Private provision in its institutional context

lessons from health

Gerald Bloom

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This paper's aim is to contribute to the development of common understandings of this reality and to the formulation of practical strategies for meeting the needs of the poor.

The paper concludes that the evolution of appropriate institutional arrangements and accompanying beliefs and expectations will take a long time and involve many stakeholders, and that an important first step is to develop a realistic language for understanding problems and assessing options for change.

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Title: Private provision in its institutional context: lessons from health

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One characteristic of discussions about strategies for the provision of services to poor people has been the persistence of ideological debates about the relative roles of public and private sectors. These debates are strongly influenced by the experiences of the advanced market economies and often do not reflect the reality of countries where most poor people live. This paper's aim is to contribute to the development of common understandings of this reality and to the formulation of practical strategies for meeting the needs of the poor.

During the second half of the twentieth century, the health policies of many low and middle-income countries were largely based on expanding government health services. Some countries created effective and equitable government health services. Many did not, and some government health systems have faced difficulties associated with major social and economic change. Pluralistic health systems have emerged in which the boundaries between public and private sectors are blurred, with negative consequences for quality and cost. This is particularly the case in countries that have experienced prolonged economic crisis and in countries in transition to market economies.

The private sector is not a single entity. Providers can be classified by the economic characteristics of different health goods, the type of service, the degree to which they are part of an organised institutional arrangement and the social group whose members use them. Different strategies are needed to influence different classes of provider.

Better analysis for improved understanding

There are no simple frameworks to guide the formulation of comprehensive national strategies towards private providers in low and middle-income counties. In developing such strategies, policy analysts need to:

- learn how to analyse pluralistic health systems;
- do rigorous local and national institutional analyses (covering governments, private sector actors and civil society organisations) that focus on (local) inter-institutional relationships, including the 'social contracts' that underpin these relationships and other forms of accountability;

- understand local stakeholders, their interests and how they influence policy outcomes at national and local levels;
- be cautious and selective in drawing on insights from the experiences of the advanced market economies;
- learn from a variety of institutional innovations from around the world.

In many countries, there is an implicit social contract between providers and users of services, in which the former are accorded a reasonable income and social status in exchange for refraining from taking advantage of the power that the possession of expert knowledge gives them. This social contract is embodied in a variety of institutional arrangements. Where these arrangements are absent, users have to depend on word of mouth to choose providers, and they are vulnerable to opportunistic behaviour.

Political factors strongly influence an intervention's impact. These include the role of political parties and a variety of interest groups. Important groups in the health sector include public sector workers, professional associations and organised groups of service users. These groupings have a double-edged impact. On the one hand, they contribute to institutional arrangements that enable society to obtain the benefits of the implicit social contract between users and providers. On the other hand, individuals or groups can derive unfair advantage from partnerships and coalitions.

Towards better strategies and policies

Given the above, different strategies are needed to address the needs of different social groups and influence different classes of provider. In many countries, governments do not have the capacity to change radically the institutional framework within which providers of services function. In this case, leaders of change need to be good at working out how and where opportunities may emerge to make a positive difference at the 'margin'.

Service providers respond to immediate financial incentives and to longer-term considerations associated with career, social standing and ethical norms. Measures to improve their performance should take these factors into account. Government action can include use of financial leverage and enforcement of a regulatory framework. Government action alone is unlikely to be very effective. Governments can also provide information so that users can make informed choices about health services and influence decisions through electoral politics and other channels. They can also involve all relevant stakeholder groups in consultations and decision-making. These measures will reduce the capacity of powerful groups to protect their own interests.

All analysts agree that more effective regulation is essential. But how should one start where governments are weak? One strategy is to begin with a limited number of measures to address the worst problems. Government would seek a consensus on what constitutes

socially unacceptable behaviour. Measures for eliminating it would include government legal action, community monitoring and a very active information campaign. It is more important that initial measures succeed than that they address all possible regulatory issues.

The paper concludes with a discussion of strategies for implementing change in the health sector. It argues that the increasing concern in some countries about health-related problems is creating pressure for change. It points out that political pressure is a necessary but not sufficient condition for effective action. Elite groups must believe that interventions will work and will not damage their interests excessively. The challenge of meeting these conditions is great in countries where the boundaries between public and private sectors have become blurred. A change strategy in these countries will include:

- documentation of the ways that individuals and institutions are coping with the present situation and identification of good practices;
- measures to address key issues, combining government regulation, training of heath workers, provision of public information and involvement of a variety of organisations;
- use of financial leverage to influence providers, including contracting for services and experimentation with demand-side approaches;
- encouragement of innovative partnerships and institutional arrangements;
- generation of evidence on the impact of different interventions on the performance of the private sector.

The evolution of appropriate institutional arrangements and accompanying beliefs and expectations will take a long time and involve many stakeholders. An important first step is to develop a realistic language for understanding problems and assessing options for change. This can be fostered by helping stakeholders develop an evidential basis for their points of view and facilitating dialogue between stakeholders. The dialogue could focus on issues commonly agreed to require urgent action. It should identify both short-term measures and strategies for establishing coherent institutions.

1 Introduction

National and international discussions about private provision of health and other social services in low and middle-income countries are often highly polarised debates between supporters of opposing views about ideal social arrangements. These views bear little relation to the experiences of service users and providers in many countries. The gap between the languages of policy debate and local experience has impeded the development of practical ways to deal with present realities.

It is even difficult to pin down the meanings of *public* and *private*. A recent guide for policy-makers in low and middle-income countries defines private providers as '[those] who work outside the direct control of the state' (Smith *et al.* 2001). This begs the question of what is meant by 'direct control'. In some countries, *private* practitioners are constrained by a variety of government regulations; in others, *public* health facilities are remarkably free from government control. This highlights the need to understand the differences between public and private in their institutional setting. This is particularly important in countries where government administrative systems are fragile or institutional arrangements are changing rapidly.

This paper complements several recently published discussions of options for influencing the private sector in low and middle-income countries (Harding and Preker 2002; Mills *et al.* 2002; OECD 2003; Smith *et al.* 2001; World Bank 2004). Its aim is to contribute to the development of common understandings of the realities of public and private provision and of policies for improving performance. It argues that we need to situate strategies towards private providers in the context of local relationships between the state, market and civil society. Such strategies involve the creation of new (implicit) social contracts between providers and users of services. This cannot be achieved by exclusively top-down or bottom-up approaches. Government and other stakeholders need to collaborate in the design and implementation of strategies for change.

2 Public and private in advanced market economies

Our knowledge about public and private health providers comes mostly from the advanced market economies (Harding 2002). National leaders of change and officials in donor agencies need to understand the limitations of this knowledge so they can avoid unintended consequences that worsen the situation of the poor.

Most theoretical literature on the influences on private providers comes from the advanced market economies. They have highly structured health systems, which were created in a context conducive to the functioning of complex arrangements. This context includes economic stability, a relatively slow pace of social change, efficient tax and social security systems, a well-organised legal and regulatory framework, and sufficient trained personnel to operate these institutions.

The advanced market economies are largely rules-based societies. They have highly developed governance systems that underpin popular expectations that institutions will behave in a predictable manner and that individuals will mostly adhere to agreed behavioural norms. These deeply ingrained attitudes are a source of stability.[1] Analytical tools for understanding how particular organisational arrangements affect health system performance evolved in this context.

One aspect of the advanced market economies has been a clearly understood distinction between the public and private sectors. This distinction reflects the different historical legacies of government bureaucracies and private enterprises.[2] It has become less clear-cut as public and private institutions, and the relationships between them, have become more complex and as analytical tools have developed. The following paragraphs illustrate with examples from health economics and public administration.

Health economics was created during the construction of the welfare state. Its early advances were stimulated by debates between proponents of idealised visions of government-funded and -organised health services and markets for health care. The outcome of these debates is a widely accepted consensus that certain features of health and health services mean that an unregulated market results in sub-optimal outcomes in terms of efficiency, equity and safety (Bennett *et al.* 1997; Hsiao 2000). The analyses of health economics assume the existence of a well-ordered market economy within which state-organised arrangements compensate for specific failures.

