Improving the quality of private sector delivery of public health services: challenges and strategies

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Despite significant successes in controlling a number of communicable diseases in low and middle income countries, important challenges remain, one being that a large proportion of patients with conditions of public health significance, such as tuberculosis, malaria, or sexually transmitted diseases, seek care in the largely unregulated ‘for profit’ private sector. Private providers (PPs) often offer services which are perceived by users to be more attractive. However, the available evidence suggests that serious deficiencies in technical quality are often present. Evaluations of interventions to promote evidence-based care in high income countries have shown that multi-faceted strategies which increase provider knowledge have had some success in improving service quality. A wider range of factors needs to be considered in low and middle income countries (LMICs), especially factors which contribute to discrepancies between provider knowledge and practice. Studies have shown that PPs, especially, perceive or experience patient and community pressures to provide inappropriate treatments. LMIC governments also lack the capacity to enforce regulatory controls. Context-specific multi-faceted strategies are needed, including the local adaptation and dissemination to providers of relevant evidence, the education of patients and communities to adopt effective treatment-seeking and treatment-taking behaviour, and feasible mechanisms for ensuring and monitoring service quality, which may include a role for self-regulation by provider organizations or provider accreditation. Developing, implementing and evaluating strategies to improve the quality of service provision will depend on the involvement of the key stakeholders, including policy makers and PPs. Focusing on studies from Asia, Africa and Latin America, this paper develops a model for identifying the influences on PPs, mainly private medical practitioners, in their management of conditions of public health significance. Based on this, multi-faceted strategies for improving the quality of treatment provision are suggested. Interventions need to be inexpensive, practical, efficient, effective and sustainable over the medium to long term. Achieving this is a significant challenge.

Introduction

Traditionally, resources for the control of important public health related diseases have been channelled through the public sector. This, however, has had limited success, especially in those LMICs where a high proportion of qualified doctors work in the ‘for profit’ private sector (Dolin et al. 1994). Current trends in LMICs towards reducing the size of the public sector and limiting the range of services provided, along with encouragement to expand the private delivery and financing of health services, is increasing pressure to develop the role of the for-profit private sector in the delivery of public health-related services (World Bank 1993). There is, however, little knowledge of the quality of care provided by the for-profit private sector in these contexts, although there is a welcomed increase in debate about their role (Musgrove 1996; Creese 1996; Berman 1996; Swan and Zwi 1997).

In many countries a high proportion of patients prefer to use private-for-profit providers (PPs), ranging from qualified private medical practitioners (PMPs) to informal providers, despite higher fees than the official charges in the public sector. The reasons for this pattern of utilization are many and have been attributed mostly to issues of acceptability, including greater ease of access, shorter waiting periods, longer
or more flexible opening hours, better availability of staff and drugs, more sensitive health worker–client attitudes, and greater confidentiality in dealing with diseases such as TB and sexually transmitted diseases (STDs) which carry social stigma (Aljunid and Zwi 1997).

In a number of countries, whether low, medium or high income, a substantial proportion of public sector doctors also engage in private practice (Roemer 1993). This is likely to increase given the pressures on public sector budgets and the need for ministries of health to either explicitly or implicitly allow health workers to seek other means of supplementing their incomes. In India, where half of the world’s TB cases are found, between 60% and 84% of health expenditure already takes place in the private sector, where 73% of medical practitioners work (Bhat 1993); and about 60% of TB cases initially seek treatment from PPs (Uplekar and Rangan 1996). Recent work in India and Africa has confirmed that the great majority of malaria cases are treated outside government services (McCombie 1996). Recent research from Sri Lanka indicates that many clients using public sector services for malaria treatment also consult with PPs. Disease control objectives in LMICs are unlikely to be achieved without involving private providers.

