

Blind Optimism

Challenging the myths about private health care in poor countries

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

Summary

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

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

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

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

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

Six of the most common arguments made in support of private-sector health-care provision are examined in this paper.

The first is that the private sector is already a significant provider of services in the poorest countries, so must therefore be central to any scaling-up strategy. A recent report by the International Finance Corporation (IFC), the private-sector investment arm of the World Bank, claims that over half the health-care provision in Africa comes from the private sector. In fact, Oxfam's analysis of the data used by the IFC finds that nearly 40 per cent of

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

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

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

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

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

The difficulty of managing and regulating private providers also creates inefficiencies, especially where government capacity is weak and there are too few private providers to ensure price competition. In Cambodia, the low number of technically acceptable bids received in one of the largest contracting-out health-care schemes meant that in many cases contracts were awarded without competition and the overall size of the programme

had to be reduced by 40 per cent. Private providers were found to have lower operating costs in only 20 per cent of contracting programmes for which data is available. Even then the full transaction costs to government of managing private providers are not counted: these can divert as much as 20 per cent of spending from health budgets.

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

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

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

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

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

studies of developing countries reviewed by the International Monetary Fund (IMF).

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

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

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

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

Recommendations

For donors

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

For developing-country governments

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

For civil society

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

1. Introduction

The stakes could not be higher. Every minute a woman dies in pregnancy or childbirth for want of simple medical care; every hour 300 people die of AIDS-related illnesses; and every day 5,000 children are killed by pneumonia. It is nothing short of scandalous that in some countries today fewer children are being immunised and more mothers are dying than when the MDGs were set eight years ago. There is widespread agreement that this poor progress will only be reversed through a massive expansion of health-care provision in poor countries: there is less agreement on how this can be achieved.

For over two decades the World Bank and other international organisations decried the failure of public health-care in developing countries to deliver health for their citizens, and promoted a greater role for private health-care providers as a viable and preferred alternative. Through conditions on their loans to poor countries, the World Bank insisted on extensive changes in health systems, including the introduction of health-user fees, which still exist in most poor countries. The 2004 World Development Report, 'Making Services Work for Poor People', laid out the basic approach: governments should encourage private health-care providers to serve those who can afford to purchase their services, and contract with for-profit and not-for-profit private providers to deliver on the governments' behalf for those who can't. ¹

The approach, also increasingly popular in many OECD countries, is known as 'New Public Management' (NPM), and attempts to introduce market-like behaviour into public services. It recasts the role of government from provider to one of regulator and purchaser of services. ² Health care becomes a commodity to be paid for, ideally by citizens themselves, and the market helps to rationalise services. Competition between providers for government contracts and the financial rewards of attracting paying customers are thought to drive up efficiency, quality, and overall access.

Alongside the World Bank today, an increasing number of other aid donors include language on the necessary engagement of the private sector in their respective health policies. The United States Agency for International Development (USAID), the Department for International Development in the UK (DFID), and the Asian Development Bank go further and have followed the Bank's example in spending millions of aid dollars funding large-scale programmes to contract-out service delivery to the private sector in countries such as Afghanistan, Bangladesh, and Cambodia.

During the last 18 months, there has been a noticeable increase in donor support for private-sector engagement in health in poor countries. In 2007, the IFC, the private-sector investment arm of the

World Bank, launched a report sponsored by the Bill and Melinda Gates Foundation and researched by McKinsey & Co. The report, 'The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives',³ came with the announcement that the IFC will mobilise \$1 billion in equity investments and loans to finance the growth of private-sector participation in health care in sub-Saharan Africa.

The World Bank's 2007 Health, Nutrition and Population (HNP) strategy commits it to work in 'close collaboration' with the IFC to improve the policy environment for public-private partnerships in health.⁴ More recently, the World Bank and other donors have proposed a global 'Affordable Medicines Facility for malaria' (AMFm) for distribution of malaria drugs through subsidising private providers (see Box 5). The UK government has already pledged £40 million to help fund it.

These significant efforts in support of private sector-led solutions are to date unmatched by commitments from the World Bank to build its expertise and capacity to support an expansion of government health-care provision. This calls into question claims by the Bank that it is agnostic about who provides. Despite the demonstrable historical record of direct government provision, the Bank in fact considers it as a potential option in only one of its six models of health-service delivery outlined in its 2004 World Development Report. Even there, it accepts no comparative advantage of the state over private contractors and leaves the option conspicuously under-developed.⁵

At the same time, powerful private-sector health companies⁶ have asserted an increasing role in international and national health policy-making (in the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization, for example) demonstrating a structural conflict of interest which most official development agencies appear willing to overlook.⁷ Rich countries are also promoting the commercialisation and privatisation of health-care services in the General Agreement on Trade in Services (GATS) negotiations and in an array of bilateral trade agreements.⁸ These have the potential to lock countries into a position in which the profit-seeking private sector can accuse government health services of unfair competition.⁹

These trends justify an urgent review of the arguments and evidence on private-sector engagement in the health-care systems of poor countries and their impact in achieving the important goal of universal and equitable access. Oxfam recently examined some of the relevant evidence regarding private financing of health care in a joint agency paper on health insurance.¹⁰ This paper focuses on the role of the private sector in health-care delivery.

The paper weighs the claims made in favour of increased private provision of health care in poor countries. It focuses mainly on the

informal and formal for-profit private sector operating independently of, and contracted by, governments. It also looks briefly at the evidence available on the performance of civil-society providers. The paper then examines the opportunities for scaling-up public provision towards achieving universal and equitable access. It concludes that donors should reassess their support for private-sector solutions and focus far more on making the public sector work – if we are to achieve health for all.

Box 1: What does the private health services sector consist of?

The private health care sector in poor countries is diverse and fragmented including for-profit and not-for-profit formal and informal providers. The make-up of the private sector is heavily influenced by political, historical and economic factors and so differs from country to country.

Formal for-profit providers include multinational and national companies and enterprises as well as private qualified individuals operating a range of large and small-scale health-care facilities and pharmacies for commercial gain. These providers are legally registered and recognised by governments.

Informal for-profit providers are unlicensed and unregulated. They are usually small-scale and include a wide range of individuals and enterprises including traditional healers, birth attendants and ‘injectors’ as well as drug shops and stalls. In many low-income countries, there has been a rapid increase in the number of unqualified individuals masquerading as health professionals to meet growing demands for modern medicine.

Not-for-profit providers include faith-based organisations, charities, social enterprises and other non-government organisations offering a wide range of health services. Activities can be formal or informal, regulated or unregulated. While not motivated by profit many organisations do still attempt to recover costs of services provided. In this report, this group will be referred to as civil-society providers.

Private and civil-society providers operate outside the public health system but are also increasingly being contracted directly by the state to deliver services on its behalf. This is part of a wider trend that involves introducing market principles into health services and revising the role of governments as purchasers, regulators and overall stewards of public health systems rather than as direct providers.

2. Examining the evidence for greater private provision of health care

Despite over two decades promoting the benefits of private-sector provision of health care in low-income countries, the World Bank and other donors have produced remarkably little empirical evidence to support this policy direction. The recent IFC report claims that the private sector can significantly help to improve the scope, scale, quality, and efficiency of health service delivery in Africa, yet admits that the evidence is scarce and that few of the ideas tried have been systematically evaluated and replicated on a larger scale.¹¹

The case for private provision rests on six main arguments:

1. the private sector is currently the majority provider in many countries and should therefore be at the heart of scaling-up;
2. greater private provision can complement government and take the strain off public health services;
3. private provision is more efficient;
4. private provision is more effective and of better quality;
5. private provision can reach the poorest;
6. the private sector can improve accountability through competition.

Argument One: 'The private sector is the majority provider so should be at the heart of scaling-up health services'

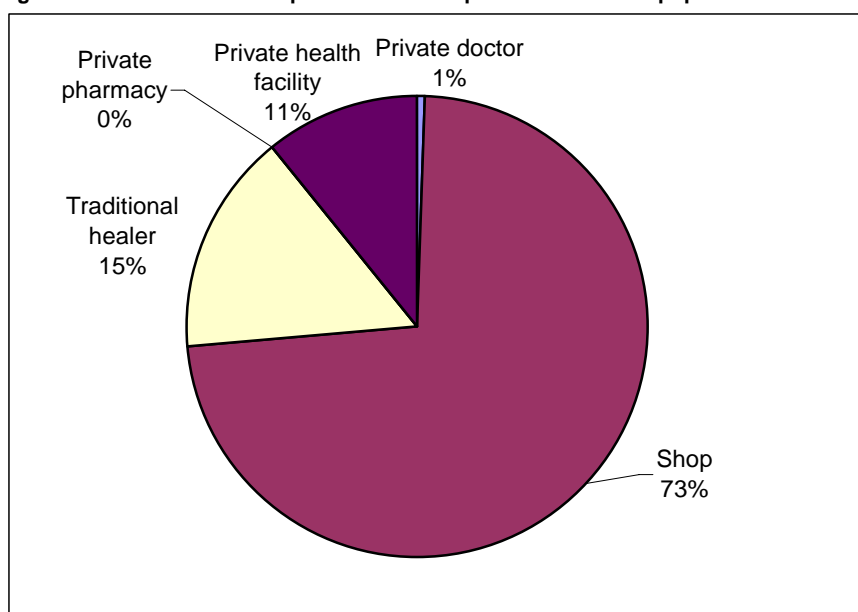
'A poor woman in Africa today is as likely to take her sick child to a private hospital or clinic as to a public facility.' IFC Executive Vice President and CEO

'When poor people cannot get free services they do not go to private clinics they go to the bush first and look for herbs.' Senior Civil Servant, Ministry of Health, Malawi

One of the most common arguments used by advocates of increased private-sector provision in poor countries is that it already plays a major role in providing health services and is already being used by the poor. The recent IFC report claims that 'almost two thirds of total health expenditure and at least half of health-care provision in Africa are accounted for by the private sector.'¹² Because the private sector is already such a significant player in health care, the argument goes, then it is just a matter of 'common sense' to promote its further expansion to meet the needs of poor people.