Several explanations have been advanced for government involvement in the health sector. One is to provide financial support for services that benefit the community as a whole, such as public health services. Another is to enable people to protect their families against the high cost of major illness and to provide a safety net for the poor.[3] A third is to support the establishment of mechanisms to make the benefits of highly specialised knowledge widely available. This is particularly important because some services are risky, and people need to be confident that the experts they consult are competent. They also need to believe that their advisors will not abuse the power that possession of special knowledge provides.

Our understanding of public administration has evolved beyond the simple vision of a unified bureaucracy that automatically serves the public interest. There has been a great deal of work on *government failures* and on measures to compensate for them. These measures are often referred to as the 'new public administration' (Hood 1991; Minogue 2001). These failures include insufficient incentives to improve efficiency, lack of responsiveness to local needs, and a tendency to be influenced by powerful interest groups. Public administration is now understood as part of society, not above it.

One response has been to introduce measures that take into account the incentives that government institutions and individual employees face. This has involved a variety of initiatives to link pay and institutional growth to performance. These arrangements are often formalised in contracts. Another response has been to make service providers more answerable to communities and/or specific client groups. This has been done through the establishment of a variety of accountability mechanisms and the production and dissemination of information on performance.

The regulatory role of government has been of particular concern. On the one hand, government intervention is needed to ensure that markets operate in the public interest. On the other hand, interest groups may influence government to use its regulatory powers on their behalf. There have been efforts to design regulatory systems to take these conflicting possibilities into account.

The state is increasingly seen as an important actor in a partnership that includes civil society groups, not-for-profit service delivery organisations and the private sector (Cohen and Peterson 1999; Hulme 2001; Robinson and White 1997). Local governments have evolved a variety of relationships with different service providers and funders of services. This has led to new understandings of government as a coordinator of services or creator of a level playing field for a variety of stakeholders. One of its important functions is to ensure that the interests of the poor and powerless are taken into account. Some people refer to this as government's stewardship role.

It is generally agreed that the health sector in advanced market economies resembles neither a competitive market nor a unitary public service. Most policy debates now focus on the influence of alternative institutional arrangements on health system performance.

2.1 The ideological nature of understandings of public and private

Discussions about the appropriate relationship between government and private providers are often heated. This section links these strongly held views to the important role that shared attitudes and expectations play in the performance of the complex arrangements necessary to meet health and other social needs. Officials of donor agencies need to understand these influences on their understanding of the private sector so they can analyse other countries' situations objectively.

People must trust that institutions will perform according to agreed rules and that individuals will adhere to behavioural norms in order for a society to reap the benefits of the arrangements described above. They will be willing to allocate funds to government or a social insurance scheme, for example, only if they believe that the scheme will use the resources appropriately and that people will not cheat excessively. Similarly, they will accept the validity of government regulations and expect people to adhere to them if these regulations are believed to be in the general interest. Where this level of trust is absent, people make their own arrangements to protect themselves and those close to them.

One of the great social achievements of the advanced market economies has been to maintain stable institutional arrangements during the past half century, despite the continuing pressure from a variety of groups for changes in rules they believe are against their interests. This stability is derived from a combination of organisational structures and associated beliefs. At the beginning of the 1990s, Esping-Andersen (1990) argued that one could put most of the advanced market countries into three categories based on these arrangements and beliefs. He referred to these categories as 'welfare regimes' to signal their relative stability.

Esping-Andersen described three welfare regimes in terms of the pattern of entitlement to benefits and the relative roles of market and state. Liberal regimes give more importance to individual choice and the role of the market. They tend to have means-tested benefits, modest universal transfers or modest social insurance plans. Corporatist regimes were typically shaped by the Church, and are strongly committed to the preservation of traditional familyhood. They assign rights on the basis of class and status, and often have work-related benefits. Social democratic regimes are composed of countries where the principles of universalism were extended to the new middle classes. They give a great deal of weight to equity. Esping-Andersen could not fit the UK easily into any one of the categories.

Esping-Andersen explained the clustering of countries by their common social histories. He argued that welfare regimes were constituted of a constellation of institutions, government policies and ideological understandings that embodied different balances of values. Their stability derived from the complexity of the institutional arrangements and the shared popular expectations and attitudes. Macintosh (1999) makes a similar point in

referring to the path dependency of health systems. She suggests that the impact of interventions is strongly influenced by a country's historical legacy.

Reforms during the past decade have reduced the distinctions between regime types. These reforms have been associated with highly charged political debates. This is understandable given the history of competition between social groups in the creation of welfare regimes and the importance of attitudes and behavioural norms in sustaining them.

Debates about changing the relationship between markets and the state are about more than the immediate impact of a particular innovation. They also concern longer-term influences on the performance of institutions. A number of people have voiced concern about the possible impact of reforms associated with the new public management on the values and beliefs essential to the good performance of public services (Hood 1991). They suggest that the emphasis on financial incentives may reduce attitudes of public service and professional ethics (Gilson 2003; Segall 2001; Titmus 1970). Others take the opposite point of view in suggesting that dependence on the state reduces individual initiative.

All these commentators agree that shared understandings and behavioural norms are important to the effective functioning of health and welfare systems. However, it is very difficult to accurately predict the impact of a change in institutional arrangements on public attitudes. The complexity of the chain of cause and effect has contributed to a tendency for discussions on the role of the private sector to have an ideological flavour. Different positions tend to embody the values and experiences of particular countries or social groups. They provide a way to make sense of the processes that underlie the long-term development of a country's social sector. However, the ideological nature of these understandings makes it dangerous to apply insights gained in one country to other places with different histories and institutional arrangements.

3 Public and private in low and middle-income countries

During the second half of the twentieth century, many political movements that eventually came to power in low and middle-income countries promised equal access to health care on the basis of need. The new governments subsequently made this promise a basis for their health policy. Countries varied in the degree to which they translated this policy into action. A number of countries pursued relatively egalitarian health strategies. These included the command economies and a number of populist governments. Many other countries favoured the post-colonial elites in their government health services.

Despite these differences, many countries shared similar approaches to health system development, including the creation of a network of government facilities, an increase in the number of government health workers, and the provision of services that were free or highly subsidised. Many countries abolished the private health sector or assumed it would provide services for only a small group of rich people. There was a general expectation that the public sector would meet the needs of the rest of the population and gradually replace 'unscientific' traditional practices. The convergence of approaches in countries following different development paths was expressed in the acceptance of primary health care as the basis for international health policy.

The origin of the promise of access to health care in many countries' post-colonial or post-revolutionary transition gave it an important status. Governments dared not renege on this promise publicly, despite the obvious incapacity of their public systems to meet needs and the consistent unwillingness of the better-off to fund services adequately for the poor. The gap between the ideal vision and the reality of health systems has grown. However, political attitudes formed decades ago still dominate public discussions about government's role in the health sector.

Low and middle-income countries now differ greatly in their institutional arrangements for health. Some have publicly financed and organised health systems that resemble those in the advanced market economies. Many others have greatly expanded private sectors. Bloom and Standing (2001) point out that many countries now have pluralistic systems, in which the boundaries between public and private have become blurred. They cite a number of examples from countries in transition to market economies and countries that have experienced chronic economic and institutional crisis. Berman (1998) shows that a very high proportion of health care transactions in India are private.

Several possible explanations have been advanced for the emergence of pluralistic systems. Some emphasise the influence of international ideologies and the policies of donor agencies. Deacon (1999) suggests that there is a worldwide debate between advocates of 'European universalistic social expenditure' and 'USA residualism'. Simms *et al.* (2001) suggest that particular approaches to structural adjustment and health sector reform were major factors in the deterioration of the health systems in a number of African countries. Other analysts focus on the deleterious impact on health system development of competition between donor agencies and changing international policies.

Another trend of thought seeks explanations for the emergence of pluralistic systems in local political and institutional realities (Berman 1998; Bloom and Standing 2001; Leonard 2000). It points to the gap between the language of politics and policy and the situation on the ground, and challenges the view that low and middle-income countries will necessarily replicate the institutional arrangements of the advanced market economies in the foreseeable future. It calls for more effort to understand how the local and the international interact to influence health system development. The following sub-sections consider the changes that have occurred in Africa and in transitional economies.