The limited available evidence, however, points to major problems in service quality in LMICs, especially in the private sector. Most studies assessing the quality of health care in Africa, Asia and Latin America have focused on drug availability, prescribing and dispensing practices. The prescribing of inappropriate drugs, inadequate dosages, polypharmacy and the excessive use of injections have been reported in a wide range of LMICs (Ross-Degnan 1992; Trostle 1996). Antibiotics may be prescribed in 35–60% of clinical encounters, and constitute up to 50% of national drug costs (Nizami 1996), despite being appropriate in fewer than 20% of cases (Hogerzeil 1993; Trostle 1996).

Most PPs in India are either unaware of or fail to comply with recommended best practice in TB diagnosis, in the use of recommended drugs, treatment duration, management of defaulters, record keeping and case finding (Uplekar and Rangan 1996). In a 1989 study of 102 PMPs, 80 different treatment regimens were prescribed for TB, most of them inappropriate and expensive, and only 39 doctors volunteered that they would order a sputum test to establish the diagnosis in a possible case of TB (Uplekar and Rangan 1993). Aljunid and Zwi (1996) found that PMPs in a rural district of Malaysia were less likely to maintain the cold-chain for childhood vaccines than were their public sector counterparts.

There is increasing interest in high income countries, especially in North America and Europe, in the potential for improving the quality of clinical practice and outcomes for patients through promoting evidence-based care. The evidence-based movement has clearly articulated the need to improve the evidence-base of clinical practice (Sackett and Rosenberg 1995). Establishing what is current best practice is the first step; the second being to ensure that such guidance is widely disseminated and used as the basis for promoting appropriate behaviour by providers. There is emerging expertise and experience in high income countries in developing clinical guidelines, and in ensuring their effectiveness and uptake (Thomson et al. 1995). Several thousand papers have been published assessing the outcomes of interventions to improve clinical practice (Davis et al. 1995); and recent reviews have reported the results of over 100 rigorously evaluated continuing medical education (CME) interventions, almost exclusively from North America and Europe (Oxman et al. 1995; Grimshaw et al. 1995).

Where similar interventions have been implemented in LMICs, evaluations have often been less rigorous, consisting of before-and-after evaluations of provider knowledge and practices without appropriate control groups (Ofori-Adjei 1996), or without evidence of impact on practice (Lindtjorn 1987; Laing and Ruedzio 1989). Interventions, to a great extent, have been predicated on the untested hypothesis that strategies that increase provider knowledge will result in improved practice. Ross-Degnan et al. (1992) have concluded, in relation to drug-prescribing, that ‘very few reports provide results which can serve as the basis for generalizable policy initiatives for promoting the rational use of drugs’.

Interventions to optimize provider practice need to be context-sensitive and based upon an understanding of the range of factors which determine or influence provider behaviour. In developing and implementing strategies for improving provider practices, consideration needs to be given to the importance of the policy, professional, economic and regulatory contexts in which public and private providers operate, provider knowledge and the factors that determine it, the availability of and access to diagnostic and
treatment resources, and the complex range of interacting needs, demands and expectations of providers, patients and communities. Specific attention needs to be given to identifying discrepancies between knowledge and practice, and determining which of the factors highlighted above account for such discrepancies. Having identified these, it may be possible to develop effective and affordable, practical strategies for reducing, eliminating or countering them, and for providing incentives for shifting provider behaviour in a positive direction.

This paper presents a model which may assist in elucidating the complex range of factors that influence provider decisions in private sector clinical encounters in LMICs, and considers macro-level factors not included in previous models (Igun 1994; Paredes et al. 1996). It reviews some of the lessons and conclusions which can be drawn from the results of published studies of interventions to improve healthcare delivery in high and low income countries, and the potential and limitations of such strategies. Finally, it outlines categories of interventions to be considered and evaluated for improving provider practices; research priorities; and a process for involving key stakeholders in the identification of multifaceted interventions to improve quality of care and health outcomes.