Oxfam's analysis of the data used by the IFC finds that nearly 40 per cent of the 'private provision' it identifies in Africa is, in fact, just small shops selling drugs of unknown quality.¹³ In some countries such as Malawi, these shops constitute over 70 per cent of private providers (see Figure 1). Evidence from India also shows that poor women are the main users of unqualified shopkeepers as a source of information and drugs.¹⁴ In the rich world we would not expect a woman to take her sick child to a corner shop for diagnosis and treatment yet this is most poor people's experience of private-sector provision. If the shops are removed from the calculation, counting instead only the clinics staffed by trained health workers, what most people would think of as 'health services', the share of services provided by the private sector falls dramatically. Comparable data across 15 countries in sub-Saharan Africa reveals that only 3 per cent of the poorest fifth of the population who sought care when sick actually saw a private doctor.¹⁵

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



Source: Oxfam's diagram created using data from the Malawi Demographic and Health Survey (2000)¹⁶

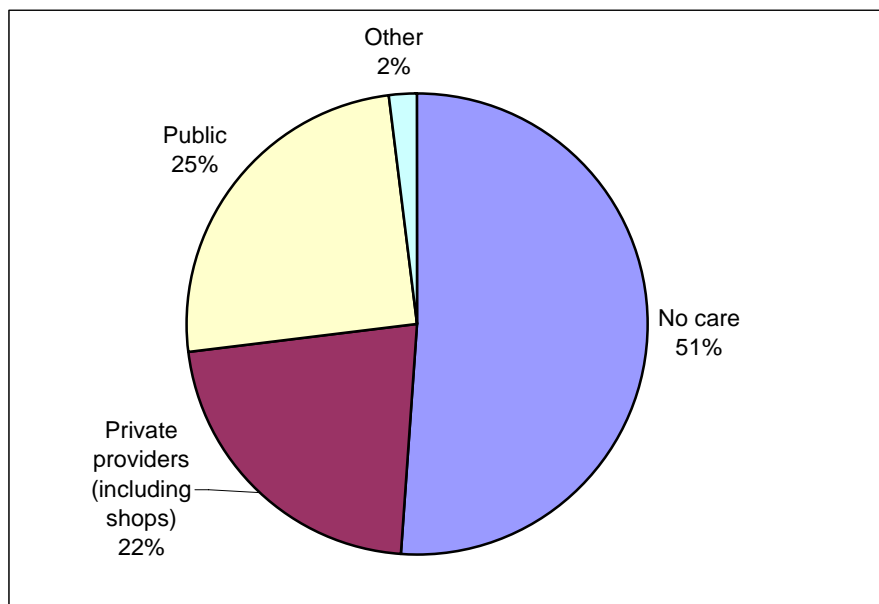
Saving mothers' lives, which many agree should lie at the heart of any scale-up strategy, requires more than the advice of a shopkeeper: it needs trained midwives and doctors.¹⁷ Indeed, the World Bank's own analysis of where women go to give birth, shows that government services generally perform far better than the private sector for rich and poor women alike.¹⁸ In India, 74 per cent of women who seek antenatal care rely on their chronically under-funded public health system.¹⁹

Reaching the 10 million people who lack access to HIV medicines and responding to the ever-growing burden of chronic diseases such as diabetes, cancer, and cardiovascular disease, now responsible for 60 per cent of deaths worldwide, also requires far more than the service of drug shops. It requires multiple visits to well-functioning health services that have effective and affordable medicines, qualified personnel, and the capacity to monitor, treat, and provide ongoing care for patients.

Furthermore, the proportion of existing care provided by the private sector tells us nothing about whether the 'right to health' is being fulfilled. For example, the IFC says that the Indian health-care system is underwritten by the private sector;²⁰ it provides 82 per cent of outpatient care.²¹ It is true that the number of first class private hospitals in India is rapidly increasing and health tourism is set to become a billion dollar business by 2012.²² But this same system denies 50 per cent of women any medical assistance during childbirth.

The Pan American Health Organisation has estimated that 47 per cent of Latin America's population is excluded from needed services.²³ Figure 2 shows data from 26 sub-Saharan countries: over half of all the poorest children receive no health care at all when sick.

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



Source: Oxfam's diagram created using data from the Demographic and Health Survey data from 26 sub-Saharan African countries 1990-2001.²⁴

A massive scale up in health provision is required, and there is no *a priori* reason why the private sector should continue to provide the same or an even greater proportion of services. In fact, to take the failing *status quo* in health care, in which the private sector, in some

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

Argument Two: 'Greater private health-care provision can complement and relieve government'

Another common argument promoting increased private provision of health services is that it can bring in desperately needed additional capital and capacity in low-income countries. The premise of recent presentations by the World Bank and the IFC²⁵ is that even with the anticipated growth in public spending and external aid, sub-Saharan Africa will not be able to fund basic health care for many years to come. The argument then continues that there is no choice but to turn to the private sector to complement the public sector and relieve some of its burden.

The first point to make is that current resource trends for the health sector should not be accepted as inevitable. Financing for health has increased in recent years and has made a significant difference. But aid donors and developing-country governments must be pushed to do much more in order to achieve the MDGs and fulfil the right to health.

Putting this point aside, there is still an unanswered question about whether the private sector actually brings in extra resources - money and people - to complement public-health systems and help reach the poor:

What money?

Funding for the private sector must come from somewhere. The private for-profit sector invests money to make money. Private-sector provision of comprehensive health services to poor people is generally not profitable and usually requires significant public subsidy. This is encouraged by the IFC: it advocates that both governments and donors earmark a higher proportion of public money and aid to fund private-sector health entities.²⁶ The World Bank also asked donors to come up with over \$1 billion in aid to subsidise the private sector and help reduce medicine prices for malaria in poor countries (see Box 5). Without a rise in the overall level of aid, increasing the proportion of resources for the private sector is simply not possible without reducing that available for the public sector.

Developing-country governments are often encouraged to provide cash subsidies and tax breaks to attract private providers into their risky low-income health-care markets.²⁷ The cost to the public purse can be substantial. In South Africa, the majority of private medical scheme members receive a higher subsidy from the government through tax exemption than is spent per person dependent on publicly provided health services.^{28 29} Another common strategy to promote private health-care delivery is to encourage or even force the rich to opt-out and buy their own care outside of the government system. But when rich people opt out of public health systems and use private services, they are less likely to support government spending on health care. Governments are then left with depleted funds to serve citizens who are more costly to reach and who suffer disproportionately from health-care problems. Evidence from Chile showed that the introduction of an opt-out option damaged the efficiency and equity of the entire health-care system.³⁰

What health workers?

'After paying for electricity and water and buying food, there's nothing left. I can't survive on my salary. So I do shifts as a locum in a private hospital in Lilongwe. It's not good though. Our ways of surviving are killing the system.' Dr. Matias Joshua, Dowa District Hospital, Malawi

Money is not the only finite resource for which the private sector directly competes. Health-care systems are built of human beings – professionals who have the skills and training necessary to manage, organise, and deliver health-care services. These professionals are already in desperately short supply. The World Health Organization's 2006 'World Health Report'³¹ calculates a shortage of 4.25 million physicians, nurses, and support workers in 57 countries. sub-Saharan Africa is the worst affected region.

Claims that the private sector can increase a nation's overall capacity to deliver health care, frequently ignore the fact that the private sector does not generally bring with it extra people. Rather, as the IFC itself explains, its rapid growth can exacerbate shortages of qualified medical personnel by drawing them into higher paying, for-profit activities.³² In Thailand, for example, government efforts to redress the inequitable distribution of health workers led to an impressive rise in numbers of rural doctors from 300 to 1162 in just six years during the 1980s.³³ Reforms supporting private hospital investment dramatically reversed these gains by pulling personnel into private urban hospitals. This left public rural clinics with a skeleton of staff to treat the poorest and most vulnerable in society with the worst health problems. Figures from the Ministry of Public Health illustrate the point: the net loss of government doctors increased from 8 per cent in 1994 to 30 per cent in 1997.

What this competition for scarce money and personnel shows is that far from sharing the burden, the private-sector growth can siphon off

precious public resources needed to provide health-care services for poor people.

Box 2: Market failure in health provision

The World Bank has argued that as long as competition is introduced into health systems by separating the role of purchaser from providers, then it doesn't actually matter who delivers the services.³⁴ But consensus on the advantages of introducing market mechanisms into public services does not exist and indeed the advantages are highly contested in both the developed and developing world. It is generally acknowledged however, that there are a number of inherent market failures in market-based health-care provision, all of which need to be overcome if it is to work.³⁵

Firstly, the pursuit of profits means private providers have no incentive to serve those unable to pay.

Secondly, patients are poorly informed of their needs and unable to judge many aspects of quality, so rely on providers to correctly diagnose them and prescribe treatment. This is known as 'asymmetry of information' and it also exists in different forms between government and contracted providers. The result is perverse incentives to over-charge, under- or over-treat and/or lower quality, especially when associated with fee-for-service payment systems.³⁶ Losses can be substantial: the US government has estimated that improper Medicare fee-for-service payments, including non-hospital services, may be in the range of \$12–23 billion per year, or 7–14 per cent of total payments.³⁷

Thirdly, healthy citizens benefit the population as a whole, over and above the health status of each individual. Curing a person of an infectious disease such as TB benefits not just the individual, but also everyone who may have contracted the disease, and therefore society as a whole. Markets do not reflect this additional value, just the value to the individual, which can lead to under-investment in these areas, especially for diseases prevalent in poor countries where the majority of people are unable to pay.

Finally, citizens in poor countries and poor-country governments often do not have a choice of health provider. In many instances they are lucky if they have one at all. This means that competition, the main engine for efficiency in the market, is absent.

Historically, it was partly because of these market failures that governments across the developed world intervened to provide health services. The World Bank and others do not contest these market failures, but nevertheless think that they can be overcome through careful regulation, something even the wealthiest countries have struggled to achieve.

Argument Three: 'The private sector is more efficient'

'Fortunately, the positive news is that we've got the best health care system in the world. And we need to keep it that way. We need to keep it that way by keeping the private market strong, by resisting efforts that are happening in Washington D.C., to say the federal government should be running health care. See, we don't believe that. I don't believe it. I believe the best health care

system is that health care system generated in the private markets.'
President George W. Bush, Jan 28, 2004

'[It is] wrong when 46 million Americans have no healthcare at all. In a country that spends more on healthcare than any other nation on Earth, it's just wrong.' US Senator Barack Obama, 'The Time Has Come for Universal Healthcare' Speech made to Families USA conference January 17, 2007

Public health services have long been criticised for inefficiencies due to hierarchical structures and bureaucratic systems and processes. Private providers are portrayed as more efficient alternatives. But do attempts to make the private sector work in the public interest really come with a lower price tag than direct government provision?

In fact, the growth in private-sector participation in health in many countries has been associated with high costs and low efficiency. The rapid proliferation of the number of private health facilities in China since the 1980s led to significant declines in productivity, rising prices, and reduced utilisation.³⁸ Lebanon has one of the most privatised health systems in the developing world. It spends more than twice as much as Sri Lanka on health care yet its infant and maternal mortality rates are two and a half and three times higher respectively.³⁹ The US commercialised health system costs 15.2 per cent of GDP, while across the border the Canadian national health system costs only 9.7 per cent of GDP^{40 41}, has lower infant and child mortality rates, and people live two years longer on average.⁴²

A large part of the reason for rising costs is that market-based health-care systems have inbuilt incentives to pursue the most profitable treatments rather than those dictated by medical need.⁴³ Chile, one of the first developing countries to extensively implement private-sector involvement in its health-care system, has one of the highest rates of births by Caesarean section in the world.⁴⁴ Extra profits from surgery and higher bed occupancy rates mean that Caesarean sections can be over four times more likely in private facilities than public.⁴⁵ On the other hand the wider economic benefits of preventative care – saving economies millions of dollars by avoiding unnecessary treatment and lost productivity – do not translate into profits and so are less likely to be provided by the private sector. Since the introduction of market incentives in public health systems in China, health-care facilities have diverted resources away from preventative services to revenue-generating activities instead.⁴⁶ This has coincided with significant increases in prevalence rates of measles, polio and TB.⁴⁷

Private-sector proponents argue that by contracting the formal private sector, governments can manage these market failures and take advantage of private-sector competition to drive down costs. The theory is based on a number of assumptions:

1. that enough competent private providers exist to create competition;
2. that private providers are actually able to deliver the same services at lower cost;
3. that the benefits of separating the purchaser and provider roles and introducing contractual relationships outweigh the transaction costs of their implementation;
4. and finally, that governments have the capacity to manage and benefit from formal contractual relationships with the private sector.⁴⁸

The evidence base for each of these four assumptions is lacking.^{49 50}

Firstly, genuine competition is hard to achieve in low and middle-income countries where few private providers can deliver services on the scope and scale required. In one of the largest experiments with contracting in Cambodia, the low number of technically acceptable bids meant that in many cases contracts were awarded without competition and the overall size of the pilot programme had to be reduced by 40 per cent.⁵¹ In Afghanistan, contracting takes place across the country and competition for remote areas is similarly weak.⁵² The World Health Organisation (WHO) concluded from its extensive literature review on contractual efficiency that *'the conditions necessary for competition, and even contestability, are generally absent from most areas of most low and middle-income countries'*.⁵³

Secondly, in the most recent review of contracting for health, only five studies were found that attempted to compare operating costs between public and private providers. Two of the studies found private providers were either less efficient or more costly than their public counterparts (Bangladesh and Cambodia)⁵⁴ and two produced inconclusive results. In only one case, Costa Rica, were the results of contracting-out found to be positive on efficiency and here no improved impact on health outcomes was observed.⁵⁵

Box 3: 'Policy-based evidence making?'⁵⁶ **World Bank assessments of contracting out health services to private providers**

There have been several attempts to review the evidence of the effects of contracting-out health services in developing countries in the last ten years.⁵⁷ Mixed results and the poor quality of data mean that most authors reach cautious, if any, conclusions; all have called for further research. In contrast, the World Bank makes a more upbeat assessment. It concludes from a review of ten contracting projects that the current weight of evidence suggests that contracting 'will provide better results than government provision of the same services' and that it 'should no longer be considered an untested intervention or so-called leap of faith'. It continues by suggesting that 'contracting for health service delivery should be expanded'.⁵⁸

Given the serious methodological flaws conceded by the authors,⁵⁹ together with more recent evidence that undermines some of their

findings,⁶⁰ the conclusion that contracting itself is responsible for any improved outcomes is overly simplistic.