3.1 Informalisation in Africa

The chronic crisis in African has led to a much greater emphasis on understanding how institutional arrangements influence development. In testimony to the British Parliamentary Select Committee on Development, the former Secretary for International Development drew attention to the complex nature of the crisis in Southern Africa, where countries with high levels of poverty and high burdens of ill-health have to cope with periodic shocks from crop failures in a context of weak systems of public administration and inadequate mechanisms for public accountability (Short 2003). She warned against over-reliance on short-term measures that do not take into account the underlying institutional and political issues.

Duffield (2001) draws attention to a large gap between much development discourse and development reality. He argues that many donor policies and procedures are premised on the assumption that African countries will eventually be similar to the advanced market economies. He suggests that most support programmes are designed on the basis of this assumption. This has diverted attention from new realities, such as the increasing proportion of economic activity outside the formal economy.

Duffield suggests that local government officials and political actors have become increasingly involved in informal economic activities in many countries. This has led to the evolution of institutional arrangements outside formal government regulatory frameworks and apart from agreements between governments and donors. He concludes that donors and international agencies should take this economic, political and institutional reality into account. This will involve engagement with a variety of actors outside the regulated formal sector.

Several authors make similar points about health. Semboja and Therkildsen (1995) link the rapid growth of private health provision in East Africa to the prolonged financial crisis of the public sector. Van Lerberghe *et al.* (2002) describe health worker strategies to cope with chronically low public sector pay. Reynolds White and Birungi (2000) point out that a very high proportion of drugs are purchased privately in Uganda. Mackintosh and Tibandebage (2002) analyse the emergence of markets for hospital services in Tanzania. Leonard (2000) draws attention to the systemic nature of this reality in describing how health workers and users of services respond to economic incentives in an environment that includes little government supervision or professional regulation. He suggests that the health sector increasingly resembles a poorly regulated private system in many countries. Bloom and Lucas (2001) make a similar point in arguing that government and donor policies should be based on an understanding of economic and institutional realities. They call attention to the many local adaptations that people are making and the need to learn from them.

All these authors suggest that the rules and regulations of the public health sector no longer provide an adequate framework for understanding most African health systems. A variety of coping strategies have become so ubiquitous that they can no longer be regarded as aberrations. They argue that new institutional arrangements are emerging with associated behavioural norms. They suggest that government and donor policies should take this into account. This will involve learning from local innovations that work. The way forward may involve different kinds of relationships between donors, government, service providers and other stakeholders.

3.2 Transition from a command economy

The experience of the transitional economies has contributed to our understanding of how trusted and trustworthy institutions become established. Some countries have tried a blueprint approach, involving the enactment of laws in the expectation that institutions and social actors would follow the new rules. The former Soviet Union took this approach in the early 1990s. Its subsequent experience has led to questions about whether this is the best way to move from one set of institutional arrangements to another (Stiglitz 2003). A lot of economic activity in the former Soviet Union now takes place outside the legal framework (Reddaway and Glinski 2001). Informal payments account for a major source of health finance (Ensor and Savelyeva 1998). A large proportion of health workers operate outside the law.

The Chinese experience has led to an understanding of transition as the gradual creation of new institutional arrangements and the behavioural norms that make them work (Oi 1999; Rawski 1999; Saich 2001). The Chinese leaders describe transition management as ‘crossing a river while feeling for the stones’. This refers to the tentative nature of the process and the inability to predict the endpoint. The central government and Communist Party have kept tight control over national security and political power. But, they have given local administrations, enterprises and individuals a lot of scope to develop innovative

institutional arrangements for economic relationships. The government has altered the legal framework from time to time to formalise changes that had already been shown to work locally (Lubman 2001). This has helped prevent the emergence of unbridgeable gaps between individual livelihood strategies and the law. However, it has delayed the creation of rules-based decision-making systems. A lot of economic activity takes place in a hazy region not covered by the law (Francis 2001).

The management of change in the health sector has mirrored the rest of the economy. It is difficult to categorise health facilities as either public or private. Most are owned by one or another level of government and are subject to a variety of regulatory constraints inherited from the command economy. As much as 90 per cent of their revenue comes from private sources. Health facilities operate in an environment with remarkably few of the regulatory rules found in advanced market economies. Many rural facilities resemble a lightly regulated, mildly subsidised private sector.

Bloom and Fang (2003) argue that effective health system reforms depend on the creation of institutional arrangements that encourage health workers to perform well. For this to happen, relevant actors must know their roles, stakeholders must understand the rules of behaviour and be able to meet their aspirations by conforming to them, and it must be widely assumed that people will mostly follow the rules. The social construction of these rules is an important aspect of transition. The government must redefine its role and ensure that local officials have the capacity and motivation to perform well. These officials have to stop interfering in personnel management and investment decisions, but they have to be more active in regulating provider behaviour.

The African and Chinese experiences suggest that we need to shift our focus from the arrangements in advanced market economies to the situation in low and middle-income countries and to the ways that improvements may be achieved. They draw attention to the influence of appropriate institutional arrangements underpinned by shared expectations and behavioural norms on the performance of health systems. They also point to the need for an understanding of how institutional arrangements are constructed. They raise questions about the realism of the attempt to import institutional arrangements for welfare provision from advanced market economies.

3.3 The analysis of public and private in situations of rapid change

Several analysts have drawn attention to the lack of a theoretical framework for understanding the public and private sectors in the reality of many low and middle-income countries. This reality includes large numbers of people excluded from the formal economy, fragile and inefficient government bureaucracies, and weak legal and regulatory systems. It may also involve rapid economic and institutional changes associated with structural adjustment, a transition from a command economy or reconstruction after a conflict. These changes influence beliefs and ethical norms.

Moore (1999a) has pointed out that theories about the relationship between the private sector and the state are often posed in terms of market and state failure. These theories cannot predict the outcome of a particular intervention when there are major failures of both. Toye (1999) makes similar points in calling for analyses of the actual situation and the identification of realistic strategies for change that take into account weaknesses of institutions and political constraints to change.

Joshi and Moore (2002) discuss the dilemma that analysts of institutional development face. They posses a toolbox of analytical frameworks developed in the rules-based, advanced market economies. These frameworks enable them to formulate clear and testable hypotheses about the likely implications of a particular reform option. They also enable analysts to develop general ideas about different institutional arrangements. However, they provide little guidance for predicting how institutions will respond to the same reform option in different contexts.

McCourt (2001) reaches a similar conclusion in rejecting blueprint approaches to public management reform and advocating a strategy that takes into account the contextual contingencies that influence the impact of a particular intervention. Rose (2003) points out the need for caution in transferring approaches between countries with different social arrangements. He suggests that some low and middle-income countries resemble the segmented societies of late nineteenth-century Europe more than they resemble the highly organised Europe of today, and they can learn from the historical experience of the construction of the social sector in these countries.

Theories imported from the advanced market economies tend to be normative, asking what arrangements one might wish to have. Analysts commonly pose the question: 'If there were a working command-and-control bureaucracy, what would be the likely impact of introducing certain forms of regulation?' The actual situation is often so different from the assumed starting point, and the capacity of local institutions to implement particular changes is often so limited, that the answers may be of little practical use. Also, the attitudes and expectations of local actors may be different from those in a stable market economy, leading them to respond differently to a particular institutional innovation.

The alternative approach begins with the reality of messy arrangements in low and middle-income countries and asks why some work better than others. The aim is to understand how institutions operate in their environment. This approach is exemplified in the following studies: by Tendler (1997), of the reasons why certain reforms worked in Ceara State in Brazil; by Mackintosh and Tibandebage (2002), of the reasons why some hospitals perform better than others in Tanzania; and by Leonard (2000), of how different ways of paying health workers have evolved for different kinds of health problems. These analyses focus on the kinds of arrangements that provide incentives for actors to perform well and foster attitudes of public service.

Policy analysts can use both approaches. They can replicate models from the advanced market economies in the more regulated parts of the economy. Also, they can apply basic lessons about the importance of incentives and the need to understand the motives of government regulators to most circumstances. However, they need to recognise the limitations of theories derived from experiences in very different contexts.