Factors determining private practitioner behaviour in low and middle income countries (LMICs)

The use of unreliable or biased sources of information (e.g. out-of-date textbooks and promotional literature from pharmaceutical companies), the failure to maintain awareness of recent evidence, especially among less recently qualified practitioners, and lack of access to reliable evidence, are all likely to contribute to an inadequate provider knowledge-base and poor clinical practice (Avorn et al. 1982; Paredes 1996). While these problems will affect both the public and private sectors, those working in the latter are more likely to be isolated, to be working alone, to have less contact with current literature (except that provided by the pharmaceutical industry) and may have fewer incentives to shift their behaviour towards recognized ‘good practice’. Most providers, whether in the public or private sector, may also lack the skills to carefully appraise evidence for its validity and applicability to the local context, as well as the clinical skills and resources for ensuring effective diagnosis and treatment provision, and the communication skills to facilitate effective treatment-taking by patients.

It is often simplistically assumed that when providers are aware of the correct course of management they will adopt it. However, discrepancies between practitioner knowledge and practice are widely prevalent in all countries and have been recently documented in a small number of studies from LMICs (Gani et al. 1991; Paredes 1996; Ofori-Adjei 1996; Trostle 1996). In one study, 36 of 40 physicians were found at structured interviews to know the correct indication for antimicrobials in cases of children’s diarrhoea, whereas 35 of the 36 still prescribed antimicrobials unnecessarily to one or more of four patients seen by each (Paredes 1996). These studies highlight the inadequacy of interventions directed solely at enhancing provider knowledge. Awareness of this has encouraged the development of new concepts and disciplines such as that of pharmaceutical health promotion and pharmacoepidemiology which seek to recognize the complexities of shifting provider treatment behaviours (Mant 1994; Spitzer 1991).

Among the reasons for discrepancies between provider knowledge and practice are a range of macro level factors and the social and economic contexts of the clinical encounter (Figure 1). A number of the macro factors have been alluded to earlier: these include the relationships between the public and private sectors, the financing system operating and whether clients pay charges (official or unofficial) when using public sector services; and the existence of laws, regulations and enforcement mechanisms for ensuring that services of minimum quality are delivered. The existence of regulations to protect health service users, and the political willingness and capacity of national governments to enforce them will be an important determinant of PP behaviour.

The position of other powerful stakeholders may also be important, especially the organized medical profession which may support the objectives of regulation and standard-setting, or conversely may protect their members from external controls. Protection of its members, at the cost of tolerating malpractice, has been suggested as a feature of the medical profession in a number of LMICs (Roemer 1991; Bennett and Ngalande-Banda 1994). In India, the 1986 Consumer Protection Act has been used to protect patients’ rights, where these have been neglected by statutory medical bodies, through enforcing norms
Figure 1. Private provider behaviour
designed to protect consumers (Yesudian 1994; Bhat 1996). The financing system in the public sector may influence whether clients use the private sector, especially where prescribed drugs are charged for or where users have to make unofficial, under-the-counter payments to ensure that they are treated properly (Asiimwe et al. 1997).

Provider knowledge and attitudes are also important, and will in turn be influenced by the source and quality of professional training, years of practice and experience, specialization and access to continuing professional development courses, as well as access to information, guidelines and treatment protocols and the ability to critically appraise evidence. Furthermore, the needs and expectations of both provider and treatment seeker, as well as the local social environment will be influential. A number of these issues have recently been helpfully reviewed (Sledge and Feinstein 1997). Service user and community expectations and pressure (especially for antibiotics and polypharmacy), the reliance of PPs on prescribing and dispensing drugs to obtain remuneration from service users, the use of inappropriate prescribing as a strategy for the early termination of clinical encounters in order to increase patient throughput, and commercial inducements from pharmaceutical companies each have an effect (Paredes et al. 1996; Nizami et al. 1996; Bhutta and Balchin 1996; Trostle 1996).

