Health markets and future health systems: innovation for equity

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Many low- and low-middle income countries have pluralistic health systems, characterized by widespread and often highly segmented markets offering a diverse range of health-related goods and services[1,2,3]. Out-of-pocket payment for health care averages more than 50% of all health spending in these countries[4], with non-state providers, both private and not-for-profit, typically providing the majority of outpatient curative care[5,6]. If health services are to benefit the poor, it is essential to gain a detailed understanding of such markets that can both inform attitudes towards them and guide innovations that attempt to engage with them to improve health outcomes.

The spread of market relationships in the provision of health services has coincided with the growth of markets in other sectors. In some countries this has been associated with economic liberalization and economic growth. In others, its emergence is linked to economic decline and the failure of state-provided services to meet popular expectations. In many circumstances the spread of markets has been much faster than the capacity of the state and other key actors to establish regulatory arrangements to influence their performance. A large proportion of market transactions now take place outside a legal regulatory framework or in settings where regulatory regimes are poorly implemented, particularly for the poor. In addition, the boundaries between public and private sectors have become blurred. In many countries users routinely make informal payments for services or drugs at public facilities, or consult government health workers privately[7]. In others, public providers are officially encouraged to generate income in order to supplement often very limited government subsidies[8].

The marketization of health services has created both opportunities and challenges for poor people. They may have greater choice about where to seek drugs and medical advice, but cost is often a barrier to access. There are examples of excellent services but, as Das et al[9] document, the quality of services that both public and private health workers provide is often flawed, partly in response to perverse incentives. Such incentives also result in an emphasis on medical care at the expense of prevention and health promotion. It is widely recognized that both government and other intermediary organizations can play important roles in altering these incentives and improving the performance of these markets. There is less agreement on what those roles should be in different development contexts and how health systems can construct the institutional arrangements for them to play these roles effectively.

The spread of market relationships has advanced so far in many countries that official policies often have limited relevance to the realities that poor people face when coping with health problems. We propose an approach which explores the operation of health markets in order to help explain how health systems are changing, identify potential opportunities for intervention and innovation, and guide the design of monitoring systems that can track and learn from both the intended and unintended consequences of such innovations. We then examine different types of emerging innovations, and focus on two in Nigeria and Bangladesh.

Conceptual framework

This section describes an approach for analysing and understanding health markets in low- and middle-income countries. It draws on the framework for understanding markets that poor people use presented in a recent paper by Elliot et al[10] and summarized in Figure 1. The authors of that paper place at the centre the relationship between providers and consumers, that is in our case, the relationship between health service providers and patients. Those relationships are greatly influenced by a multi-dimensional and complex environment made of formal and informal rules and of agencies that undertake a number of supporting functions. Strategies for change need to take into account the diverse components of this context as well as ways to improve the management of a single organization or intervention. They also need to acknowledge the importance of conflicts of interest and the degree to which power relationships influence the organization and functioning of relevant markets. For example, many health-related markets are segmented, with well-regulated components used mostly by the better off and unregulated ones used by the poor[2].

An important aspect of the relationship between providers and patients concerns the transfer of the benefits of medical expert knowledge to the latter. This transaction is characterized by varying degrees of asymmetry of information