Cambodia is one example of this problem. Here, contracted INGOs achieved improvements in access, equity and quality indicators in comparison to control districts where government services continued as before. The evaluations are considered the most rigorous of all contracting studies and the results widely used by the World Bank and others as justification for contracting elsewhere. But successful outcomes were automatically taken to be a result of contracting out and other, arguably far more important, factors were played down. These included: salary increases of five to eight times that paid by government; improved staff management including agreements to cease private practice; and drastic reductions or wholesale removal of user fees supported by increases in financing of nearly two and half times that spent in government-run districts.

Thirdly, the full additional procurement, management, and administration expenses involved in co-ordinating and regulating contracted providers are rarely if ever considered in cost comparisons. These costs can be high. The costs of managing and monitoring contracted nutrition services in Senegal and Madagascar are estimated at between 13 and 17 per cent of the overall budget.⁶¹ In Chile and Argentina private management of public hospitals has increased administration costs to 19 and 20 per cent of health spending respectively.⁶² In the UK, administrative costs doubled after the introduction of market reforms within the National Health Service.⁶³

Finally, while transaction costs are present in any health-care model that separates the purchaser and provider roles, efficiency savings are even less likely when weak and inexperienced governments form relationships with for-profit private providers. An extensive review of private health-care provision in developing countries found that contractual risk was often shifted onto governments 'putting no pressure on contractors to be efficient'.⁶⁴ A review by the World Bank in Africa found several cases where governments attained an unfavourable risk-sharing position with respect to private contractors.⁶⁵ Even in South Africa, a relatively strong state, the government's lack of knowledge about actual costs of provision and the extent of competition led to efficiency gains being captured by the company, not the government, in the form of higher profits.⁶⁶

It should be of fundamental concern to both governments and donors to establish whether providing health services through private providers will ultimately cost more or less than doing the same through the public sector. The available evidence suggests the private sector can cost considerably more.

Argument Four: 'The private sector can help raise the quality and effectiveness of health services'

Quality in health care is a matter of life or death. If a child sick with pneumonia is given treatment for malaria the consequences can be fatal. Quality cannot be left to chance.

Market incentives to make profits by lowering quality are at their worst in the informal private health-care sector. Inability to pay and low levels of education mean the majority of people in poor countries become dependent on unqualified drug peddlers, fake doctors, and other providers who present a serious threat to their health. The IFC agrees that it is the lower-income and/or rural populations that 'are most profoundly affected by the failings of private health care in sub-Saharan Africa.'⁶⁷

A large-scale study in rural Viet Nam comparing public and largely informal private providers found quality in both fell well below the national standard but was significantly poorer in the private sector. Moreover, poor treatment practices for children suffering respiratory or diarrhoeal infections were particularly pronounced for those private practitioners with no previous experience of working in Viet Nam's public health system.⁶⁸

Box 4: Falling between the quacks

'Barefoot labourers, skinny housewives, and half-naked, snuffling toddlers wait outside a corrugated iron and plywood shack in a Delhi slum to see 'the Bengali doctor'. Noor Muhammed, the nattily dressed 30-something inside, is indeed Bengali, but, as he cheerfully admits, not a doctor. Yet as he makes quick temperature and blood-pressure checks and hands out tablets, many of them antibiotics, his patients nod respectfully, and pay.

India has more fake than genuine doctors, according to K.K. Kohli, who chairs the anti-quackery committee of the Delhi Medical Council. In Delhi alone there are around 40,000.

"They take acute patients and make them chronic", says Dr Kohli, citing quacks who misdiagnose, prescribe steroids as pick-me-ups, mix their own remedies, and buy cheap, out-of-date antibiotics. Their most common error is prescribing and selling antibiotics unnecessarily. Sandeep Guleria, a professor at the All India Institute of Medical Sciences (AIIMS) in Delhi, says quacks have helped cause the high levels of drug resistance in India.

Ten years ago Delhi's state government drew up an 'Anti-Quackery Bill' of which nothing more was heard. But the real problem is less the quacks themselves than the health-care vacuum in which they flourish. The public health system remains skeletal.'..... ' In slums, sick poor people go to quacks because government-run clinics are too far away and the queues too long. In many rural areas, there are no clinics.'

'Some quacks, of course, may be perfectly responsible. Mr Noor, for example, swears that he refers all "serious cases" to government hospitals. How he diagnoses them is not clear.'

Source: Economist(2008) 'Quackdown: the high cost of medicines bought on the cheap', *The Economist*, 21 February 2008.

Numerous studies from the WHO have raised serious concerns about the quality of drugs sold by private providers. In China one third of drugs dispensed by private vendors are counterfeit, enabling their vendors to earn huge mark ups.⁶⁹ Profit motives also drive irrational or over-prescribing of medicines, leading to growing drug-resistance for deadly diseases including HIV, TB, and malaria. The large numbers of people dependent on shops for drugs is being used to justify the subsidisation of malaria medicines sold by private providers through the proposed Affordable Medicines Facility for malaria (see Box 5). But one study across seven sub-Saharan African countries found that the majority of malarial drugs in private facilities failed quality tests altogether.⁷⁰

It is not at all clear that contracting can ensure better quality. A comparative study in South Africa found technical quality in contractor hospitals was significantly inferior to that in public hospitals. Incentives to maximise income led to contractors limiting the quantity and quality of key inputs including critical staffing and equipment and supplies, to the point of failing to meet what the evaluation defined as realistic public sector standards. In contrast, contractors performed better than government on maintenance of hospital buildings and amenities.⁷¹ In Lesotho overall quality is

similar between contracted and public providers. However, only 37 per cent of sexually transmitted infection cases were treated correctly by contracted providers compared with 57 per cent and 96 per cent of cases treated in 'large' and 'small' public health facilities respectively.⁷²

The World Bank has itself reported that the private sector generally performs worse on technical quality than the public sector.⁷³ Data from Uganda for example, shows that only 19 per cent of private health facilities correctly treated simple malaria, a mere 6 per cent of them did so for simple diarrhoea without blood, and 36 per cent did so for pneumonia.⁷⁴ In the last 12 months alone, over 184 private hospitals, clinics, and laboratories have been closed in Nigeria's capital city, for failing to meet basic standards of hygiene and staff training.⁷⁵ Private-sector TB services in Nepal have low patient retention and cure rates and are related to the rise of multi-drug resistant strains of the disease. As a consequence, one WHO study concluded that the damaging effects of further private-sector growth in Nepal may prove irreversible.⁷⁶

Box 5: Malaria subsidy: Should shops be health-care providers?

A proposal was made by the World Bank in late 2007 to heavily invest in private provision of new drugs for malaria. The mechanism, known as the 'Affordable Medicines Facility for malaria' would provide a subsidy to private providers so that they can sell the drugs at much lower prices. The Global Fund is to host the facility and donors are being asked to provide over \$1 billion to support it.⁷⁷

Currently most of the malaria treatment bought by the Global Fund and other key actors such as UNITAID is delivered through the public and CSO sectors, so the proposed subsidy would mark a significant break with common practice. While recognising the current problems with public provision in many countries, Oxfam has expressed serious concerns about this proposal. The subsidy currently does not explain how private providers will safely dispense the medicines. There is a strong risk that subsidising private providers in this way will lead to continued over- and under-prescribing.⁷⁸ This was the case with previous drugs for malaria such as Chloroquine and Fansidar, and was partly responsible for the resistance that made both drugs ineffective. The subsidy also does not address the fact that many cannot afford to pay for any treatment, subsidised or not, meaning that the poorest, and particularly children, are unlikely to benefit.⁷⁹ Most importantly, the alternative of rapidly scaling-up and strengthening free public provision has not been sufficiently explored. The malaria subsidy if applied only through the private sector risks setting a damaging precedent of further diverting international donor attention away from addressing the problems of the public sector. As a result failure of public provision becomes a self-fulfilling prophecy.

While the World Bank and the UK government support the subsidy other governments such as the US and Canada do not. The latter have voiced similar concerns to Oxfam around the feasibility of the proposal and whether it will be able to reach the poorest.

The evidence on the poor quality of the private sector should not be used to play down the problems of many public health-care systems in developing countries. These are real and, as discussed in section 3, addressing them will require resources and skilled leadership. What the evidence does highlight is that the private sector brings with it serious and inherent market failures that constitute an additional significant barrier to improving the quality and effectiveness of health services, especially for poor people. Just as for efficiency, there is no evidence that the majority of resource-poor developing-country governments have the capacity and technical expertise necessary to counter this market failure.

Argument Five: ‘The private sector can help reduce health inequity and reach the poor’

‘...the extent to which health care institutions reject or mistreat people at their most vulnerable is widely understood to be one of the markers of how a society sees itself. To build an exclusionary health service is to legitimise broader social exclusion.’ Professor Mackintosh, 2003 ⁸⁰

Equity in health means that health services are provided according to need and not ability to pay. In practical terms this means that the poor should receive more investment because their health needs are usually greater.

Proponents of private provision rightly point out that public provision is inequitable in many countries. They say, the private sector, working through the introduction of market mechanisms and with proper government regulation, can do a better job of reaching the poorest. The World Bank contends that ‘making the provider accountable to the client through prices can strengthen client power and lead to better results’.⁸¹ They maintain that the failings of government are sometimes so bad that ‘market solutions may actually leave poor people better off.’⁸²

Both current evidence and historical experience seem to indicate that an expansion of private-sector participation and broader commercialisation of health-care provision can dramatically increase inequality in both access and health outcomes. In fact it was largely this inequality that led to the increasing role for the public sector in the majority of developed nations.⁸³

Data from 44 middle- and low-income countries suggests that the higher the level of private-sector participation in primary health care, the higher the overall level of exclusion from treatment and care.⁸⁴ Although this correlation does not clarify whether high levels of private participation cause exclusion, it at least suggests that the private sector does not in general *reduce* it.