Patient-pressure, and the belief that patients will alternatively choose to self-medicate or visit ‘quack doctors’, is frequently cited by public and private providers for treatment practices which they apparently know to be harmful or ineffective (Ofori-Adjei 1996; Santosso 1993; Nizami 1996). PPs cite competition, low profit margins and the need to foster client loyalty as contributing to practices such as the prescribing of inadequate dosages of antibiotics. Real or perceived patient pressure may also interact with providers’ prior experiences, their perceptions of the expectations of patients’ families, and their concerns about maintaining professional and social prestige as good physicians (Paredes et al. 1996; Prawitasari Hadiyono et al. 1996).

It is of particular interest that medical practitioners who operate in both the public and private sectors behave differently, depending on which sector they are working in. Practitioners who prescribe oral rehydration salts (ORS) for diarrhoea in their public sector work, may continue to prescribe antibiotics in their part-time private sector practice (DDM 1993). The increasingly blurred division between public and private sector work in many countries, with many doctors holding a public sector appointment while engaging in overt or furtive private practice, necessitates an understanding of how and why practitioners act differently, depending on the practice context. The attitude of government and the public sector to the private sector (collaboration, denial or suspicion) is important and interventions to improve prescribing behaviour in both sectors will need to recognize this, as well as ways of addressing the existence and nature of dual working roles in both sectors.

These three sets of influences: the macro-context, provider knowledge and attitudes, and the needs and expectations of clients interact during the clinical encounter to influence practitioner behaviour. Provider practices, even if they appear to be inappropriate, in that optimal practice is not observed, are nevertheless likely to be ‘rational’ activities which meet the economic, social and cultural needs of providers, patients and communities (Sachs and Thomon 1992; Trostle 1996), within a particular policy, professional and regulatory environment. During the clinical encounter the practitioner needs to weigh up a range of influences including knowledge of best practice, the desires and knowledge of his/her client, and the anticipated level of remuneration from the consultation. Depending on the interaction of these factors, along with those identified earlier, the practitioner will select a form of management which may be appropriate, in that it increases the likelihood of patient cure and contributes to population disease control, or inappropriate in that health outcomes may be poorer, side effects of treatment may be greater, communicable diseases may continue to be transmitted, resources may be wasted, resulting in negative impact on population disease control activities.

While lessons learned from high income countries about the effectiveness of different continuing medical education (CME) strategies for addressing knowledge deficits are important, the approach to improving quality of care in any setting should be based on a more sophisticated understanding of the context-specific factors (cultural, social, professional and organizational) influencing provider and patient behaviours; the role, potential and appropriate balance of incentives and regulatory controls for modifying provider behaviour; available monitoring and regulatory enforcement capacity; and an
understanding of the clinical and social rationales for such behaviours. Interventions which are responsive to the needs, motivations and expectations of providers, patients and their communities – in the contexts in which they live and work – are more likely to be effective than those which seek only to increase the skills and knowledge of providers (Trostle 1996). Interventions in LMICs, in particular, need to be inexpensive, practical, effective, efficient and sustainable. We now turn to some strategies and mechanisms that may be useful in attempting to shift provider behaviour in these directions.

Interventions to promote evidence-based care: experience from high income countries

Improving patient care in high income countries requires more than the dissemination of research findings through CME and training strategies, even when these are accompanied by audit, feedback, and evidence-based guidelines (Oxman et al. 1995). Interventions may lead to increased levels of knowledge in the absence of concomitant improvements in practice. Oxman et al. (1995) reviewed 102 rigorous evaluations of different types of CME interventions (see Table 1). The studies included were restricted to those where an objective assessment of outcomes (including changes in clinical process and/or clinical outcomes) had been made, where an intervention was compared with a usual-care control group, and where practitioners were allocated to one or other group in a random or quasi-random fashion.