They can also draw lessons from successful experiences in other parts of the world. One common factor is the quality of leadership. This points to the need to train people to play this role. Another lesson is that success depends on the creation of an environment in which actors have incentives to work together to achieve common objectives. These incentives include immediate financial reward and the well-being associated with career prospects, social status and a sense of public service.

4 Private providers in low and middle-income countries

It is misleading to talk of the *health sector* or of *private providers* as if the words refer to single, clearly defined entities. In reality, a number of actors provide a variety of goods. One can classify these actors in several policy-relevant ways.

4.1 Economic characteristics of health care goods

Chakraborty and Harding (2002) classify health care goods on the basis of contestability and measurability, and suggest that these characteristics influence the institutional arrangements for providing them (Table 1). Goods for which there are competing suppliers and for which users can easily compare one good with another are more likely to be provided through a competitive market. Goods that are neither contestable nor measurable are more likely to be provided by government. The arrangements for the provision of goods with intermediate characteristics often combine characteristics of markets and government.

Table 1: The nature of health care goods based on institutional economics

	High contestability	**Medium contestability**	**Low contestability**
High measurability	Retail: • drugs • medical supplies • other goods	Wholesale: • drugs • medical supplies • other goods	Production: • drugs • high technology
Medium measurability	• routine diagnostics • hospital support services	• management services • training	• high-tech diagnostics • research
Low measurability	Ambulatory care: • medical • nursing • dental	• general hospitals • public health services • health insurance	• policy-making • monitoring and evaluation

Source: Chakraborty and Harding (2002), Table 2.1

K. Leonard (2000) suggests that different economic characteristics of health goods are relevant in rural Cameroon. He argues that people choose providers on the basis of the need for practitioner effort, patient effort and medical expertise. They go to traditional healers or mission hospitals for problems that require practitioner effort, to government clinics when they require neither practitioner nor patient effort, and to government hospitals when specialised medical expertise is important.

4.2 Organised and unorganised health care economy

Bloom and Standing (2001) identify five categories of health-related activities: public health services; skilled consultation and treatment; provision of medical-related goods; physical support of the acutely ill, chronically ill and disabled; and management of inter-temporal expenditure (Table 2). They point out that societies have evolved a variety of arrangements to organise each category of activity. They argue that the division between public and private is blurred in many low and middle-income countries, and suggest that the division between 'organised' and 'unorganised' institutional arrangements is more relevant. Organised arrangements involve the state and state-supported institutions, such as professional licensing boards. Unorganised activities are made up of the myriad of local adaptations outside the legal framework.[4]

Table 2: Pluralistic health systems at the beginning of the twenty-first century

Health-related function	Unorganised health care economy		Organised health care economy
	Non-marketised	Marketised	
Public health	Household/community hygiene		Government public health service and regulations Private supply of water and other health-related goods
Skilled consultation and treatment	Use of health-related knowledge by household members Some specialised services such as traditional midwifery provided outside market	Traditional healers Unlicensed and/or unregulated health workers	Public health services

Health-related function	Unorganised health care economy		Organised health care economy
	Non-marketised	Marketised	
		Covert private practice by public health staff	Licensed health workers and facilities Licensed/regulated NGOs
Medical-related goods	Household/community production of traditional medicines	Sellers of traditional and western drugs	Government pharmacies Licensed pharmacies
Physical support of acutely ill, chronically ill and disabled	Household care of sick and disabled Community support for AIDS patients, people with disabilities	Domestic servants Unlicensed nursing homes	Government hospitals Licensed or regulated hospitals and nursing homes
Management of inter-temporal expenditure	Inter-household/inter -community reciprocal arrangements to cope government budgets, with health shocks	Money lending Funeral societies Local health insurance schemes	Organised systems of health finance: /informal credit compulsory insurance, private insurance, bank loans, micro-credit

Source: Bloom and Standing (2001)

Killingsworth (2003) describes the complex markets that have emerged in Bangladesh, the former Soviet Union and China due to the widespread charging of unofficial fees at public facilities. He points out that the impact of fee-charging on the behaviour of providers and the performance of the health system depends on the social history and the meaning of these fees to users and providers. He underlines that the boundary between organised and unorganised depends on this history. In some cases, so-called informal arrangements become so incorporated into public expectations of the working of the local health economy that they are no longer considered to be extraordinary or corrupt.

4.3 Segmented health care systems

One can analyse the health sector in terms of the social groups that actors serve. Health systems tend to mirror the social segmentation of the society within which they are embedded (Bloom 2001). This segmentation may be on the basis of place of residence (urban, rural or remote; rich or poor), income and other characteristics that influence access to services (age, sex, ethnicity, displacement, disability etc.). In many countries, one finds varying degrees of integration into the global economy that extends from elites, who are part of the international economy, to salaried workers, who are integrated into the organised national economy, to people living outside the organised economy.[5]

This segmentation is often reflected in the health sector, where the better-off are more likely to secure health goods through the organised health economy than are the poor. One common pattern is for the wealthy to depend on private providers and private insurance with international standards. A larger group of employees may have work-related benefits that subsidise access to providers in the organised sector. The poor tend to use low-cost government providers or the private sector. These providers commonly request payments and are often unregulated.

There is a myth that government health services are for the poor and private services for the rich. This is true in some countries, but not in many others. It is more accurate to say that the powerful and the rich tend to use the highest quality private services and also the most sophisticated government referral hospitals. The weak and poor tend to use less organised services, which often include government health facilities that have suffered from chronic under-funding and a variety of non-government providers and drug sellers. Table 3 provides a stylised example of the providers that different social groups use.

Table 3: Who uses what provider in segmented health systems?

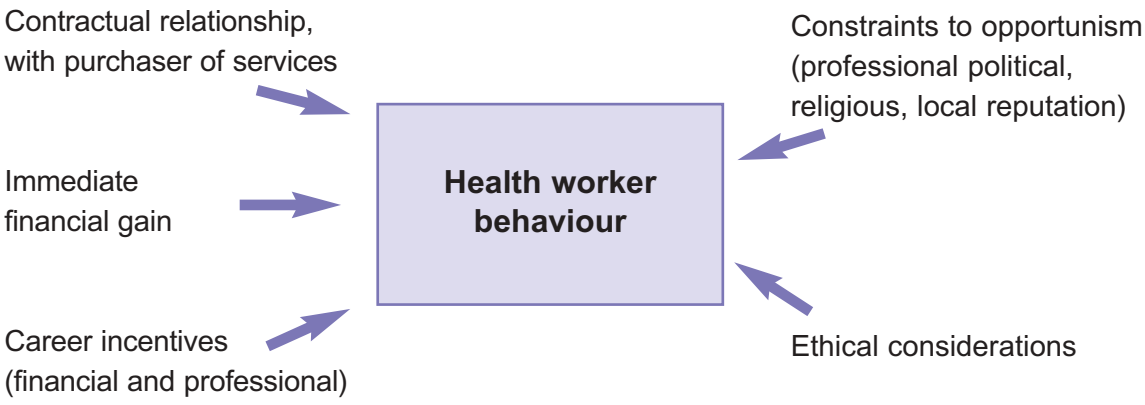
Function	Weak and/or poor	Salaried workers	Powerful and/or rich
Public health	Some public provision in shantytowns or rural areas Community arrangements	Urban public health services	Live in communities with their own water and sanitation systems

Function	Weak and/or poor	Salaried workers	Powerful and/or rich
Skilled consultation and treatment	Government clinics and government hospitals (may require under-the-counter payments) A variety of practitioners with skills in western and traditional medicine, often outside the legal framework	Government clinics and hospitals Facilities owned by social security schemes or companies Private doctors and hospitals	Private hospitals, general practitioners and specialists The most sophisticated government referral hospitals
Medical-related goods	Government facilities, NGOs and unregulated drug sellers	Government facilities Private providers Licensed pharmacies	Hospitals and private doctors Licensed pharmacies
Physical support of ill and disabled	Household care of sick and disabled, with different kinds of community support	Hospitals, nursing homes Household labour	Domestic servants Hospitals and nursing homes
Management of inter-temporal expenditure	Household, family and community arrangements Community health insurance and micro-credit Unregulated money lenders Government safety nets	Employment-related health insurance Commercial insurance and loans Pawn shops/money lenders etc. Family and informal arrangements	Access to private insurance, savings and loans Company or government employment benefits

4.4 Institutional arrangements

This section looks at the influences on service providers (Figure 1). They certainly respond to immediate financial rewards, but they also respond to more than that. They often eschew short-term gains for longer-term ones. Individual practitioners may value opportunities for professional development and the benefits associated with high social status. People working in health facilities may attach great importance their facility's reputation. Many countries have evolved complex professional regulatory structures that embody an implicit contract between providers and society, in which providers are given high status and a reasonable income in exchange for a commitment not to take advantage of the power their expert knowledge gives them. Other countries have achieved similar results through revolutionary political ethics, religious considerations and other means.

