence of rapid institutional development in the pharmaceutical sector. Both China and India have large firms that are becoming important global suppliers of pharmaceutical products. The development of the wholesale and retail markets has been slower, and there are serious problems with cost and quality in both countries. One important development in India has been the rapid creation of retail pharmacy chains. A review for this report identified seven which have announced plans to establish 8,000 shops over the next few years. Most shops are in urban areas, but there are also plans to establish low-cost rural pharmacies. These chains have involved a number of different actors, including a large pharmaceutical manufacturer, a U.S.-based pharmacy franchise, a large hospital chain, and a network of rural shops. It is difficult to predict the ultimate alignments that might emerge between these actors, or how this will affect the quality of drugs supplied and the kind of advice provided on prescriptions. This raises important challenges concerning regulation and consumer

[14] An example of accreditation scheme is the ADDOShops initiative in Tanzania. Accreditation to the ADDOs network is granted to those who meet and keep predefined standards of quality.
[15] E.g., Greenstar and Blue Star.
[16] E.g., CFWshops and CareShops.
[17] The success factors of ProSalud and Aravind, for example, lie in their high-quality delivery system, including standardization and strict quality control.
[18] E.g., Aravind organizes community outreach activities to increase awareness about its services and build trust. PSI initiates media campaigns to promote its franchise brands. Farmacias Similares have built a strong image of quality around the person of Dr. Simi and his motto “Lo mismo pero más barato” (the same but cheaper).

information. It is conceivable that India will become an important source of institutional innovation in retail pharmacy.

Many of those innovations are still at a pilot stage. There is very little information on their performance. We reviewed the available evidence in peer-reviewed journals and grey literature identified through a search of PubMed, Popline, and Google and visits to Web sites of umbrella organizations. Most reports are of case studies. Although they do not provide formal and rigorous evaluations, they are an important source of information. We found a few general reviews of evidence on private for-profit sector interventions (HLSP 2004; Mills et al. 2002; Patouillard et al. 2007; Prata et al. 2005). Other reviews focus on family planning (WHO 2007; Peters et al. 2004; PSP-One 2006), accreditation and certification (Shawn 2001), or on faith-based organizations (Reinikka and Svensson 2003). All these reviews mention the lack of systematic evidence on impact and the need for rigorous evaluations. Most studies concern highly subsidized models such as social franchises and models that focus on family planning and reproductive health services. Three main outcomes have been studied: client satisfaction, quality of services, and access by the poor. The first has been assessed in the majority of the studies, but very few studies measure quality of services and access to the poor. We could not find any evaluation on population health outcome or on the macroeconomic impact of those innovations.

Franchising models have been found to increase clients' satisfaction and perceived quality and have tended to lead to an increase in service use (Agha et al. 2007; PSI 2007, Plautz et al. 2003; Stephensen et al. 2004). The few studies that explored objective measures of quality had mixed results. Impact varies within a same organization with important differences between locations and across services and chosen criteria to measure quality (PSI 2007; Prata et al. 2005). When Stephensen and colleagues (2004) assessed family franchises in India (Janani), Pakistan (Greenstar and Green Key), and Ethiopia (Biruh Tesfa, Ray of Hope), they found an increased volume of services but did not find any association with reproductive health outcome.

The very few studies that assess access by the poor show mixed results. A study by Montagu et al (2005) in Kenya concluded that the K-MET network did not increase inequalities in access to health services in rural areas. Hennink and Clements (2004) showed that even if the services are offered in poor neighborhoods in Pakistan, "users of the services are not the urban poor themselves but select sub-groups of the local population." Several papers outline the trade-off between serving the poor, offering quality services, and making a profit (PSP-One 2006;

Lonnroth 2007). Patouillard and colleagues (2007) emphasize the need to assess the impact of interventions on the poor.

A review of accreditation schemes by Shawn (2001) found that they seem to work well in middle- and high-income countries but have shown few results in low-income countries. However, an evaluation of a network of accredited drug dispensing outlets in Tanzania showed a major decrease in the availability of unregistered drugs in the intervention group, suggesting an increase in drug quality (Sigonda-Ndomondo et al. 2003).

Another strategy that builds on existing structures has been the efforts by associations of nurses or midwives in Central and Eastern Africa to enable their members to practice privately. In many of these countries, the nurses have established a powerful position in the public sector but have been excluded from private practice. More recently, these restrictions have been removed, but institutional arrangements to support their establishment of a practice and build their reputations are not well developed (Rolfe et al. 2008).

Another source of legitimacy in many countries is the many different faith communities. Reinikka and Svensson (2003) found that faith-based hospitals provided higher quality health services at a lower cost in Uganda. Studies have demonstrated the great importance of networks associated with a religious denomination in building trust in many parts of Africa. A variety of health-related initiatives have built on this social capital. One example is the community health insurance schemes that have been linked to a church hospital or the church hierarchy. Another is the reputation that church hospitals tend to have for competence and ethical behavior. In fact, studies have shown a considerable amount of variation in the performance of different church hospitals (Tibandebage and Mackintosh 2005), depending on local relationships. Nonetheless, it would appear that the identification of a hospital with a well-known religious denomination tends to enhance its reputation (Leonard 2002).

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