Market reforms of public health systems in both China (see Box 6) and Viet Nam have coincided with a substantial increase in rural people reporting illness but not using any health services.⁸⁵ High

costs mean that those unable to pay are increasingly excluded: self-medication is the cheapest and now most common form of health care among the poorest in Viet Nam.⁸⁶

Box 6: Privatising health care in China: a failed experiment

From 1952 to 1982 the Chinese government-owned, funded, and operated health-care system achieved enormous improvements in health and health care. Infant mortality fell from 200 to 34 per 1,000 live births, and life expectancy almost doubled. Since the 1980s, cuts in government health spending and wide-scale privatisation have had devastatingly inequitable consequences for people's lives. Services that were once free are now charged for by profit-driven hospitals. Insurance to cover costs has been introduced but 80 per cent of the rural poor are not covered. The numbers and quality of health-care facilities and personnel in rural areas are inadequate resulting in huge disparities in health outcomes. Infant mortality is now 3 times higher in rural than urban areas. Illness is now the leading cause of impoverishment in rural areas.⁸⁷

It took the shock of the 2003 SARS outbreak, to make the government realise that the highly fragmented, inequitable and profit-driven health-care system was unable to respond to the nation's health needs. A government-endorsed report concluded that the success of China's health system during the planned economy period was based on the dominant role played by the government. Market-based reform has led to a decline in both the fairness of medical services and the efficiency of investment in the health sector.⁸⁸ More recently high out-of-pocket payments for health have been blamed for low domestic spending in China; an issue now receiving urgent attention as the government attempts to boost domestic demand in order to safeguard its economy from the international financial crisis.⁸⁹ Reforms to reverse the market-driven policies of the last two decades and allow a much stronger role for government in health care have been announced.

Source: Economist: Adapted from 'Health care in China: losing patients' *The Economist*, 21 February 2008; and Blumenthal and Hsiao (2005)⁹⁰

Cutbacks in public health provision and increasing reliance on the private sector have further exacerbated gender inequality. In many countries such reforms have been associated with an increase in unattended home deliveries and with women and children delaying care due to high costs involved.⁹¹

When provision involves payment, when it is patchy, selective, or inequitable, then the burden of disease and caring falls disproportionately on women and girls. They are the ones who miss out on treatment and care and who take on the extra burdens of unpaid care at home. This unequal burden in turn reinforces gender inequality in employment and further risks of poor health. Unpaid care responsibilities trap many women into lower paying, less secure and more hazardous occupations as these jobs offer more flexible hours and can often be undertaken in the home.⁹²

Women also make up the bulk of lower skilled formal health workers and have suffered most from private-sector cost-saving policies in the form of rising workloads, lower wages and increased job insecurity.⁹³

The twin aims of making a profit and providing health services for poor people seem only compatible with significant public subsidy and/or through providing sub-standard services. The World Bank maintains its support for subsidies but this again raises the question of cost: how much of taxpayer's money will be needed to guarantee private-sector profits? Oxfam's research in Georgia found that one of the biggest companies involved in the government's drive to privatize health care has decided to withdraw from the programme: the subsidy offered was not enough to serve the poor and make a profit.⁹⁴

The alternative – securing profits by providing a lower standard of services to poor people – is supported by the IFC. It promotes a two-tier model: profit-motivated providers are advised to set up high-end, high-quality, and well-equipped clinics for middle- and upper-income populations, and low-cost, 'extremely high' turnover and limited service hospitals for the poor.⁹⁵ The explicit assumption is that poor people only require basic and time-limited medical care (doctors are advised to see 100 patients a day – one every four minutes).

Argument Six: 'The private sector can improve accountability'

The World Bank's 2004 World Development Report focuses on the crucial issue of accountability in health provision. The Report maintains that accountability can be enhanced by promoting competition among private providers to tender for government contracts. At the same time, the Report argues, enabling poor people to choose among providers obliges the providers to become more responsive and accountable otherwise their clients, the poor, will choose to take their custom elsewhere and, for example, 'female patients who feel more comfortable with female doctors can go to one.'⁹⁶

However health systems by their very nature are complex and poor accountability and corruption can be a problem regardless of whether services are privately or publicly provided.⁹⁷ The World Bank theory that private providers are more responsive than public ones is not backed up by the evidence. First, as already noted, competition between qualified private health providers does not exist in many low-income countries. Accountability based on consumer preference in this context does not work. In Malawi, for example, there are only 40 female Malawian doctors for a population of 13 million, thus making the choice cited by the World Bank highly implausible.

At the same time the process of contracting providers has significant potential for corruption, both in securing the tenders from government in the first place and in the provision of the services themselves. Even if contracts are awarded fairly, regulating private

providers in the public interest is exceptionally difficult, even in developed nations. In the US, fraud on the part of health providers is a huge problem, leading to billions of dollars of losses each year.⁹⁸ Regulation is made more problematic when governments are weak and lack authority and qualified personnel. A report commissioned for the Government of India found that hospitals contracted and subsidised by the state to provide free treatment to poor patients were simply failing to do so.⁹⁹

Finally, when the private sector provides health services on behalf of the state it can make it more difficult for citizens to hold their governments to account. It becomes easier for politicians to hide behind the excuse that their policies are good, but the company got it wrong.

Box 7: Civil-society providers: the perfect compromise?

Civil-society providers of health services are often lumped together with for-profit providers under the label 'private sector'. This is inappropriate as it overlooks critical differences. Civil-society providers have some inherent advantages over for-profit private ones, precisely because in the same way as the public sector they are not motivated by profit.

Across the world missions, charities, and NGOs are a lifeline for many and in some African countries constitute a significant proportion of existing services. This does not mean that civil-society providers can or should try to scale-up to replace the state.¹⁰⁰ A commitment to do good does not always guarantee competence and high performance. Some reports have found that charities and mission hospitals are no more effective in terms of coverage and equity than state services.^{101 102} And CSOs can be prone to some of the same problems as for-profit providers, especially in terms of duplication and fragmentation,¹⁰³ charging for services,¹⁰⁴ accountability, and competing for public health professionals.¹⁰⁵

Most CSOs will agree that to be most effective and to make best use of their comparative advantages, they must only ever be a complement to, and not an alternative to, public health systems.

Who provides care does matter

If the goal is universal and equitable access to health care, then the evidence is clear and - contrary to current World Bank assertions - who provides it does matter. Not only does the performance of the private sector in many cases fail to live up to the claims of its proponents but its growth can come at a cost to the efficiency, quality, equity, and accountability of health services.

3. Learning from success: what works to deliver health care for all?

To scale-up and reach the poorest and most vulnerable citizens with the health care they need, developing country-governments must learn from those countries that have been most successful. A robust and growing body of international research attempts to provide the basis for such learning. The Commission for the Social Determinants of Health, a three-year international investigation by an eminent group of policy-makers, academics, former heads of state, and former ministers of health, assessed the available evidence and recently concluded that worldwide, publicly financed and delivered services continue to dominate in higher performing and more redistributive health-care systems.¹⁰⁶ A study by Equitap (a network of 15 research teams across Asia and Europe) comparing national health data in Asia went further and found that no low- or middle-income country has achieved universal or near universal access to health care without relying solely or predominantly on tax-funded public sector delivery.¹⁰⁷

In developing countries, government spending on health is as important as income per head in influencing child and maternal mortality.¹⁰⁸ In richer countries as well, spending a higher proportion of total health expenditure via government is associated with longer healthy life expectancy and lower under-five mortality.¹⁰⁹

In various 'breakthrough' periods Botswana, Mauritius, Sri Lanka, South Korea, Malaysia, Barbados, Costa Rica, Cuba, and the Indian state of Kerala¹¹⁰ all cut child deaths by between 40 and 70 per cent in just ten years.¹¹¹ Studies have shown that while specific approaches differed, the critical factor for success in all of these countries has been committed action by governments in organising and providing health services for the vast majority of their populations.

Botswana and Mauritius both inherited tiny hospital-based health services at independence, but by the 1980s at least 80 per cent of the their populations lived within 15km of a public health facility.¹¹² In the early 1980s Nicaragua increased access to health care from 25 per cent to 70 per cent of the population, as part of a major programme of public investment.¹¹³ In Sri Lanka, when a woman gives birth there is a 96 per cent chance she will be attended by a qualified midwife.¹¹⁴ Medical treatment is available free of charge from a public clinic staffed by a qualified nurse, within walking distance of her home. Once one of the nations worst affected by malaria, Sri Lanka is close to being one of the first to eliminate the disease altogether.¹¹⁵

The reality of public failures

Slow or piecemeal progress towards achieving the health MDGs shows that governments in many poor countries are falling far short of their responsibilities. Too often citizens find public health services unavailable, understaffed or prohibitively expensive. Low wages, weak management, and corruption are all part of the problem. Poor working conditions can result in low productivity of staff. Drug shortages can occur due to lack of money as well as weak procurement and distribution systems. Poor people, women, and other marginalised groups continue to face the greatest barriers to accessing care due to cost, distance, lack of information and knowledge, lack of voice, and unresponsive providers. Quality is often unacceptably low. In Tunisia for instance, one study found only 20 per cent of pneumonia cases were managed correctly and 62 per cent of cases received antibiotics inappropriately.

Some governments are failing to live up to their promises to increase their own spending. The Indian government spends twice as much on its military forces as on health. The country's progress on reducing child deaths has slowed to such an extent it has been overtaken by its lower income neighbour, Bangladesh. In Africa, only five countries have so far met the Abuja commitment to allocate 15 per cent of government spending to health. Meanwhile out-of-pocket fee payments, estimated to make up 50 per cent of total health expenditure across Africa, further exacerbate poverty and serve to exclude poor people from the services they need.

Inadequate resources also lead to poor governance. Very low salaries mean that charging informal payments for services has become commonplace in many African, East Asian, and Eastern European countries, as has absenteeism on the part of public health workers. A lack of resources for training and career development starves public health services of competent leaders and managers to address inefficiencies, corruption, and unresponsive bureaucratic procedures.

Donors, World Bank, and IMF: playing a part in public failure

The World Bank and IMF, as well as some rich country donors have, through their aid and policy prescriptions, significantly hampered the ability of governments to provide health for all.

It is now well documented that during the economic crises of the 1980s and 1990s the Structural Adjustment policies of the World Bank and IMF required drastic cuts in public spending with minimal safeguards for health. Government health budgets in sub-Saharan Africa and many Latin American countries shrank by as much as 50 per cent during this time. The World Bank's prescriptions also included lending conditions that required the introduction of fee payments for health services, with devastating consequences. These fees still exist in most poor countries.

The World Bank and IMF have since accepted that making cuts without protecting the health of the poorest was a mistake. Whilst this *mea culpa* is welcome, they must also recognise that these cuts, and failed policies, were a significant cause of government failure to deliver in recent decades. The WHO's Commission for the Social Determinants of Health supports this view. It concluded that reforms driven by international agencies that introduce market behaviour into public health systems and encourage a stronger role for the private sector have further undermined governments' performance and ability to address inequity. But donors rarely join up these dots; government failure is almost always presented instead as inevitable and exclusively the fault of governments themselves.