Figure 1: Influences on the behaviour of health workers



This social contract is often expressed in a variety of institutional arrangements. Some institutions are directly involved with the supply side, such as professional licensing and regulatory agencies, and bodies representing particular provider groups. There are also a range of civil society organisations representing users, grouped on the basis of locality, ethnicity, religion, specific needs and so on (Loewenson 2003). They function as lobby groups, purchasers of services and partners with local and national governments in health-related programmes. Cornwall and Lucas (2000) present a number of innovative arrangements that have emerged to make health services more accountable to communities. These include active community participation in health projects, establishment of health committees and so on.

There are also arrangements between private providers, such as branding and franchising arrangements based on affiliation with religious organisations, international non-government organisations or private companies. People may take this kind of labelling of providers into account in choosing whom to consult. For example, they may be willing to pay more for what they believe to be better quality services in facilities linked to a religious order. Or, they may pay more for brand-name drugs if they do not trust their government

to assesses the quality of generic products adequately.

It may be in the interest of the supplier of a regulated or branded product to foster distrust in their competitors. Branded drugs are usually much more expensive than generic ones, and certified medical specialists earn more than other health workers. Trust has social value in enabling people to choose competent providers and effective drugs. It also has economic value to trusted providers. That is why government regulation is so important.

Joshi and Moore (2002) emphasise the importance of the long-term partnerships that are emerging between the state and organised groups of citizens around the provision of competent and affordable services. They label these arrangements 'co-production' and suggest that they will become more common as people seek ways to adapt to the reality of relatively weak states.

There is a trend towards the decentralisation of functions away from national governments. One aspect of decentralisation is the official policy of devolving powers over finances and enforcement of regulations to local governments. The patterns of political influence on local and national governments may differ. Some partnerships between local governments and non-government providers are much more responsive to local needs than top-down national policies. There are also examples of local governments that choose not to enforce regulations that would damage the interests of local power-holders. The appropriate policy for change will differ between these two circumstances (World Bank 2004).

Another form of decentralisation is the shift of power to local institutions as a result of the diminished power of central governments. This has created space for the emergence of a variety of organisations. This decentralisation has led to changes in the relationship between users and providers. The most obvious is the growth in consumer consciousness. There are plenty of examples of people making informed choices about the providers to consult. For example, they may travel further or pay more to attend what is considered to be a better source of care.

There are fewer examples of people asserting their right as citizens to have certain standards of service. Ministries of Health are often low in the government pecking order, reflecting a lack of political pressure for action in their area of responsibility. This is surprising, since governments have been committed for years to the provision of equal access to services and are loathe to disavow this commitment publicly. One possible explanation is that it is very difficult to assess quality services and then to assign responsibility for problems (World Bank 2004). The public has little information on the performance of health providers. Could the growing concern about health that one discerns in many countries lead to greater political pressure to improve the performance of the health sector? The number of civil society organisations with an interest in service delivery is growing. This has led to new forms of relationship between users, providers and other organisations. These partnerships have had limited political influence. But this may be changing.

5 Interventions

Governments have a number of instruments for improving private provider performance. Harding (2002) categorises them in terms of their intrusiveness, extending from direct provision to dissemination of information (Table 4). She could have added, the power of governments to influence the political agenda.

Table 4: Government tools for influencing the private sector

Level of intrusiveness	Tool or method	Application
Most	Direct provision	Rural public hospitals and clinics, preventive services Sanitation
	Financing	Budgetary support, subsidies, concessions, contracting
	Regulation and mandates	Taxation, licensure, accreditation, employee heath insurance, required immunisation of schoolchildren
Least	Information	Research–product testing, provider information, consumer information

Source: Harding (2002) from Musgrove (1996)

Smith *et al.* (2001) classify interventions in terms of their purpose and the actors they are meant to influence (Table 5). They define three purposes: to increase coverage by goods and services; to limit harmful practices; and to improve quality and control costs. They also define three types of intervention: alteration of the regulatory framework or the overall fiscal rules; targeting of providers through training, support of marketing activities; and contracting them to provide services and support for users through provision of vouchers or exemptions from charges and provision of information.

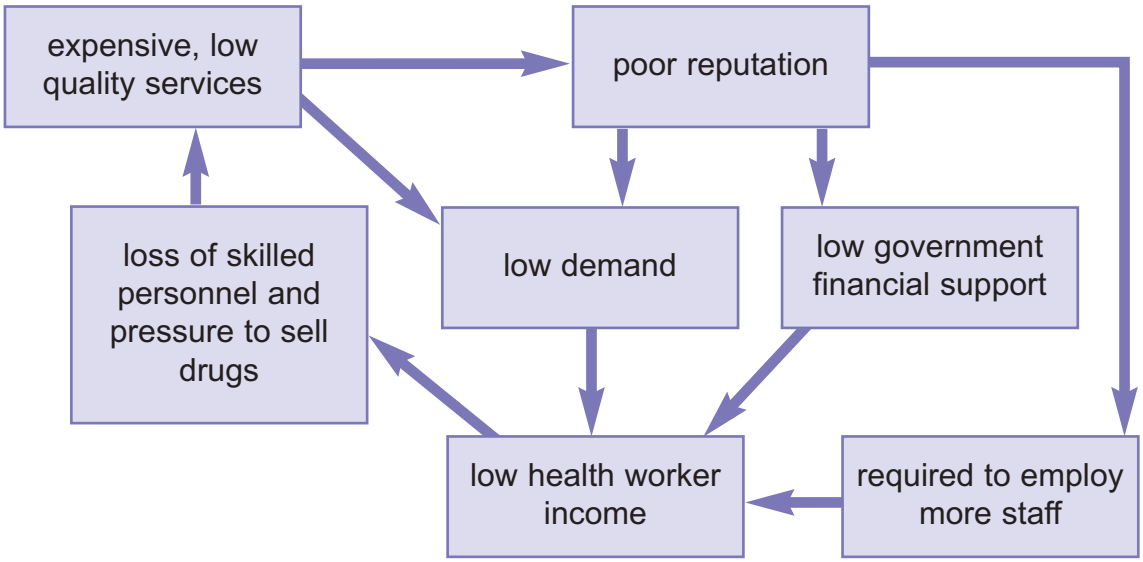
Table 5: Strategies for working with private providers

Purpose of intervention	Actors the intervention targets		
	Policy-makers	Providers	Users
Increase coverage of products and services with a public health benefit	Lower regulatory and fiscal barriers to greater availability	Subsidise marketing of products Recruit providers into an accredited network for specific services Contract with providers of essential health care	Expand demand among target groups Introduce exemption schemes for target groups
Limit harmful practices and improve quality	Enact and enforce legal restrictions and regulatory controls	Provide training supports and incentives to conform to good practices	Enact consumer protection law and raise awareness of consumer rights Increase service user knowledge through education campaigns
Control costs	Set price levels	Finance through prospective payment mechanisms	Public information on permitted prices

Source: Smith *et al.* (2001)

These are useful frameworks. However, institutional and political dimensions also must be taken into account in selecting an intervention. In the absence of appropriate institutional arrangements, providers, users and governments can find themselves in a vicious circle that drives the earnings and reputation of health workers down and results in expensive, low quality services (Gilson 2003). This vicious circle is illustrated in Figure 2, which refers to rural China (Fang and Bloom 2003). The challenge is to find ways to change this vicious circle into a virtuous one.