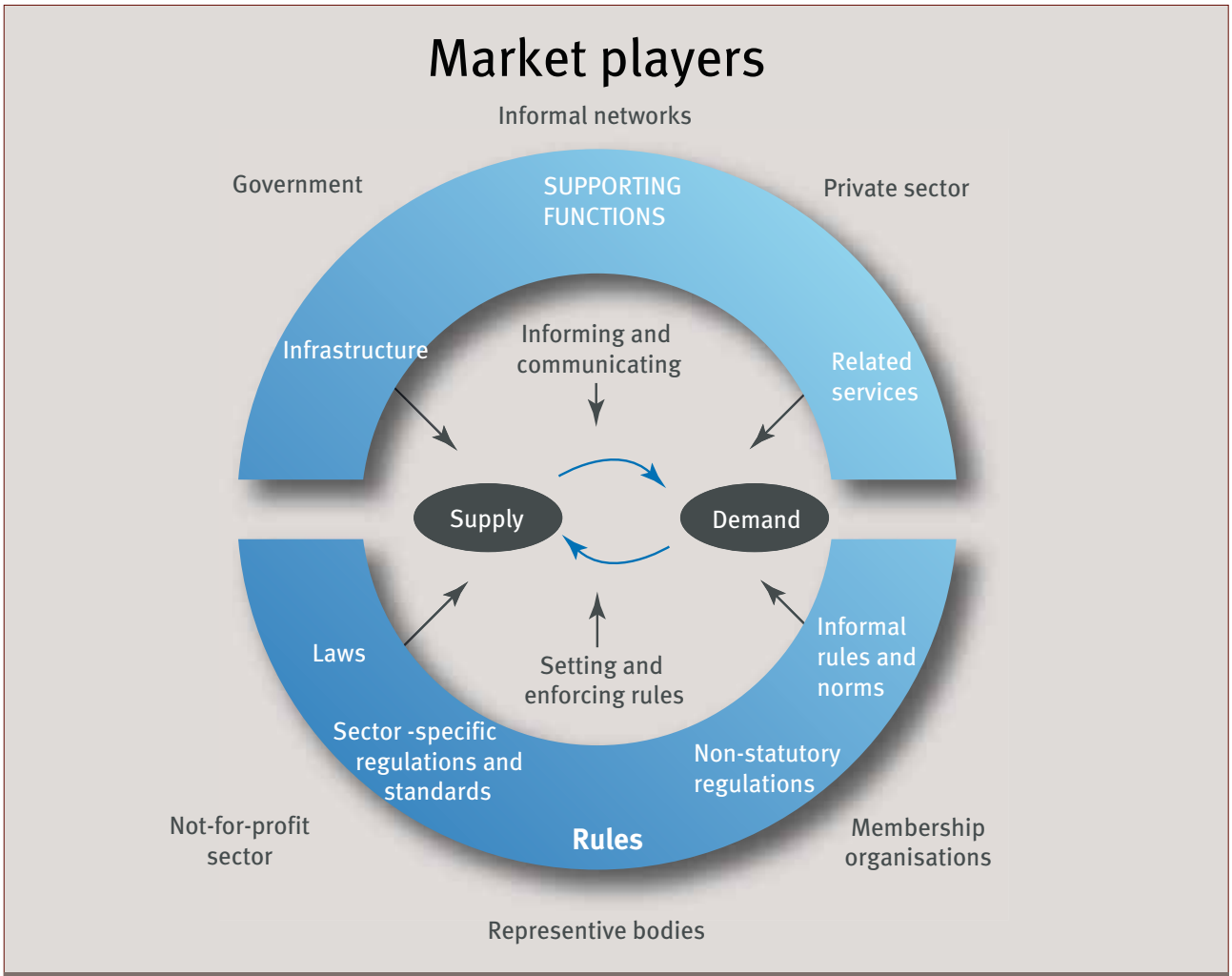

Figure 1: Conceptualizing market systems

and a consequent imbalance in power, which possessors of expertise can use to their advantage. Societies have evolved mechanisms to address this problem through a combination of regulation by the state, different forms of self-regulation and organizations that build and maintain a reputation for competent and ethical behaviour. The relevant actors include the regulatory arms of central and local government, professional and trade associations, large service provision organizations, and a variety of civil society organizations and consumer associations.

Current rules and regulations often do not take into account the importance and diversity of health markets in developing countries, and thus many actors operate outside a legal framework. Barriers to appropriate regulations are often linked to a lack of government capacity to enforce them or incentives to do so[11]. Many government regulatory agencies focus on the services used by the better off and shy away from attempts to regulate the informal sector which is of paramount importance for the poor. This has led to the emergence of a variety of partnerships between governments and other actors to co-produce rules and improve market performance[12, 13].