The way most donors give aid to health has also not helped. As far back as 1978, many donors, and especially UNICEF and the World Bank, found the comprehensive primary health-care approach outlined in the Alma Ata declaration to be too ambitious. Instead donor support focussed on 'selective primary health care' as an 'interim' more pragmatic solution, emphasising only a handful of interventions. But this 'interim' measure became the default approach. Aid for health has increased rapidly in the last decade but this has mostly been in the form of a rapid proliferation of new global health initiatives for a small number of specific diseases. In the same period, the allocation of aid for primary health-care services dropped by almost half. Rich country donors have admitted that these new aid channels frequently bypass government health plans and priorities and fail to adequately strengthen health systems.

Finally, while giving aid with one hand, many rich countries are at the same time recruiting health workers in considerable numbers from poor countries and further exacerbating already severe health worker shortages.

Given the systematic erosion of public spending and support for universal free public health services over the last three decades, writing off the public sector as a solution that has been tried and has failed is the equivalent of tying a footballer's shoelaces together and then blaming him for losing the match.

Nevertheless, many donors, including the World Bank, take evidence of government failure and public dissatisfaction as a green light to press ahead with wide-scale restructuring involving a greater role for private provision but without any analysis of the long-term consequences. At the same time, opportunities to make governments fulfil their responsibilities and improve and increase public provision are too often being missed.

Exploiting the advantages of public provision

Those promoting private-sector solutions have dedicated much research to government failings in delivering services. They have done less to research government strengths. Integrated public health services have a number of natural advantages in terms of efficiency, quality, and equity that can help explain their ability to succeed. These same advantages have as yet proved unobtainable through private provision.

Economies of scale

In terms of efficiency, the public sector can exploit huge economies of scale. This includes procurement where lower prices can be negotiated through bulk purchasing for drugs and equipment; spending that can also focus on technology and innovation to improve patient health rather than perceived attraction to users. National or district level systems for administration, staffing, and training reduce management costs of multiple private providers. Provision at scale also enables specialisation: a full range of products and services can be offered at lower cost than if provided by individual operators. Public health systems are therefore more successful at containing costs.¹¹⁶ Cuba spends 27 times less per person on its public health system than that spent in the US yet has a lower infant mortality rate and a longer average lifespan.¹¹⁷ The IFC agrees that when it comes to economies of scale the private sector, characterised by fragmentation, is at a disadvantage. To combat this it recommends that private providers form collaborative networks or franchises co-ordinated by a central agency to spread overhead costs and expand the type of services on offer.¹¹⁸ However, it is not easy to see how these proposed collaborative networks would work in a system based on competition between providers to drive down costs. In fact, such an approach threatens to create large private monopolies.

Quality and accountability

In terms of improving quality, regulation of public sector providers, although difficult, may be easier than regulating private ones. Where standardised systems and formal mechanisms of accountability exist, they make it easier to monitor the quality of services and to hold those responsible for poor services accountable. Introduction of new drugs, such as those recently developed for malaria, is easier within a unified system, as is ensuring that old drugs are no longer used.

Corruption is definitely a problem in many public health systems, and needs to be rooted out and dealt with. There are no easy answers but it is naïve to believe diverting public money to the private sector

will help. On the contrary, direct government provision of health services can help establish clear lines of responsibility. Government employees, health workers, and civil servants are accountable to local government and often also to parliamentary scrutiny so investment in these institutions and in civil-society watchdogs can help expose and inhibit corruption.¹¹⁹ In Malawi, for example, Oxfam's partner, the Health Equity Network, conducts and publishes regular surveys of public satisfaction with government services.¹²⁰ Citizen demand has helped to strengthen gender equity by monitoring sexual and reproductive rights and eliminating discrimination against women health workers.¹²¹ The Network's scrutiny has also uncovered a critical flaw with the government's medicine supply system, which they are now pressing the government to change.

Legislation on the right to health, and on the rights of citizens to information so they can participate in public policy, budgeting, and holding providers to account, have made significant improvements in the transparency and responsiveness of public health systems in Sri Lanka, Thailand, and Mexico City.¹²² By providing a vehicle for accountability to citizens, such legislation can encourage responsiveness to real needs and experience, and can offer a political counterweight to the self-interested lobbying of private firms. And when all people have access to the same level of public services, higher income citizens are also more likely to use their political influence to push governments on quality and accessibility commitments.

By investing in public provision it is not just health service users who know who is responsible, but also health providers. Public sector unions in developing countries are in a unique position to monitor and hold governments to account for the way public services are delivered. Union structures can be used to deal with collective concerns about a government, a group of staff, or an individual's unaccountable decisions and behaviour. Demands for improved working conditions can help improve service quality for users and tackle corruption. In Cambodia and the Czech Republic, salary top-ups for health workers, combined with commitments to codes of good ethical practice, led to a decline in informal bribe payments and greater access to health services by poor people.¹²³

Reaching the poorest and tackling health inequity

Those promoting the benefits of the private sector consistently criticize public health systems for disproportionately benefiting the rich. While problems are real in many countries, these problems are not insurmountable, and the evidence suggests the inequities of increased private provision are far worse, as the previous section showed.

When there is political will, governments are naturally in a much stronger position than the private sector to address inequity at

national level and ensure that every citizen has the same access to health services. The state has the ability to redistribute, using resources raised from richer groups in society to provide services for poorer groups. Redistribution through the public system also makes it possible to address inequities between regions, between towns and rural areas, and critically, between women and men. Public primary health-care services based on a network of local clinics are the most successful as they can reach and treat those illnesses that disproportionately affect poorer groups.¹²⁴

In Thailand, the transfer of doctors and nurses to rural areas by the state was central to addressing the poor health services available in rural areas.¹²⁵ Indian States that invest more in public health services have been more successful at reducing rural-urban inequality in access.¹²⁶ Policies of universal access in Sri Lanka, Malaysia, and Hong Kong, benefit the poor more than the rich. In 11 out of a sample of 12 Asian countries studied, government health spending was found to be 'inequality reducing'.¹²⁷ Even in highly inequitable Latin America, benefits of public health spending tend to be weighted towards the poor.¹²⁸

In contrast, evidence from Latin America, Southern Africa, and Asia has shown that where the role of government in delivering health services has diminished, services have been skewed away from those most in need to those most able to pay.¹²⁹

Even inequitable public health systems can be a key tool for fighting inequality.¹³⁰ This is because even if the rich get more than their share of the benefit in many countries, they also pay more of the taxes. When the tax revenue from the rich is taken into account, the overall benefit of health spending was found to be 'progressive' in 30 studies of developing countries reviewed by the IMF.¹³¹ This means that even relatively poorly-targeted public provision of health services helps narrow the gap in living standards between the poor and the rich.

The public ethos

'The shortages of nurses are really bad. You have to keep going even though you are very tired. I work from 4pm until 7.30am the next morning. That's 16 hours. There are five of us on the paediatric ward, and usually we have 200–300 kids. And I do day shifts covering for when we don't have enough people. We are hard working; we are sweating. We keep going— what else can we do?' Midwife in Lilongwe hospital, Malawi

In the public sector, staff often have greater commitment to their patients, because they see themselves as public servants, contributing to the national interest. In Sri Lanka studies have shown that the high levels of productivity are partly attributable to a culture among health workers of dedicated service to citizens.¹³² Worldwide, the vast majority of public health workers work very long hours for minimal financial reward, motivated by their desire to help the sick.

The fact that men and women still undergo years of training in order to enter public service in conditions of extreme under-funding is testimony to the importance of the public service ethos. Policy pressures to commercialise, accommodate private interests, and shift to material incentives have the opposite effect, leading staff to focus on income-earning potential from patients and undermining claims by the poor.¹³³ These policies have encouraged unethical and abusive behaviours to become the new norm in some health system settings.¹³⁴

Building government legitimacy

Public provision of services such as health care also plays an important additional role in state building. Public services can play a central role in building trust between citizens and the state and in establishing the legitimacy of government institutions.¹³⁵ Health services, especially in the remotest areas, are sometimes the only direct interaction citizens have with the state.¹³⁶

The hallmark of independence in many developing countries was a rapid expansion in health infrastructure and services and significant improvements in people's health.¹³⁷ In recent post-conflict states such as Timor-Leste and Nepal, health care is playing an important role in building democracy and state legitimacy.¹³⁸ Conversely, when services are provided outside of government, this can have a negative impact. A citizen in Afghanistan for example, is more likely to recognise the legitimacy of their new government if it is the one providing services and not a US NGO or a private company.

A reduction in the state's role in health care can cause instability and unrest. In China for example, gaps in health care due to privatisation have been cited as an important reason for growing anger towards the government in some rural districts and have led to increasingly frequent local riots and disturbances.¹³⁹

Applying the lessons of the past: more recent public successes

Recent country experiences have shown that the public health successes of the past cannot be written off as historical curiosities. On the contrary, when donors co-ordinate their support behind committed governments, impressive results can be achieved.

In Uganda, between 2000 and 2005, the government developed one unified plan for the health sector, and donors supported this with pooled funding. This enabled a significant expansion in public provision: 400 new clinics were built, 2,900 new health workers trained and deployed, and the proportion of the population living within 5km of a clinic increased from 49 to 72 per cent. The salaries of the lowest grades of nurses were doubled.¹⁴⁰ In 2001 the elimination

of user fees led to a huge increase in demand for services, which more than doubled in some instances. Uganda has seen falls in both infant and maternal mortality.

In Timor-Leste over 75 per cent of health facilities were seriously damaged or destroyed during the conflict in 1999 that eventually led to independence from Indonesia. Only 20 doctors remained in the country. As in Uganda, pooled aid through a sector-wide approach enabled rapid rehabilitation of the public health system and the implementation of free universal health care. In just three years, immunisation coverage increased from 26 to 73 per cent. Skilled attendance of births increased from 26 to 41 per cent.¹⁴¹

Wide use of informal private providers in developing countries to treat acute health conditions such as malaria has been used to justify subsidisation of this sector (see Box 5). However, recent government investment in the prevention and treatment of malaria in four African countries has shown that public health systems are able to respond rapidly and scale-up services for acute illnesses – with dramatic results. A combination of mass distribution of long-lasting insecticidal nets and nationwide distribution of artemisinin-combination therapy medicines through the public sector resulted in a decline of more than 50 per cent in in-patient malaria cases and deaths throughout Rwanda and Ethiopia. There was also a 33 per cent decline in deaths in children under five years old in Zambia and a 34 per cent decline in deaths in Ghana.¹⁴²

Action for success

No public health system is doomed to fail but making them work takes political commitment and leadership, investment, good policies, and popular support. Where these elements have been available, governments in poor countries have achieved remarkable results and often at a low cost.

The private sector does not provide an escape route to the very serious problems facing many public health systems. Developing-country governments and international donors must instead focus their efforts on tackling these problems head on. The lessons from successful health systems are surprisingly consistent.¹⁴³ Policies and strategies should be dedicated to achieving universal access. Services should be free of charge and accessible to all, even in the remotest rural areas.¹⁴⁴ Governments should train and recruit enough health workers and invest in leadership and management. They should adopt a strong primary health-care approach but also invest in secondary care, including rural hospitals, to protect the poor from the higher costs of these essential services.¹⁴⁵ Success depends on striking a balance between preventative, promotive, curative, and palliative interventions.¹⁴⁶

Governments should legislate on the right to health and on the rights of citizens to information. Governments must commit to transparency in their policy and budget decision-making and, as will be discussed in the following section, CSOs should be supported in their important role of empowering citizens to monitor health spending and influencing the practices of local public health-care facilities and workers. Aid from rich country donors should be provided as long-term predictable support to build the health system and for the training, recruitment, and retention of public health professionals.