Figure 2: The vicious circle in health services in poor rural localities in China



The *2004 World Development Report* focuses on the relationships between service users, providers and policy-makers (World Bank 2004). It discusses them in terms of three aspects of accountability: the ability of users to make informed choices of providers; the ability of citizens to influence policy-makers; and the ability of policy-makers to influence providers. The following analysis adds the institutions that create links between these actors.

One must unpack the concept of the public sector. In many countries, the so-called public health services have many private characteristics because of the ways that facilities and individual health workers have adapted to financial constraints and weak monitoring systems. There is a big gap between formal employment contracts and the functioning of the system. Public employees often combine public and private activities (inside or outside the legal framework).

It might be better if formal arrangements were more consistent with actual practice. This could lead to a change in the understanding of the purpose of public funding of government facilities to reflect the mixture of public and private services they provide. The options include: major increases in public sector budgets to finance salaries at a competitive level; substantial cuts in the number of public employees and a consequent rise in the number of people practicing privately; and contracts for certain services with public sector providers, which leave them free to provide other services privately. Each option provides different incentives for providers and creates different challenges for regulators. There are major political constraints to any of these options, which is why the present situation has evolved. However, the cost to political leaders of the absence of

incentives for providers to perform well may eventually outweigh the benefits of the present arrangements, whereby individuals find their own livelihood strategies to supplement low salaries.

Some tasks are better carried out by full-time, salaried, public employees. For example, regulators of private providers must be impartial and seen to be so. Their role has to be defined, they have to be adequately paid and they have to face incentives to perform in the public interest. Government officials responsible for the design and implementation of public sector reforms need to understand this regulatory function. Where it is impossible to fulfil these conditions, efforts to regulate will have to be modest and will involve partnerships with intermediate organisations.

A variety of institutions may have an interest in finding ways to escape the vicious circle of a low trust, low quality health service. Possible strategies include professional regulation, branding and arrangements to purchase services on behalf of communities. Government regulators/monitors can play an important role by providing information to relevant stakeholders on the performance of providers (or by contracting an independent agency to do so). This enables people to make informed choices about whom to consult, and it also increases the possibilities for effective regulation and purchasing of services.

A third dimension concerns local institutions and behavioural norms. A variety of arrangements limit opportunistic behaviour between community members. This is one reason why rural people tend to use practitioners who live nearby and tend to be more willing to contribute to local savings or insurance schemes than to national ones. Intervention strategies can build on local arrangements to foster new contracts (explicit or implicit) between providers and users of services. This can take place through formal representation of users on facility governance boards, establishment of complaints procedures, and a variety of arrangements for communities to participate in purchasing and/or managing local health services. For example, some community health insurance schemes in Ghana have begun to negotiate with hospitals about the cost of services they provide.

Political struggles influence all three dimensions (Walt 1994). These struggles can be particularly intense in highly segmented societies, where people have a lot to win or lose (Bloom 2001). The interests of powerful users and providers of health services influence the allocation of public resources and the use of state regulatory powers. If one ignores these factors in the design of an intervention, the outcome may have unintended consequences.

One aspect of politics is the role of political parties. Successful reforms are often associated with the coming to power of a party committed to the improvement of health and health services. This assures sustained commitment when groups whose interests are threatened resist change. Parties also play a role in more routine decisions. For example, sector-wide approaches are generally negotiated between civil servants in donor and

recipient agencies. The election of a new government can lead to problems. Newly elected politicians may wish to renegotiate the agreement to take into account different policies and political interests. This may 'waste' time, but it is the cost of a system of competitive party elections. There are examples where the neglect of this issue contributed to a breakdown of a Sector-wide Approach (SWAp) agreement. This illustrates the more general principle that it takes time and effort to reach common understandings with stakeholders about institutional arrangements. Where this kind of understanding does not exist, the arrangements may be fragile.

Other types of organisation influence decisions and their implementation. There are many examples where government regulatory powers have mostly benefited powerful stakeholders (Goudie and Stasavage 1997). In segmented health systems, members of different social groups tend to use different types of professional or non-professional practitioner. Regulatory bodies often act in the interests of the practitioners used by powerful social groups. For example, the doctor-dominated Health Professions Council in Zimbabwe has denied nurses the right to prescribe drugs privately, although they provide this service in the public system (Mutizwa-Mangiza 1999; Ndlovu 2001). Nurses often lobby against measures that would provide their non-professional competitors with more knowledge and the right to charge for services. As a result, many health care transactions take place outside the legal framework. This protects licensed practitioners from competition, but it leaves people who use other providers unprotected.

In some countries, public sector workers are a powerful interest group that opposes the allocation of public funds to private providers. This is the case in China, where very little public funding flows to village doctors; in many aid-dependent countries, where government employees derive income from salaries, a variety of donor-funded top-up payments and the illegal sale of drugs; and in some Latin American countries, where civil service unions are politically influential.

Some governments have responded to the power of service providers by shifting to a demand-side model of public finance. This can involve anything from giving people vouchers, to funding a government institution or civil society organisation, to signing contracts with providers on behalf of the community. The hope is that competition will force providers to become more efficient. However, competition without appropriate institutional arrangements does not necessarily lead to better services. Measures are needed to inform users about provider performance and set limits on opportunistic behaviour by providers (through strategic purchasing or regulation). Otherwise, the cost-effectiveness of services may fall (Figure 2).

Demand-side reforms cannot substitute for politics. If governments cannot implement public sector reforms, they may also be unable to prevent interest groups from influencing demand-side institutions. One can learn lessons from the history of social security schemes. In a number of middle-income countries, their management has been strongly influenced by powerful groups of beneficiaries and health workers. Costs have tended to

escalate, and many governments have faced the choice between subsidising them or accepting the political cost of reducing benefits for powerful groups. This illustrates the need to take into account the political dimensions of institutional reforms.

What do pro-poor health policies towards the private sector entail? They do not mean that governments should only address the needs of the poor. People who earn more than a subsistence income expect their government to create and enforce a regulatory framework that enables them to have access to competent health providers and safe and reliable drugs. They also need to be able to protect their families against the high cost of serious illness. However, a health system that is largely geared to that social group will be too expensive for many others. It may even draw public funds away from services that the poor mostly use. Poor people need to have confidence in the health workers they consult and the drugs they buy. They need assurance they will be able to cope with the high cost of health care should a family member fall ill. Governments have to find ways to balance the needs of these different social groups. They face the following challenges in designing a regulatory framework:

- to ensure that participants in the organised economy obtain the benefits of modern health care technology (through use of regulated specialised providers, drugs and equipment), while extending access to safe and effective services to the rest of the population;

- to establish mechanisms, other than command-and-control bureaucratic systems, to regulate the quality of providers used by social groups outside the organised economy;

- to protect regulatory structures against capture by interest groups.

Some countries have constructed coalitions in favour of pro-poor policies (Birdsall and Hecht 1997). Notable examples in the health sector are Sri Lanka, Botswana, Cuba and Costa Rica, all of which constructed highly organised government systems. It may be more difficult to agree on policies in societies with large structural inequalities and pluralistic health systems. Moore (1999b) suggests that it is important to convince members of elite groups that it is in their interest to support a policy initiative in order for it to succeed. They have to believe that the policy will work and will not threaten their own interests too greatly.

6 Building appropriate institutional arrangements

Previous sections describe the gap between the language of national and international policy and the reality of local health systems. One source of this gap is that many popular movements promised they would provide access to health services on coming to power. When, governments failed to achieve these objectives, they did not change the policy promises. This led to policy paralysis, whereby governments were unable to acknowledge a changing reality and make the difficult decisions needed to address growing problems.

Health is rising up the political agenda once more. In China, opinion surveys report that the high cost of medical care is one of the greatest concerns of urban people. Rural people have similar worries. The new government had made health one of its highest priorities before the SARS outbreak, and it subsequently has invested a lot of political capital in promises of reform. In Africa, many participatory poverty appraisals reveal great concern about health. The HIV epidemic, which affects all social classes, has given health a high political profile. Most governments have not responded to these concerns in a coherent manner, but the political cost of failing to act may be rising. Political pressure is a necessary but not sufficient condition for the creation of an effective coalition for change. Elite groups have to believe that reforms will work and that their interests will not be damaged too much.