Elsewhere, the same authors concluded that practice-enabling strategies (e.g. practice visits and patient education) and reinforcing strategies (reminders and feedback) are the most effective forms of CME, when
combined with predisposing or disseminating strategies (Davis et al. 1995). Grimshaw et al. (1995), in a review of 91 studies which rigorously evaluated the effectiveness of clinical guidelines at changing the practices of health professionals, concluded that the key features of successfully implemented interventions were ‘active professional participation and implementation strategies that are closely related to decision making’. However, despite the emerging evidence indicating the types of innovative interventions and strategies which are more effective at producing change, conventional strategies known to be ineffective in improving practitioner behaviour continue to be the norm in high income countries (Davis et al. 1995).

Additional strategies, such as the use of financial or other incentives to promote desirable public health service provision, as in the contract reforms directed at general practitioners in the United Kingdom to achieve immunization targets, may play a useful role in encouraging appropriate behaviour (Lynch 1994; Barnum et al. 1995). Nevertheless, experience is limited, there have been few evaluations, and it is likely that such measures are highly sensitive to the local context, thus necessitating caution in generalizing these lessons. It is also possible that targets which are perceived by practitioners as unrealistic may discourage them from providing any of the intended services, leading to greater inequalities in access in less well served areas (Iliffe and Munro 1993). The range and quality of services may not necessarily improve: in the United Kingdom, efforts to encourage general practitioners to provide family planning services shifted care towards such practitioners, but there was a reduction in the range of available contraceptives, compared with those available through dedicated family planning clinics (Iliffe and Munro 1993).

An emerging literature on organizational science suggests that the change process involves a complex set of interrelationships between various stakeholders involved in ‘an unending struggle not only to order and impose their own scientific change initiative, but also to legitimise the social (re)presentation of that initiative’ (Ferlie 1996). Influences on change include personal, environmental, situational and behavioural factors, as outlined in Social Learning Theory (Bandura 1986), the propensity of peers and colleagues to adopt new ideas (Nowlen 1988), and the adoption of new or different practices by opinion leaders which allow other practitioners to see the potential consequences of change (Rogers 1983; Lomas 1991; Thomson 1995).

Success in effecting change is associated with an ongoing process of negotiation between different interest groups at the local level and is highly context-sensitive (Latour 1987). Guidelines, if they are to be effective, have to be carefully developed through an inclusive process and need to be appropriately directed and disseminated at the right target groups (Thomson et al. 1995). A prerequisite to getting research into practice is an understanding of how knowledge is interpreted locally. Different stakeholders need to see the connection between what is advocated globally and their own local situation (Ferlie 1996). The beliefs of practitioners are an important key to influencing their behaviour (Graham 1996). Put simply, if the results of research are to be successfully implemented, they have to be translated into local evidence-based care, taking into account the interests and roles of the different stakeholders.

Successful translation and local ownership requires an understanding of the networks, and the establishment of links, between the different stakeholders, and the implementation of a process which facilitates dialogue with a view to reaching consensus. Emphasizing the process of translation of evidence into local knowledge should not devalue the importance of the evidence-base, nor the need for scientific rigour in evaluating interventions. One of the unwritten assumptions of the knowledge-driven model for implementing research findings is that those who need to be involved in changing practice perceive that a problem exists, and have a shared perception of the problem (Williamson 1992). Lessons learned from the implementation of clinical guidelines in pilot sites within the UK National Health Service (NHS) include: the need to involve key stakeholders from an early stage in agreeing the need, and identifying priority areas, for change; the central role of clinicians as motivators and agents of change; the importance of utilizing existing professional networks in the adaptation and dissemination of guidelines; and the linkage of this process to clinical audit and quality assurance processes (Humphris and Littlejohns 1996).