The successes of some public health systems do not mean that problems and challenges do not exist, but they do prove that change and progress is possible. As the Commission for the Social Determinants of Health argues, rather than abandoning the public sector in the face of current problems in poor countries, urgent and dedicated action is needed to strengthen and scale-up public funding and delivery of health care.¹⁴⁷

4. Controlling costs and risks in private-sector health-care provision

The existing evidence strongly suggests that encouraging growth in private health-care provision may do more harm than good. This does not mean that the existing private sector can be ignored. It will continue to operate and brings both costs that must be managed and potential benefits, for example in research and innovation, that need to be better understood and capitalised upon.

A first step would be to abandon ideological presumptions and conduct an honest and comprehensive appraisal of the structure, characteristics, and impacts (both positive and negative) of the private sector. What types of private providers operate in which markets? What is their market behaviour and why? Are they small- or large-scale providers? What is their impact on the public health system? What type of services do they offer? Who do they reach and with what? Who do they exclude? In most poor countries there is a 'striking lack of evidence' for even these basics.¹⁴⁸

Secondly, rather than adopt unproven, ideologically-driven strategies, a more common-sense approach for governments and donors would be to look to the experiences of countries that have had success in scaling-up access to health care. What does the private sector look like in these countries? How has it been managed and regulated? Again, there is a dearth of information but what is available provides some guidance.

High-end formal private sector

In most low-income countries and especially in sub-Saharan Africa, the high-end and expensive formal private sector is under-developed and largely irrelevant for the majority of the population who cannot afford its services. Using tax or aid dollars to subsidise the activities of this sector is a waste of public money. Even in middle-income Mexico and Argentina, for example, where public systems were reformed to encourage the rich to opt out, the capacity to regulate large-scale, and often powerful, private health-care providers is lacking. As a result the redistributive function of the public system was compromised.¹⁴⁹

In the short-term, existing private providers and any of those applying for investment from international lenders should at least be required to sign up to a code of conduct to minimise the costs and damage to the public health system. Such a code could include the responsible recruitment of health personnel and could be made

publicly available in order to promote monitoring and accountability. At the same time private health-care companies must pay their taxes to ensure they help cover the costs of regulation and contribute to the public health system.

Developing countries would be wise to preserve their authority over health policy-making, including the authority to reverse any decisions on the role of the private sector, by excluding health policy altogether from bilateral, regional, and international trade and investment agreements, including the GATS negotiations in the WTO. Rich country governments that benefited from trial and error approaches involving both the public and the private sector in their own health-care systems should not push for the removal of such choice for developing-country governments.

Low-end formal and informal private sector

What should be done regarding the plethora of unregulated and unlicensed shops, practitioners, and drug peddlers that constitute the majority of private health providers in low-income countries? Their wide-scale use by the poor and marginalised, especially for acute health-care needs, calls for urgent action to minimise dangerous practice and improve standards.

Quality control through regulation seems near impossible due to the fragmented and mobile characteristics of these providers. When the weakness of under-resourced and sometimes corrupt government bureaucracies is also taken into account, the task is enormous. Even when operators are closed down, they frequently move around the corner and reopen.¹⁵⁰ Evidence from different countries has shown that negotiated interventions have greater promise of being effective.¹⁵¹ These include training for drug sellers and health-care providers for simple over-the-counter treatment backed by widespread public education to promote safer health-care seeking behaviour.¹⁵²

There are a number of reasons why such interventions will always be limited and their cost-effectiveness open to question.¹⁵³ Sustainability is unlikely: new providers are always entering the market. Interventions to date have proved hugely resource-intensive.¹⁵⁴ Low levels of education and skills amongst most providers mean the services that can be delivered safely will always be limited. Most importantly, without a guaranteed minimum standard of health care accessible to all, competition to attract low-income, poorly educated patients will continue to drive a race to the bottom amongst private providers in both price and quality.¹⁵⁵

Here the lessons from successful countries, especially in Asia, need to be more widely understood and applied. In Sri Lanka for example, a competent, free and universally accessible public health-care system

appears to act as an effective regulator of the private sector and helps to crowd out the informal unregulated private sector.¹⁵⁶ In order to attract the custom of the better off, the formal private sector in Sri Lanka has had no choice but to match the public health system on quality.¹⁵⁷ It competes on speed and responsiveness.¹⁵⁸

In many states in India, the quality of public-sector health services is unacceptably poor, putting no pressure on the private sector to offer anything better. In the Indian state of Kerala, by contrast, the quality of the public hospitals, whilst far from perfect, appears to put an effective quality 'floor' under the health services provided by the private sector.¹⁵⁹ Evidence of public health systems providing necessary competition for the private sector can also be found in Africa. Following the removal of user fees in Uganda for example, private providers also lowered their fees.¹⁶⁰

Placing emphasis on investing in a universal free public health service as a 'beneficial competitor' to private health-care providers in low-income countries does not mean abandoning direct interventions to improve the standards of private providers.¹⁶¹ But it does mean that a condition of any such investment must be an equal or greater investment in the more long-term and sustainable strategy of strengthening and scaling-up the public health system as the dominant provider. This solution can no longer be put on hold.

The role of civil society

Holding governments to account

Civil society in both developing and developed countries has an absolutely critical role to play in holding governments to account and insisting they do all they can to realise their citizens' right to health. Many CSOs already influence policy, promote transparency, and monitor government performance. At national and global level, CSOs are achieving significant changes in policy especially concerning the rights of people living with HIV and AIDS, drug prices and treatment, patient rights, tobacco control, promotion of breastfeeding, control of infant formula, and primary health care.¹⁶² Worldwide, Oxfam supports CSOs to hold rich country donors and developing-country governments to account. In Armenia, Oxfam in partnership with others, succeeded in persuading the government to make primary health care free of charge thus enabling universal coverage for the population. CSOs can take credit for many of the globally recognised health spending targets, including the Abuja 15 per cent commitment in Africa, and for the creation of the Global Fund for HIV/AIDS, TB, and Malaria. The latter has to date committed \$10.7 billion in 136 countries and saved 1.8 million lives.

CSOs can play an important role in empowering citizens to monitor health spending and influence the practices of local public health-care

facilities and workers. In the poor, remote community of Lakandra in Dailekh district in Nepal, for example, the Safe Motherhood project works to increase demand and facilitate access to maternal and neonatal health services for socially excluded groups. By identifying barriers to access, and feeding information back to the public, the project helped increase the number of antenatal and postnatal care clinics from one to four per month, and got representation for marginalised groups on the local health management committee.

Civil society providing health services

Successful countries have also sought to make use of the comparative advantage of CSO health-care providers as a complement rather than a substitute for a strong public sector system. As discussed earlier, the fact that civil-society organisations are not seeking to make a profit means they are not subject to the same market failures as for-profit providers. Often they are supported with money from the public in rich countries, bringing much needed extra finance into the system. They also have advantages such as innovation and have experience in devising ways to reach the poorest and most marginalised communities. Governments can learn from CSO experience and incorporate it into public sector practice. In addition, the need to regulate CSOs could help provide the incentive to government to work on regulation and quality standards across the health system.

CSO health-care providers should preserve these comparative advantages by resisting pressures to commercialise their operations in competition with the for-profit sector. Instead CSOs and governments should seek wherever possible to work collaboratively on the basis of shared principles of solidarity and equity. In several African countries such partnerships have worked well to expand overall access to health care (see Box 8).¹⁶³

Box 8: Working together: mission hospitals and the Uganda Government

In Uganda, the Christian church manages 42 per cent of all hospitals in areas underserved by the public health system. The mission hospitals faced a funding crisis in the late 1990s, and the Uganda government began subsidising their operations. Support included salaries for government doctors posted at hospitals and access to the national pooled medicine fund.

The move led to the development of a more structured partnership promoting broader collaboration in diverse areas including policy development, co-ordination and planning, human resources for health management, and community empowerment. Unlike government facilities, mission hospitals have not yet removed user fees, but they have been reduced using government subsidy. This has led to increases in utilisation by the poorest and most vulnerable people, particularly women and girls.

The Sector Wide Approach in Uganda, whereby donors pool their funding for health in support of recurrent costs, has enabled the government to

provide regular funding direct to the mission hospitals, helping to build what has become an effective partnership based on trust and negotiation rather than competitive contracting.

Source: Adapted from Lochoro et al. 2006 'Public-private partnerships in health: working together to improve health sector performance in Uganda'.¹⁶⁴

Partnerships between CSOs and government, where the state sets a framework as the majority provider, are also needed to ensure that the humanitarian relief efforts of international NGOs contribute to strengthening the capacity and status of the public health system in the longer term.¹⁶⁵

In Timor-Leste, for example, following decades of conflict that nearly destroyed the public health system, the Transitional Government asked NGOs to step in and play a temporary role in managing and providing district health services while the capacity of the public health system was being strengthened. Nurses and midwives were allocated to every health facility to work with and learn from the NGOs. Three years after independence the newly established National Health Authority took control of service provision.

Governments may also require CSOs to sign on to the NGO Code of Conduct for Health Systems Strengthening to ensure their services do not substitute but complement and promote the expansion of decent and accountable public sector health systems. The Code provides guidance on ensuring that activities do not draw on the finite resources of the state and emphasises the importance of empowering citizens to hold their governments to account.^{166 167}

5. Conclusion

The health MDGs are badly off-track. Millions of women, men, and children in poor countries go without any health care at all when sick. The need to rapidly expand and strengthen health services has never been more urgent. Governments and rich country donors have a responsibility to invest in proven policies to achieve this scale up.

The truth is that despite years of debate and substantial investment in private-sector solutions, the evidence needed to justify a general diversion of precious aid and tax dollars from governments to private health-care providers is missing. In fact, many country experiences show that private-sector expansion can undermine public health-care systems and their capacity to deliver to those most in need. Recent international and regional comparative studies have confirmed that publicly financed and delivered services continue to play the leading role in higher performing and more redistributive health-care systems.

The private sector has the potential to lift millions out of poverty. It can create new jobs and opportunities, generate wages for buying more goods and services and teach new skills. Development is impossible without it. However in the provision of health care there are clear risks that the costs may outweigh the benefits it may produce.

The evidence available cannot be used to claim that government health-care delivery is working well in every country: in the majority of poor countries there are serious challenges to be overcome. Nor does the evidence suggest that there can be no role for the private sector. It will continue to exist in many forms and bring both costs that must be controlled and potential benefits that need to be better understood and capitalised upon within a publicly-led and well-regulated system over which citizens can exercise democratic control.

Where the evidence is indisputable however, is 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. Developing-country governments and rich country donors must act now to produce real change and prioritise the rapid scaling-up of free public health-care for all. At the same time they must halt unproven and risky policies that promote an expansion of the private sector and threaten to derail hard won successes.

Recommendations

For donors

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

For developing-country governments

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

For civil society

- Act together to hold governments to account by engaging in policy development, monitoring health spending and service delivery, and exposing corruption.

- Resist pressure to commercialise operations and call on rich country donors and government to strengthen universal public health services.
- Ensure health services provided by CSOs complement and support the expansion of public health systems, including by signing on to the NGO Code of Conduct for Health Systems Strengthening.