Where regulation is limited and information asymmetries are large, trust is a key dimension in the relationships between providers and consumers. Patients in low- and middle-income countries have shown a willingness to pay more for the services of providers whose competence they trust and many providers have adopted strategies to build and maintain a reputation for high expertise and ethics [14, 15, 16, 17]. Trust and reputation may be based on a variety of factors including directly experienced quality of services (e.g., availability of drugs, cleanliness, courteous staff), perceived status of providers (e.g., professional title, advertised qualifications and experience) and brand recognition (e.g., widely known franchise, accreditation or licensing authority). Less formal arrangements are often important at the community level, where providers operate within local trust networks. Word of mouth is an important medium for the establishment and maintenance of a facility's reputation[18].

Another important aspect of the performance of health-related markets relates to information flows. Providers and users of health services get information from many sources. In Bangladesh, for example, the primary source of information for informal providers is from sales representatives or wholesalers who are associated with generic manufacturers. Other sources include the diverse communications media that national and international advocacy groups, government agencies and commercial advertising agencies increasingly use to deliver messages to both providers and the general population. New

communication tools, such as mobile telephones and the Internet, are significantly increasing the options and capacity for information dissemination, even in some of the poorest countries. This increasing volume of circulating information creates an urgent need for trusted knowledge brokers.

Health market innovations in developing countries

Innovations aimed at improving health services have taken place in both informal and formal sectors. Those happening in organized markets have taken various forms, ranging from commercial models (mostly found in Asia and Latin America) to highly subsidized but market-oriented interventions such as the establishment of provider networks, social franchises or accreditation schemes (mainly run by nongovernmental organizations or faith-based organizations).

Notwithstanding the innovations described above, many health transactions involving poor people still take place in the informal sector, where there are minimal quality standards and no reporting requirements. To examine ways of addressing these constraints, two initiatives that involve partnerships between informal providers, policy-makers and the public to shape better health markets for the poor are discussed below.

In Bangladesh, informal providers (village doctors, medicine vendors) are the major source of health care for rural people. A recent formative study conducted in one southeastern sub-district (560 000 people) of Bangladesh by ICDDR,B found that 96% of health-care providers were informal including village doctors, traditional healers (*Kabiraj*), traditional birth attendants and spiritual healers. The study found many instances of inappropriate and even dangerous prescribing. The consortium has launched a three-pronged intervention of training informal providers, establishing an association of these providers to implement a degree of quality control and the involvement of the Bangladesh Health Watch in monitoring the performance of informal providers.

In Nigeria where malaria is a major cause of illness and death, most people depend on patent medicine vendors (PMVs) as a source of anti-malarial medication. PMVs operate in poorly markets. A scoping study by the School of Public Health at Ibadan University found that PMVs were the major source of malaria treatment (39%) followed by self-treatment (26%)[19]. It also indicated that PMVs often recommend inappropriate products that are inexpensive but also ineffective. In this complex and unregulated market environment, local PMV associations were identified as institutions with the potential to play an important role in providing information, influencing PMV behaviour, and procuring drugs. Also, a large proportion of PMVs (92%) said that community involvement in drug regulation would be highly desirable to complement the relatively weak government system. For example, they could use relatively inexpensive equipment to test the efficacy of anti-malarial drugs. Recent consultations with stakeholders found overwhelming support for an intervention that would involve a partnership between public and private sectors. ❑

Key messages

Given the pervasiveness of markets for health-related goods and services and the great degree to which the poor obtain medical care in these markets, it is time for health policy-makers to take action to improve their performance, based on a systematic understanding of how these markets operate. In doing so, they need to take account of the following:

- Attempts to achieve long-lasting change through the efforts of a single organization or a particularly innovative individual tend to be unsuccessful; it is important to understand and address market systems as a whole in order to achieve sustainable change.
- Reforms should begin with markets in which poor people are already engaged and will often involve informal providers, who operate outside formal legal and regulatory frameworks, and local agencies such as provider associations, citizen groups and local accountability structures.
- Interventions intended to benefit the poor need to acknowledge and take into account the influence of power and conflicts of interest on their outcome and this should be anticipated in a detailed stakeholder analysis.
- Interventions that focus solely on providers of health services are unlikely to have a great impact on the poor unless they are linked to measures that provide more equitable access to government funding and donor financial flows

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