Interventions for promoting evidence-based care in low and middle income countries

Figure 2 suggests a number of strategies which may be helpful in shifting provider behaviour towards
**Policy / national level**

- Strengthen two-way linkages between public and private systems, e.g., flow of information and data, patient referrals
- Negotiate PP access to essential resources (drugs, diagnostic facilities, etc.), subject to appropriate controls and evidence of the provision of evidence-based care
- Strengthen governmental monitoring capacity so as to provide audit and feedback, monitor programmes, conduct disease surveillance (measures to promote data returns)
- Consider / strengthen systems to facilitate the organisation of providers so that the public sector can negotiate, and develop and agree collaborative initiatives, with them (e.g., accreditation and self-regulation)
- Consider feasibility of provider accreditation schemes, linked to provider and community interventions
- Promote self-regulation of providers by professional representative bodies
- Consider, and where appropriate, implement and evaluate specific incentives to encourage the provision of high quality care (e.g., subsidised or free drugs)
- Develop and agree evidence-based guidelines, protocols, and information (e.g., Cochrane results) for use by different types of providers

**Local provider interventions**

- Adapt and disseminate evidence-based guidelines and information (e.g., Cochrane results) to providers
- Implement and evaluate CME strategies at local level
  - CME workshops / conferences
  - Practice visits (detailing)
  - Audit and feedback
  - Utilising opinion leaders
  - Local provider consensus networks
- Promote linkages between public, private and NGO providers

**Patient / community interventions**

- Implement and evaluate patient education interventions (e.g., seconding counselling support staff to PP group practices)
- Educate communities (using mass media, schools, community groups, community, political and religious leaders, etc.) on:
  - Key features of important public health related diseases
  - Appropriate management of such diseases (e.g., importance of completing TB treatment)
  - Limitations and dangers of drugs
- Establish / strengthen role of community / service user representative bodies (e.g., establish links with professional representative bodies, consider role in accreditation process)
- Consult with local community and patient groups to find ways to ensure effective treatment-taking for key public health diseases, while respecting rights of individual patients

**Clinical encounter**

Figure 2. Multi-faceted provider, patient and community-targeted interventions for improving the quality of health care provision in the private sector
more appropriate care. These include attention to the macro context, including the policy and regulatory environment, as well as specific interventions with providers and their clients. It may well be that multidimensional interventions, simultaneously dealing with a number of these influences, will prove to be most effective in shifting behaviour.

A. Provider training interventions

The judicious selection, adaptation and dissemination of up-to-date scientifically sound information on which to base clinical and policy decisions is necessary for promoting evidence-based care (Sackett et al. 1996; Irwig et al. 1998). The Cochrane Collaboration on Effective Professional Practice (Freemantle et al. 1995), which includes meta-analyses and reviews of rigorously evaluated interventions, is currently being extended to topics of specific value to policy makers and practitioners in LMICs. In May 1994, a Cochrane Infectious Diseases Group registered as part of the Cochrane Collaboration; and by late 1997, this group had produced 11 systematic reviews of interventions of particular relevance to LMIC settings, and 7 protocols describing reviews in-preparation, which are available in electronic format. Completed reviews are regularly updated. Other groups are adapting reviews to meet the needs of LMICs, e.g. the United Kingdom National Perinatal Epidemiology Unit is developing a computerized database, ‘The best of Cochrane for developing countries’, in collaboration with the World Health Organization (WHO). This will contain reviews of reproductive health issues and their management in LMIC settings, for dissemination to policy makers, programme managers and clinicians.

As noted earlier, dissemination of best practice is necessary but not sufficient and the applicability of evidence to local contexts needs to be considered. Recommendations for appropriate care, developed in a particular organizational and societal context, may not be financially, organizationally, or politically feasible or acceptable in another. Recommendations may also need to be adapted for use at different levels of the health service, from primary care to the specialist level, and by different types of provider, depending on professional training, levels of skill, and the availability of resources.