Notes

¹ World Bank (2004), 'World Development Report: Making Services Work for Poor People', Washington DC: World Bank

² Bennett, S., McPake, B. and Mills, A (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London: Zed Books

³ International Finance Corporation (IFC) (2007) 'The business of health in Africa: partnering with the private sector to improve people's lives', Washington DC: IFC

⁴ World Bank (2007) 'Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results', Washington DC: World Bank

⁵ World Bank 2004, *op.cit.*, page 155

⁶ There are a number of large multi-national companies involved in health-care services with expanding involvement in poor countries. Afrox Healthcare Limited operates some 7,300 beds in South Africa, Botswana, and Zimbabwe. Health insurance companies are also expanding their portfolios to include provision or partnerships with private providers. British United Provident Association (BUPA) is an international health and care specialist providing insurance and care services to nearly four million people, with members in over 180 countries. In 2001 BUPA completed a deal to buy primary health-care businesses in Malaysia, Hong Kong, and Singapore and recently entered into a joint venture with a major health insurance and care provider in India.

⁷ Ollila, E. (2005) 'Restructuring global health policy-making: the role of global public-private partnerships' in Mackintosh, M. and Koivulsalo, M. (eds.) *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, New York: UNRISD

⁸ The proposed Economic Partnership Agreement (EPA) between the EU and the Caribbean includes medical and health services. The EPA provisions make it very difficult for countries to alter conditions of foreign providers in the event that their participation does not assist in meeting national development objectives and unexpectedly undermines access for the poorest and most vulnerable people in society.

⁹ As an example, 200 private investors from the US are planning to use the North American Free Trade Agreement to sue the Canadian government if it continues to block access to investment or profit opportunities in the Canadian health care system. From Russell, F. (2008) 'Suit seeks to open Canadian health care to privatizers', *Winnipeg Free Press*, September. <http://www.winnipegfreepress.com/historic/33080179.html> last accessed January 2009.

¹⁰ Oxfam, Action for Global Health, Médecins du Monde, Save the Children, Plan, Global Health Advocates, and Act Up Paris (2008) 'Health insurance in low-income countries: Where is the evidence that it works?' Oxford: Oxfam International.

¹¹ IFC report 2007, *op.cit.*, page 18.

¹² *ibid.*

¹³ Oxfam's analysis of data from Demographic and Health Surveys (DHS) in 15 sub-Saharan Africa countries with comparable data categories for private

providers. Data sourced from T.Marek, C. O'Farrell, C. Yamamoto and Zable, I. (2005) 'Trends and Opportunities in Public-private Partnerships to Improve Health Service Delivery', Africa Region Human Development Series, Washington DC: World Bank

¹⁴ Lyer,A., Sen,G., and George,A. (2007) 'The dynamics of gender and class in access to health care: evidence from rural Karnataka, India', *International Journal of Health Services* 37(3)

¹⁵ *Ibid.*

¹⁶ Latest data available. Data sourced from Marek et al 2005, *op.cit.*.

¹⁷ McCoy,D., Ashwood-Smith,H., Ratsma,E., and Kemp, J. (2005) 'Going from bad to worse: Malawi's maternal mortality', South Africa: Health Systems Trust

¹⁸ World Bank 2004, *op.cit.*, page 138.

¹⁹ World Bank 2004, *op.cit.*, page 137.

²⁰ IFC 2007, *op.cit.*, page 15.

²¹ Sengupta, A. and Nundy, S. (2005) 'The private health sector in India is burgeoning but at the cost of public health care' *British Medical Journal* 331: 1157-1158

²² Economic Times (2004):'Medical tourism, the next big wave', *Economic Times*, 8 April.

²³ Pan American Health Organization and Swedish International Development Agency (2003). 'Exclusion in health in Latin America and the Caribbean', Pan American Health Organization, Extension of Social Protection in Health Series No. 1. Washington DC

²⁴ Data sourced from Marek et al 2005, *op.cit.*.

²⁵ Presentation by Julian Schweitzer, Director: Health, Nutrition, and Population, Human Development Network, World Bank. Oxfam debate 'In the public interest? What role for the private sector in delivering health care for all?' at the World Health Assembly, Geneva, May 2008. IFC and World Bank roundtable discussion 'Health in Africa' at the World Bank Offices, Brussels, 26 February 2008

²⁶ IFC 2007, *op.cit.*, page 28.

²⁷ Bayliss, K. and Kessler, T. (2006) 'Can privatisation and commercialisation of public services help achieve the MDGs? An assessment', United Nations Development Programme, Working Paper number 22, New York: UN

²⁸ In South Africa the tax deductibility of medical scheme contributions reduces government tax revenue considerably. In 2001 this subsidy amounted to \$1 billion in lost revenue. From McLeod, H. (2005) 'Mutuality and solidarity in health-care in South Africa'. *South African Actuarial Journal* 5: 135-67

²⁹ McIntyre, D., Gilson, L. and Mutyambizi, V. (2005) 'Promoting equitable health care financing in the African context: Current challenges and future prospects', EQUINET Discussion paper number 27. www.equinet africa.org/bibl/docs/DIS27fin.pdf, last accessed 15 October 2008

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- ³⁰ Baeza and Munoz (1999) in Mills, A. (2007) 'Strategies to achieve universal coverage: are there lessons from middle-income countries?' Background paper for the Commission on Social Determinants of Health, Geneva: WHO
- ³¹ WHO (2006) 'World Health Report', Geneva: WHO
- ³² IFC 2007, *op.cit.*, page 3.
- ³³ Wibulpolprasert, S. and Pengpaibon, P. (2003) 'Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience', *Human Resources for Health* 1(12).
- ³⁴ This point has been repeatedly made by the current Director of Health at the World Bank, most recently at an Oxfam debate 'In the public interest? What role for the private sector in delivering health care for all?' at the World Health Assembly, Geneva, 2008.
- ³⁵ For example, see Hsiao, W. (1995) 'Abnormal economics in the health sector' *Health Policy* 32:125-39.
- ³⁶ Mackintosh, M. (2007) 'Planning and market regulation: strengths, weaknesses and interactions in the provision of less inequitable and better quality care', Background paper for the Commission for the Social Determinants of Health, Geneva: WHO
- ³⁷ Transparency International (2006) 'Global Corruption Report 2006', London: Transparency International
- ³⁸ Blumenthal, D. and Hsiao, W. (2005) 'Privatization and Its Discontents – The Evolving Chinese Health Care System', *The New England Journal of Medicine* 353:1165-1170.
- ³⁹ WHO statistics, <http://www.who.int/whosis/en/>, last accessed 7 October 2008
- ⁴⁰ *Ibid.*
- ⁴¹ WHO Commission on the Social Determinants of Health (2008) 'Closing the gap in a generation: health equity through action on the social determinants of health', Commission on the Social Determinants of Health, Geneva: WHO. In the US since 2000, the average employee contribution to company-provided health insurance has increased more than 143 per cent; average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose another 115 per cent during the same period.
- ⁴² World Bank (2008) 'World Development Indicators 2008', Washington DC: The World Bank, page 118.
- ⁴³ Kuttner, K. (2008) 'Market-based failure – a second opinion on U.S. health care costs' *The New England Journal of Medicine*, 358:549-51.
- ⁴⁴ The proportion of births by caesarian section in 1997 was 40 per cent. Murray, S.F. (2000) 'Relations between private health insurance and high rates of Caesarean section in Chile: a quantitative and qualitative study', *British Medical Journal*, 321(7275):1501-5.
- ⁴⁵ Angeja, A. and Washington, A. *et al.* 'Chilean women's preferences regarding mode of delivery: which do they prefer and why?' *An International Journal of Obstetrics & Gynaecology*, 113(11):1253–58.

⁴⁶ Huong,D., Phuong, N. *et al.*,(2007) 'Rural health care in Vietnam and China: conflict between market reforms and social need', *International Journal of Health Services* 37(3)

⁴⁷ Liu, X. and Mills, A. (2002), 'Financing reforms of public health services in China: lessons for other nations' *Social Science and Medicine* 54:1691-98

⁴⁸ Palmer, N. (2000) 'The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries' *Bulletin of the World Health Organization* 78(6).

⁴⁹ Waelkens and Greindl (2001) in Bayliss and Kesler (2006) *op.cit.* page 19

⁵⁰ Much of the evidence available on contracting comes from pilot projects and programmes with not-for-profit private providers. In many cases this was not because for-profit providers were excluded but because they did not produce competitive or technically acceptable bids. Not-for-profit examples are therefore sometimes used in this section to interrogate the claims made about the efficiency of contracting as a model of private-sector engagement.

⁵¹ Bloom,E., Bhushan, I. *et al.* (2007) 'Contracting for health: evidence from Cambodia' Washington DC: Brookings Institute www.cfr.org/publication/11356/brookings_institution.html, last accessed 20 October 2008

⁵² Palmer,N., Strong, L. *et al* (2006) 'Contracting out health services in fragile states' *British Medical Journal* 332:718-721

⁵³ WHO (1998) 'Experiences of contracting: an overview of the literature.' *Macroeconomics, Health and Development Series, Number 33.*

⁵⁴ This included Cambodia where on a per capita basis contracted-out districts increased public spending by a very substantial \$2.93 per capita in 2003, against a comparison mean of \$1.59. From Bloom *et al.* (2006) *op.cit.*

⁵⁵ Liu,X, Hotchkiss, D., and Bose, S. (2008) 'The effectiveness of contracting-out primary health care services in developing countries: a review of the evidence' *Health Policy and Planning* 23:1-13.

⁵⁶ As opposed to evidence-based policy making.

⁵⁷ For example Mills, A. and Broomberg, J. (1998) 'Experiences of contracting: an overview of the literature' Geneva: WHO; *Macroeconomics, Health and Development Series, 33*; England, R. (2004) 'Experiences of contracting with the private sector: a selective review' London, DFID Health Systems Resource Centre; Loevinsohn,B. and Harding,A. (2005) 'Buying results? Contracting for health service delivery in developing countries', *The Lancet*, 366: 676-8; Liu, X. *et al*, 1998, *op.cit.*.

⁵⁸ Loevinsohn and Harding 2005, *op.cit.*.

⁵⁹ Several methodological flaws in the review are listed by the author: (i) half the cases reviewed were based on reports in the grey literature, some of which had not been peer reviewed; (ii) the methodologies and outcome measures varied substantially between studies; (iii) the experimental designs and different outcomes made it impossible to undertake a formal meta-analysis; (iv) there are likely to be other examples of contracting that we were unable to identify and these may have had less positive results; and (v) there could have been a pilot-test bias in the examples considered. From

Loevinsohn and Harding 2005, *op.cit.*

⁶⁰ Liu, Hotchkiss and Bose 2008, *op.cit.* – note that the evaluation of the largest contracting-out programme in Bangladesh has been the subject of intense controversy due to concerns about a number of potential threats to internal validity, including the small number of control groups and the criteria used to select them, cross-contamination of the control group, the lack of controls for confounders, and the choice of indicators, among others. This led to a re-analysis of the data and, as a result, more tempered conclusions than those reported in the literature review by Loevinsohn and Harding 2005, *op.cit.*

⁶¹ Marek, T., Diallo, I., Ndiaye, B., and Rakotosalama, J. (1999) 'Successful contracting of preventative services: fighting malnutrition in Senegal and Madagascar', *Health Policy and Planning* 14: 382-9.

⁶² UNDP (2003) 'Human Development Report 2003: Millennium Development Goals: A Compact Among Nations to End Human Poverty', New York: UNDP, page 114

⁶³ Health Policy Network of the NHS Consultants' Association, NHS Support Federation (1995) 'In practice: The NHS market in the United Kingdom', *Public Health Policy* 16:452-91

⁶⁴ Mills and Broomberg 1998, *op.cit.*

⁶⁵ Marek et al 2005, *op.cit.*, page 36.