There are no blueprints for reforming institutional arrangements for health. A country's capacity to import innovations from the advanced market economies is associated with (i) the existence of the rule of law and trust in legal and government administrative bodies; (ii) wide coverage by government regulatory and administrative structures, and few people living outside the organised sector; (iii) political commitment to meeting the needs of the poor; and (iv) limited social segmentation, with stakeholders represented on decision-making bodies. Standing and Bloom (2002) present a rough typology of countries, based on the existence or absence of these characteristics (Table 6).

Table 6: Categories of country relevant to health policy

Collapsed states with few or no functioning institutions

- minimal rule of law
- virtual absence of an organised health sector

Low-income countries under stress

- poor economic growth
- high proportion of the population in poverty
- frequently a history of conflict
- poor governance, decayed public health systems
- high levels of resort to disorganised health care markets

Low-income countries with stronger economic prospects

- functioning governments/bureaucracies
- endemic problems of poverty and inequality
- under-performing public health systems
- some resort to disorganised or semi-regulated markets

Transition countries moving from socialist planning systems to a market economy

- high levels of public sector employment, but limited government budgets
- need to reduce inappropriate government intervention and strengthen regulation
- blurred boundaries between public and private

Middle-income countries with established systems of public and private health care

- strong governments but uneven health systems performance
- interest groups with strong influence over health system
- areas of high deprivation and unmet health need

Source: Standing and Bloom (2002)

The challenge is greatest in countries where the boundaries between public and private sectors are blurred. Individuals and institutions have developed a variety of coping strategies in these countries. The evolution of coherent institutional arrangements will be a gradual process that involves encouraging people to test local innovations, whilst government addresses urgent needs. Meanwhile, stakeholders need to be engaged in a dialogue to build up a national understanding of problems and options for addressing them.

The government must define immediate and longer-term objectives for its work with the private sector. These objectives may be in conflict. For example, some people advocate training drug sellers and providing information to users to improve the quality of self-

treatment with drugs. Others oppose it because it encourages the development of markets and may reduce political support for an organised public health system. This highlights the need for both short-term measures to deal with immediate problems and realistic strategies to create effective institutional arrangements.

Measures to meet immediate needs should be complemented by measures to construct trusted institutions. Policy-makers have to keep in mind the negative impact that a gap between policy and implementation has on public attitudes and expectations. Strategies are likely to combine measures to improve state capacity, strengthen local accountability, make reliable information available, and support partnerships for the achievement of agreed objectives.

The factors that contribute to the decay of public health services also reduce government capacity to regulate private services. They include the lack of clarity about public management functions, low levels of pay and shortages of skilled personnel, and the lack of a public service ethos. If these factors do not change, regulation will probably favour powerful stakeholder groups. One way to reduce this risk is to focus on the problems of greatest concern to the public and link measures to establish and enforce laws to publicity aimed at winning public support and encouraging civil society organisations to become involved.

Strategies are needed to build on relationships between local actors and strengthen the capacity of communities to make providers accountable to them. This will involve provision of training and supply of appropriate information to local leaders.

Government can ensure that people have access to the information they need to be effective consumers of health services and competent judges of local health providers. This information includes how to treat common health problems and indicators of performance by different providers.

One can find a variety of institutional innovations in response to the problems of service users and providers. These could include coalitions of providers around issues of pay and quality, and partnerships between civil society organisations, local and national governments and providers of services. Private companies are another potential partner. For example, pharmaceutical companies might find it in their interest to help governments control quality and prevent counterfeits. There is a risk that powerful groups will reap excessive benefits from this kind of arrangement. Strategies to avoid this include the inclusion of stakeholders on governing bodies and the provision of timely, relevant information.

One can apply these principles to current efforts to address malaria, tuberculosis and HIV/AIDS. People clearly want help in coping with these illnesses, and there is a growing international consensus in favour of funding prevention and treatment. However, there are risks associated with increasing the flow of powerful drugs to countries with weak

administrative and governance arrangements. These products will almost certainly reach the markets and counterfeit products will appear. Government regulatory systems may not be able to prevent this, but governments can reduce the risk by providing information to the public on treatment protocols, training drug sellers, making spot checks for counterfeits, monitoring for inappropriate prescribing, and encouraging the development of public and private arrangements to treat people with these diseases. Governments can undertake monitoring and regulation in partnership with other organisations (civil society organisations, private companies and so on). They can also establish a forum to enable stakeholders to review monitoring reports, discuss options for addressing problems and share knowledge of innovative practices.

The creation of appropriate institutional arrangements will take a long time and involve many stakeholders. One important first step is to develop a realistic language for understanding existing problems and assessing options for change. This can be fostered by assisting stakeholders to develop an evidential basis for their points of view and by facilitating dialogue between stakeholders. The dialogue could begin by focusing on issues that are commonly agreed to require urgent action. However, short-term measures will have to be linked to longer-term strategies for establishing coherent institutions.

References

Bennett, S., McPake, B. and Mills, A. (1997) *Private Health Providers in Developing Countries*, London: Zed Books

Berman, P. (1998) 'Rethinking health care systems: Private health care provision in India', *World Development* 26(8): 1463–79

Birdsall, N. and Hecht, R. (1997) 'Swimming against the tide: Strategies for improving equity in health', in C. Colclough (ed.) *Marketizing Education and Health in Developing Countries*, Oxford: Clarendon Press

Bloom, G. (2001) 'Equity in health in unequal societies: Meeting health needs in contexts of social change', *Health Policy* 57(3): 205–24

Bloom, G. and Fang, J. (2003) 'China's rural health system in a changing institutional context', *IDS Working Paper* 194

Bloom, G. and Lucas, H. (2002) 'Health and sickness: Towards health systems that meet the needs of the poor' in D. Belshaw and I. Livingston (eds.) *Renewing Development in Sub-Saharan Africa,* London: Routledge

Bloom, G. and Standing, H. (2001) 'Pluralism and marketisation in the health sector: Meeting health needs in contexts of social change in low and middle-income countries', *IDS Working Paper* 136

Bloom, G., Han, L. and Li, X. (2001) 'How health workers earn a living in China', *Human Resources for Health Development Journal* 5(1–3): 25–38

Chakraborty, S. and Harding, A. (2002) 'Conducting a private health sector assessment', in A. Harding, and A. Preker (eds) *Private Participation in Health Services Handbook*, Washington: World Bank

Chernichovsky, D. (1995) 'What can developing economies learn from health system reforms of developed economies?', in P. Berman (ed.) *Health Sector Reform in Developing Countries*, Boston: Harvard University Press

Cohen, J. and Peterson, S. (1999) *Administrative Decentralisation*, West Hartford, CT: Kumarian Press

Cornwall, A. and Lucas, H. (eds) (2000) 'Accountability through participation: Developing partnership models in the social sector', *IDS Bulletin* 31(1)

Deacon, B. (1999) 'Globalisation and social policy: International actors and discourse', *GASPP Occasional Paper* 1, Stakes, Helsinki

Druce, N. and Standing, H. (2001) 'Consumer policy and representation: A framework for improving healthcare?' unpublished draft, DFID Health Systems Resource Centre

Duffield, M. (2001) *Global Governance and the New Wars*, London: Zed Books

Ensor, T. and Savelyeva, L. (1998) 'Informal payments for health care in the former Soviet Union: Some evidence from Kazakhstan', *Health Policy and Planning* 13(1): 41–9

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Princeton: Princeton University Press

Francis, C.-B. (2001) 'Quasi-public, quasi-private trends in emerging market economies: The case of China', *Comparative Politics* 33(3): 275–94

Gilson, L. (2003) 'Trust and the development of health care as a social institution', *Social Science and Medicine* 56: 1453–68

Goudie, A. W. and Stasavage, D. (1997) 'Corruption: The issues', *OECD Development Centre Technical Paper* 122, Paris: OECD