In-service training interventions to improve provider knowledge and skills, so as to reduce inappropriate dispensing, injections and polypharmacy, have proved popular among public and private providers in LMICs (Berman 1995; Ofori-Adjei 1996); and a number of different CME strategies have been tested. An intervention to educate providers on the correct management of diarrhoea surprisingly found that large seminar interventions were initially equally effective as small group face-to-face interventions (Santos 1996), which could simply reflect the impact of participation in a research exercise. Interventions which focus provider attention on the discrepancy between their own and recognized best practice may produce changes which are limited to pilot studies and may not be sustainable over a longer period of time. Longer follow-up evaluations are needed.

An intervention in Mexico using interactional educational workshops for practitioners, including feedback on prescribing behaviour and the use of peer review committees, produced improvements in prescribing behaviour sustained over 18 months among 27% of practitioners, with no improvement in 40% (Perez-Cuevas 1996). However, the practitioners were state or parastatal employees, and the evaluation of impact was on their prescribing practices in their public rather than their private sector work. Education programmes for PMPs in Egypt failed to alter negative practices, such as the prescription of anti-diarrhoeal agents, while resulting in some improvements in their public sector prescribing (Langsten 1995). The promotion and the development of skills for the delivery of evidence-based care, and a greater emphasis on public health and a population perspective in undergraduate medical training in all countries (Iliffe and Zwi 1994), should also form part of a longer term strategy to improve provider practices.

B. Multi-faceted interventions involving providers, patients and communities

Lack of knowledge may be less important than provider perceptions and experiences of patient and community expectations, especially among for-profit PPs (see Figure 1). Levels of consumer education and awareness could play an important role in promoting improved provider behaviour, especially if interventions to raise these are combined with ones targeted at improving provider knowledge. In Ghana, medical assistants had reverted to inappropriate management of malaria, one year after an intervention which initially improved their practices. This was attributed by them to the pressures of patient and community expectations (Ofori-Adjei 1996). The use of a single 90–120 minute interactional group discussion (IGD) intervention in Indonesia, where a forum was provided for service users and providers to exchange
Experiences about what takes place in the clinical encounter, along with scientific input to both, was shown in a controlled trial to have reduced inappropriate use of injections over the subsequent three months (Prawitasari Hadiyono et al. 1996). With the assistance of a behavioural scientist, each IGD focused on the discrepancies between user and provider perceptions of who was promoting inappropriate injection use. The intervention consisted of a form of reality testing to assist practitioners in focusing on the cognitive dissonance between their reported beliefs and practices. Prescribers expressed the need for peer norms to reinforce and support improvements in practice. The available evidence, as in high income countries (Davis et al. 1995; Grimshaw et al. 1995), suggests that multifaceted interventions which involve providers, patients and communities are likely to be more effective than those targeted only at increasing provider knowledge, especially if provider practices are determined more by their perceptions of patient and family expectations than by clinical need (Paredes et al. 1996; Nizami et al. 1996). However, the likely sustainability of their impact remains uncertain (Trostle 1992) and has rarely been evaluated.

C. Policy and regulatory interventions
Given the serious dearth of evidence regarding the value and feasibility of policy and regulatory initiatives, the following discussion is necessarily speculative. Regulation may have an important role to play in ensuring high quality care (World Bank 1993); and a shift by governments from service provision to financing and regulating services has been recommended (World Bank 1997). For example, pharmaceutical regulations may successfully limit the availability of drugs which have little or no clinical rationale, such as certain anti-diarrhoeal agents. Nevertheless, regulatory controls which are unaccompanied by provider and community-targeted interventions may result in unexpected and unwanted outcomes, through the appearance of equally irrational use of other drugs to replace drugs of restricted availability (Ross-Degnan 1992). The deregistration of paediatric antimotility drugs for diarrhoea in Pakistan in 1991 led to their withdrawal from most retail outlets, but in one city led to the substitution by adult formulations, with retailers knowingly contravening government regulations (Blutta and Balchin 1996). In addition, it is the misuse of antibiotics which has the gravest consequences for the public health, given the widespread emergence of antibiotic resistance. Low income countries, in particular, lack the resources and capacity to enforce regulatory controls (Bennett and Ngalande-Banda 1994), especially for ensuring the availability or controlled use of certain essential drugs. Aside from determining whether or not a drug should be available, and through what channels, regulation may be a relatively blunt or ineffective instrument for actually influencing provider behaviour.

