id21 health insights

research findings for development policymakers and practitioners

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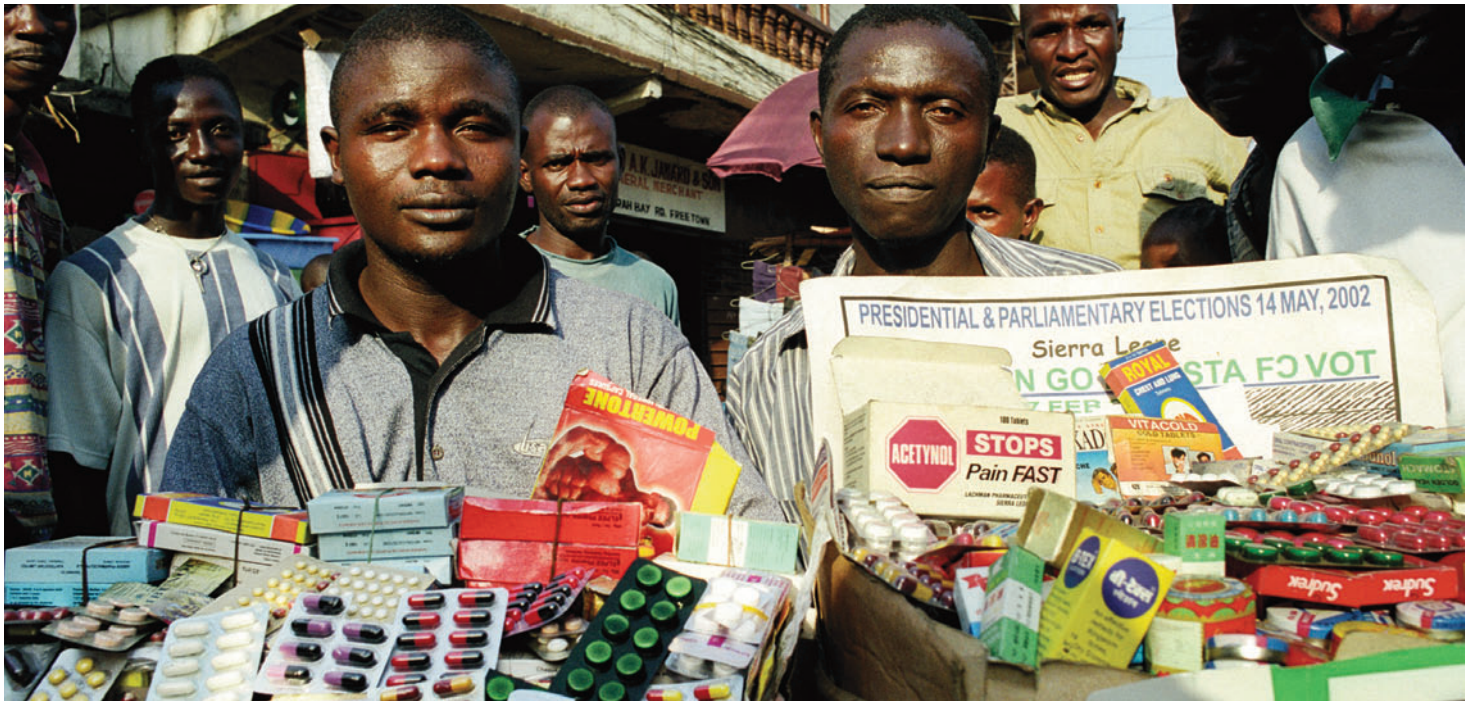

In Sierra Leone, street vendors have a number of different medicines in stock (prescription and non-prescription) but many are not in their original box or are out of date
Rob Huibers, Panos Pictures, 2002

Making health markets work for poor people

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Useful weblinks

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

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

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

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

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

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

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

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

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

Have your say

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

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Future Health Systems
Innovations for equity

Life-long burden

Chronic disease, health markets and poverty

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

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

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

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

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

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

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

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

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

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

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

Vision entrepreneurs

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

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

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

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

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

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

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