Harding, A. (2002) 'Introduction to the private participation in health services handbook', in A. Harding and A. Preker (eds) *Private Participation in Health Services Handbook*, Washington: World Bank

Harding, A. and Preker, A. (eds) *Private Participation in Health Services Handbook*, Washington: World Bank

Hood, C. (1991) 'A public management for all seasons?', *Public Administration* 69: 3–19

Hsiao, W. (2000) 'What should macroeconomists know about health care policy? A primer', *IMF Working Paper Series* WP/00/136, Washington: International Monetary Fund

Hulme, D. (2001) 'Reinventing the Third World state: Service delivery and the civic realm', in W. McCourt and M. Minogue (eds) *The Internationalization of Public Management: Reinventing the Third World State*, Cheltenham: Edward Elgar

Joshi, A. and Moore, M. (2002) 'Organisations that reach the poor: Why co-production

matters', paper prepared and presented at the 'Making Services Work for Poor People', World Development Report 2003/4 Workshop, Oxford, 4–5 November

Killingsworth, J. (2003) 'Official, unofficial and informal fees for health care', draft Discussion Note #13, presented to the Third Health Sector Development Technical Advisory Group Meeting: Health Care Financing in the Western Pacific Region, Manila, February

Leonard, D. (2000) 'Lessons from the new institutional economics for the structural reform of human health services in Africa', in D. Leonard (ed.) *Africa's Changing Markets for Health and Veterinary Services*, Basingstoke: Macmillan Press

Leonard, K. L. (2000) 'The role of incentives in the delivery of rural health care in Cameroon', in D. Leonard (ed.) *Africa's Changing Markets for Health and Veterinary Services*, Basingstoke: Macmillan Press

Loewenson, R. (2003) 'Civil society: State interactions in national health systems', CSI/2003/B12, World Health Organisation, Geneva

Lubman, S. (2001) *Bird in a Cage: Legal Reform in China after Mao*, Stanford: Stanford University Press

Mackintosh, M. (1999) 'Informal regulation: A conceptual framework and application to decentralized health care systems', in M. Mackintosh and R. Roy (eds.) *Economic Decentralization and Public Management Reform*, Cheltenham, Edward Elgar

Mackintosh, M. and Tibandebage, T. (2002) **'**Inclusion by design? Rethinking health care market regulation in the Tanzanian context', *Journal of Development Studies* 39(1): 1–20

Mamdani, M. (1996) *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism*, Kampala: Fountain Publishers

McCourt, W. (2001) 'Moving the public management debate forward: A contingency approach', in W. McCourt and M. Minogue (eds) *The Internationalization of Public Management: Reinventing the Third World State*, Cheltenham: Edward Elgar

Mills, A., Brugha, R., Hanson, K. and McPake, B. (2002) 'What can be done about the private health sector in low-income countries?, *Bulletin of the World Health Organization* 80(4): 325–30

Minogue, M. (2001) 'The internationalization of new public management', in W. McCourt and M. Minogue (eds) *The Internationalization of Public Management: Reinventing the Third World State*, Cheltenham: Edward Elgar

Moore, M. (1999a) 'States, social policies and globalizations: Arguing on the right terrain?'

paper prepared for conference on Revisioning Social Policy for the 21st Century, Brighton

Moore, M. (1999b) 'Politics against poverty: Global pessimism and national optimism', *IDS Bulletin* 30(2): 33–46

Musgrove, P. (1996) 'Public and private roles in heath: Theory and financing patterns', Human Development Department, World Bank, Washington

Mutizwa-Mangiza, D. (1999) *Doctors and the State: The Struggle for Professional Control in Zimbabwe*, Aldershot: Ashgate

Ndlovu, R. (2001) 'Situation analysis of nurses and nursing in Zimbabwe', *African Policy Dialogue Review* 1(1): 41–74

OECD (2003) *Poverty and Health*, DAC Guidelines and Reference Series, OECD: Paris

Oi, J. (1999) *Rural China Takes Off: Institutional Foundations of Economic Reform*, Berkeley: University of California Press

Rawski, T. (1999) 'Reforming China's economy: What have we learned?', *The China Journal* 41: 139–58

Reddaway, P. and Glinski, D. (2001) *The Tragedy of Russia's Reforms: Market Bolshevism Against Democracy*, Washington: United States Institute of Peace Press

Reynolds White, S. and Birungi, H. (2000) 'The business of medicines and the politics of knowledge in Uganda', in L. Whiteford and L. Manderson (eds) *Global Health Policy, Local Realities*, London: Lynne Rienner Publishers

Robinson, M. and White, G. (1997) 'The role of civic organizations in the provision of social services', *WIDER Research for Action Paper* 37

Rose, R. (2003) 'When all other conditions are not equal: The context for drawing lessons', in C. Jones Finer (ed.) *Social Policy Reform in China*, Aldershot: Ashgate

Saich, T. (2001) *Governance and Politics of China*, Basingstoke: Palgrave

Segall, M. (2000) 'From cooperation to competition in national health systems - and back? Impact on professional ethics and quality of care', *International Journal of Health Planning and Management* 15: 61–79

Semboja, J. and Therkildsen, O. (1995) *Service Provision Under Stress in East Africa*, London: James Currey

Short, C. (2003) Submission to Parliamentary Select Committee on Development, 23 January 2003

Simms, C., Rowson, M. and Pettie, S. (2001) *The Bitterest Pill: The Collapse of Africa's Health*, Save The Children Fund

Smith, E., Brugha, R. and Zwi, A. (2001) *Working with Private Sector Providers for Better Health Care*, London: Options Consultancy Limited

Standing, H. and Bloom, G. (2002) 'Beyond public and private? Unorganised markets in health care delivery', background paper for the World Development Report (WDR) 2003/4 presented at 'Making Services Work for Poor People' workshop held at Eynsham Hall, Oxford, November

Stiglitz, J. (2002) *Globalization and its Discontents*, New York; W. W. Norton and Company

Tendler, J. (1997) *Good Government in the Tropics*, Baltimore and London: The Johns Hopkins University Press

Titmus, R. (1970) *The Gift Relationship: From Human Blood to Social Policy*, London: Allen and Unwin

Toye, J. (1999) 'Nationalising the anti-poverty agenda', *IDS Bulletin* 30(2): 6–12

Van Lerberghe, W., Conceicao, C., Van Damme, W. and Ferrinho, P. (2002) 'When staff is underpaid: Dealing with individual coping strategies of health personnel', *Bulletin of the World Health Organisation* 80(7): 581–4

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*, London: Zed Books

World Bank (2004) *Making Services Work For Poor People: World Development Report 2004*, Washington: World Bank

Notes

1 The institutional arrangements of the market economy and behavioural rules that underpin them were created during a period of intense economic development and political and institutional change that extended from the early nineteenth to the mid-twentieth centuries. The result is a very large number of behavioural norms that have become well-ingrained. It is remarkable that after more than a decade of dictatorship and disastrous war, Germany was able to reconstruct a complex, rules-based society very quickly. However, experience of the second half of the twentieth century suggests that it is much more difficult to establish institutional arrangements, and the many behavioural norms that underpin them, in societies where they have not previously existed. Hence, the comment by Rose (2003) that some countries may be able to draw more useful lessons from the earlier stages of the development of rules-based market economies and arrangements for social welfare.

2 Government bureaucracies can trace their origin through the advisors to kings and princes back to the religious foundations. This may be the source of the emphasis on ethics and professionalism. Enterprises have at least as long a history. Some activities, such as lending for interest, were seen for a long time as necessary but immoral, and operated outside the legal framework in many countries.

3 In mid-nineteenth century Britain, sickness was a reason for exempting a recipient of state support from the condition of 'Least Eligibility', which emphasised the need to give powerful incentives for people to take any job. This was justified on the grounds that the sick were unable to work and that many would return to productive labour if they were helped to cope with an episode of illness. Many countries use the same arguments today to argue for targeted health benefits for the poor.

4 One reason why they are outside the law in many countries is because powerful social groups and the health workers who provide them with services lobby to prevent an extension of the regulatory framework to include non-professionals.

5 Mamdani (1996) powerfully describes this reality in distinguishing between 'citizens' and 'subjects'.