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⁶⁸ Tuan, T., Dung, V., Neu, I., and Dibley, M. (2005) 'Comparative quality of private and public health services in rural Vietnam' *Health Policy and Planning* 20: 319-27.

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⁷¹ Broomberg, J. and Mills, A. (2004) 'Quality of care in contracted-out and directly provided public hospital services in South Africa: evaluation of structural aspects', HEFP Working Paper 02/04, London School of Hygiene and Tropical Medicine

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⁷³ World Bank 2004, *op.cit.*

⁷⁴ Omaswa *op.cit.*

⁷⁵ IRIN(2008) 'NIGERIA: Shoddy private health centres closed down', *IRIN* 29 April 2008 www.irinnews.org/report.aspx?ReportID=77981, last accessed 28 October 2008.

⁷⁶ Newell, J., Pande, S., et al. (2004) 'Control of tuberculosis in an urban setting in Nepal: public-private partnership' *Bulletin of the World Health Organization* 82:92-98.

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- ⁷⁷ The Global Fund will decide whether or not to support the AMFm at its Board meeting in November 2008.
- ⁷⁸ Under-prescribing often occurs when patients cannot afford the full course of medicines.
- ⁷⁹ Médecins Sans Frontières (MSF) implemented malaria treatment pilot projects and programmes in three African countries and found that numbers of people diagnosed and treated for malaria only increased when services were provided free of charge. From MSF (2008) 'Full Prescription: Better Malaria Treatment for More People, MSF's Experience: Brussels.
- ⁸⁰ Mackintosh, M. (2003) 'Health care commercialisation and the embedding of inequality' RUIG/UNRISD Health Project Synthesis Paper
- ⁸¹ World Bank (2004), *op.cit.*, page 15.
- ⁸² *Ibid.*
- ⁸³ Hall, D. (2003) 'Public Services Work!: Information, insights and ideas for our future', Public Services International: Geneva
- ⁸⁴ Koivusalo and Mackintosh 2004, *op.cit.*.
- ⁸⁵ Huong, Phuong *et al.* 2007 *op.cit.*.
- ⁸⁶ The public health system in Viet Nam, while poorly resourced and managed, did provide near universal access to basic services until the late 1980s. In just 40 years infant mortality dropped by 90 per cent and life expectancy almost doubled as a result. Market reforms and substantial growth of the private sector since then have led to a disproportionate rise in costs for the poor. In 2003, just one inpatient episode cost a poor person the equivalent of 42 months' income compared with eight months for the non-poor. This difference in the relative cost to rich and poor people for the same care was almost double that of 1993. From Huong, Phuong, *et al.*, *op.cit.*.
- ⁸⁷ Rannan-Eliya, R. and Somantnan, A. (2005) 'Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap'. UK: DFID Health Systems Resource Centre
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- ⁹⁰ Blumenthal and Hsiao 2005, *op.cit.*.
- ⁹¹ Standing, H. (2002) 'Framework for understanding health sector reform' in Sen, G., George, A., and Ostlin, P. (eds) *Engendering international health: the challenge of equity* Cambridge: MIT Press
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⁹⁵ IFC 2007, *op.cit.*, pages 40-41.

⁹⁶ World Bank 2004, *op.cit.*, page 9.

⁹⁷ Transparency International 2006, *op.cit.*.

⁹⁸ *Ibid.*

⁹⁹ The research undertaken by Justice Quereshi concluded India's corporate hospitals were 'money minting machines'. From Qureshi, A.S. (2001) 'High Level Committee for Hospitals in Delhi', New Delhi: Unpublished Report of the Government of Delhi

¹⁰⁰ There is little evidence that CSOs can match the scale and scope of services deliverable through public health systems. A DFID funded study in Asia found that despite hundreds of NGO projects and initiatives in countries such as India, Bangladesh, Indonesia, and China, none have been able to make any discernible impact at the aggregate level on the overall experience of the poor in these countries. Even in Bangladesh, where millions are reached by NGOs, the reality is that tens of millions of poor Bangladeshis remain without effective access to health services. From Rannan-Eliya and Somanathan 2005, *op.cit.*.

¹⁰¹ Loewenson, R. (2003a) 'Civil society – state interactions in national health systems', Annotated Bibliography on Civil Society and Health, Zimbabwe: WHO and Training and Research Support Centre

¹⁰² For example, in Nepal CSOs are predominately located in urban areas providing health services to middle-income families where government facilities already exist. From World Bank (2004) 'Social assessment of the Nepal Health Sector Reform', Washington DC: World Bank

¹⁰³ For example, in Mozambique, the rapid growth of externally funded CSOs directly undermined the efficient allocation of resources to areas of greatest need, resulting in patchwork provision and growing inequality. From J.Pfeiffer (2003) 'International NGOs and primary health care in Mozambique: the need for a new model of collaboration.' *Social Science & Medicine* 56(4): 725-38.

¹⁰⁴ Missionary hospitals charge fees in most African countries and this excludes the poorest, especially women and girls. Research by Oxfam in Malawi showed that fees charged by mission facilities were a significant deterrent to the poor who would walk long distances to public facilities instead or do without care altogether. Providing care free of charge requires long-term sustainable funding, something the vast majority of CSOs struggle to guarantee.

¹⁰⁵ CSOs can offer higher wages and better working conditions than cash-strapped governments and so lure health workers away from the public sector. Recent research in Ethiopia showed that expert medical specialists could earn three times as much working for an American donor agency, as they could when working for the Ministry of Health. The researchers found that an expert medical specialist could earn a base monthly salary of \$354–513 in the Ministry of Health, compared to \$950–\$1200 in US bilateral agencies. From Davey, G., Fekade, D., and Parry, E. (2006) 'Must aid hinder attempts to reach the Millennium Development Goals?' *The Lancet* 367: 629–31.

¹⁰⁶ WHO Commission on the Social Determinants of Health (2007)

'Challenging Inequity through Health Systems', Geneva: WHO

¹⁰⁷ Higher performing countries in Asia include Sri Lanka, Malaysia, Hong Kong, and Thailand. Rannan-Eliya and Somantnan 2005, *op.cit.*

¹⁰⁸ Bokhari *et al.* 2005 cited in Mackintosh 2007, *op.cit.*

¹⁰⁹ Koivusalo, M. and Mackintosh, M. (2004), 'Health Systems and Commercialisation: In Search of Good Sense'. Paper prepared for the UNRISD International Conference on Commercialization of Health Care: Global and Local Dynamics and Policy Responses www.unrisd.org, last accessed 28 October 2008

¹¹⁰ Selected by region for their rapid and above-average achievements in health. Mehrotra, S. and Jolly, R. (eds.) (1997) *Development With A Human Face — Experiences in Social Achievement and Economic Growth*, Oxford: Oxford University Press, see chapter 2 for more detail about how countries were selected.

¹¹¹ Dates of 'breakthrough' periods in under-five mortality reduction ranged from the 1940s to the 1990s. *ibid.*, page 66.

¹¹² Oxfam (2006) 'In the Public Interest', Oxford: Oxfam International.

¹¹³ *Ibid.*

¹¹⁴ Oxfam International and WaterAid (2006) 'In the Public Interest: Health, Education, and Water and Sanitation for All', Oxford: Oxfam International

¹¹⁵ IRIN(2008) 'SRI LANKA: On track to eliminate malaria', IRIN, 24 April 2008. www.irinnews.org/Report.aspx?ReportId=77899, last accessed 28 October 2008.

¹¹⁶ Kuttner 2008, *op.cit.*

¹¹⁷ UNDP (2006) 'Human Development Report 2006', New York: UNDP

¹¹⁸ IFC 2007, *op.cit.*, page 60

¹¹⁹ For example, in Cuba, the World Bank reports that regular assemblies at the municipal level allow for consumer feedback on specific health needs and services. World Bank 2004, *op.cit.*

¹²⁰ Malawi Health Equity Network www.mejn.mw/mhen.html, last accessed 28 October 2008

¹²¹ WHO 2008, *op.cit.*

¹²² Tibandebage, P. and Mackintosh, M. (2005) 'The market shaping of charges, trust and abuse: health care transactions in Tanzania' *Social Science and Medicine* 61:1385-95.

¹²³ Transparency International 2006, *op.cit.*, page 65

¹²⁴ WHO Commission on the Social Determinants of Health 2007, *op.cit.*

¹²⁵ Oxfam (2007) 'Paying for people' Oxford: Oxfam International

¹²⁶ Sen, G., Lyer, A. and George, A. (2002) 'Class, gender, and health equity: lessons from liberalizing India' in Sen, G. *et al.* 2002, *op.cit.*

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- ¹³¹ *Ibid.*
- ¹³² WHO Commission on the Social Determinants of Health 2007, *op.cit.*
- ¹³³ Mackintosh 2007, *op.cit.*
- ¹³⁴ Owusu (2005), Van Leberghe *et al.* (2002) cited in WHO Commission on the Social Determinants of Health 2007, *op.cit.*
- ¹³⁵ Ghani, A., Lockhart, C., and Carnahan, M. (2005) 'Closing the Sovereignty Gap: an Approach to State-Building' ODI Working Paper 253
- ¹³⁶ World Bank (2000) 'Voices of the Poor: Can anyone hear us?' New York: Oxford University Press
- ¹³⁷ Hall, D. (2003) 'Public Services Work!' Geneva: Public Services International
- ¹³⁸ Alonso, A. and Brugha, R. (2006) 'Rehabilitating the health system after conflict in East Timor: a shift from NGO to government leadership' *Health Policy and Planning* 21(3):206-216.
- ¹³⁹ Blumenthal and Hsiao 2005, *op.cit.*
- ¹⁴⁰ WHO (2006) 'World Health Report', Geneva: WHO, page 77.
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- ¹⁴² WHO (2008), 'Impact of long-lasting insecticidal-treated nets and artemisinin-based combination therapies measured using surveillance data, in four African countries'. Preliminary report, Global Malaria Program, Geneva.
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- ¹⁴⁴ Rannan-Eliya and Somantnan 2005, *op.cit.*
- ¹⁴⁵ *Ibid.*
- ¹⁴⁶ WHO Commission on the Social Determinants of Health 2008, *op.cit.*
- ¹⁴⁷ WHO Commission on the Social Determinants of Health 2007, *op.cit.*
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- ¹⁴⁹ Mexico and Argentina are just two examples where social security schemes were reformed under pressure from companies and international donors allowing members to choose their own health-care providers. See, for example, Iriat, C. (2005) and Jasso-Aguilar, R. *et al.* (2005) in Mackintosh 2007 *op.cit.*

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- ¹⁶⁷ Oxfam is in the process of signing up to the code of conduct.

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For further information on the issues raised in this paper please e-mail advocacy@oxfaminternational.org.

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Oxfam International Secretariat: Suite 20, 266 Banbury Road, Oxford, OX2 7DL, UK
Tel: +44 1865 339100 Email: information@oxfaminternational.org. Web site: www.oxfam.org

Oxfam International advocacy offices:
E-mail: advocacy@oxfaminternational.org

Washington: 1100 15th St., NW, Ste. 600, Washington, DC 20005-1759, USA
Tel: +1 202 496 1170.

Brussels: Rue Philippe le Bon 15, 1000 Brussels, Belgium, Tel: . +32 2 501 6700

Geneva: 15 rue des Savoises, 1205 Geneva, Switzerland, Tel: +41 22 321 2371.

New York: 355 Lexington Avenue, 3rd Floor, New York, NY 10017, USA
Tel: +1 212 687 2091.

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