The presence of representative provider organizations, with which governments can negotiate, could facilitate the implementation of strategies for improving the quality of private sector care, through mechanisms such as provider accreditation and provider self-regulation. Practice entry can be difficult to control and in many countries it may be difficult or impossible to prevent providers who offer poor quality care from practising. An alternative strategy would be to offer PPs some form of independent accreditation, perhaps renewable on an annual basis, subject to their providing high quality care for key public health related diseases, such as TB, STDs and malaria. The onus would be on them to demonstrate, through data returns to government programme managers or other more subtle methods of monitoring (e.g. the use of surrogate clients; see Madden et al. 1997 for an excellent review), their ongoing participation in continuing professional development programmes and adherence to agreed quality of care standards. For accreditation to be attractive to PPs, however, it must offer them clear advantages, such as eligibility for a linkage with third-party payment schemes, as has been implemented in Taiwan (Huang 1995). Accreditation could also be accompanied by community education programmes to promote the utilization of these providers by service users. Other forms of professional incentive, such as fast-track access to diagnostic services, opportunities for continuing professional development and training, and access to drugs and other treatments at subsidized rates, should also be considered.

The avoidance of perverse effects of incentives, and the effectiveness of quality assurance and regulatory mechanisms, will depend on the involvement of providers. Where providers are organized in representative bodies, this could facilitate negotiations with central and local public sector policy-makers so as to develop and implement strategies for improving provider practices, especially in the private sector. The costs to the state of monitoring and regulatory enforcement are high and few LMICs have
demonstrated the ability to use them effectively (Kumaranyake 1997); therefore alternative strategies need to be tested. Professional organizations may be well-placed for monitoring and regulating the practices of their members, in that they are more likely than outsiders to be acceptable and to have the knowledge and capacity to undertake monitoring, audit and regulatory enforcement. However, mechanisms to ensure that they perform such functions impartially and in the public interest need to be established, and alternative independent bodies considered. Where networks and linkages between providers are formalized and institutionalized, this will create opportunities for provider involvement in audit and peer review, the organization of group CME strategies, consensus building, and working with local opinion leaders so as to promote innovations and evidence-based care, appropriate and relevant to local situations.

Changing user and provider behaviour in LMICs: the research agenda

The need for rigorously evaluated interventions to improve provider practices in LMICs, preferably in controlled trials, has been recognized (Ross-Degnan 1992), and recent papers have reported some such studies (Trostle 1996). Most studies to-date have focused on the therapeutics of a limited range of conditions such as diarrhoea, acute respiratory infections in children, patients presenting with fever in malaria-endemic areas, and the general use and misuse of antibiotics. The focus of research needs to be extended to the development and evaluation of interventions to improve the management of other important public health related conditions, such as TB and STDs. Indicators for evaluating the quality of drug prescribing and dispensing have been developed and validated; however, more work needs to be done on developing valid indicators of other aspects of quality of care (Hoegerzell 1992), and service delivery processes in the public and private sectors (Bennett and Ngalande-Banda 1994).

There has been little research on identifying effective quality assurance systems (Heiby 1996), or on the development and evaluation of acceptable, feasible and efficient mechanisms for monitoring service quality (Cibulskis and Izard 1996), which are necessary for the effective enforcement of regulatory controls (whether implemented by providers or the state), and the use of incentives for providers (Barnum et al. 1995). Routine data return systems involve transactional and opportunity costs for busy PP’s, their validity and reliability are often uncertain, and they need to result in clear advantages to PP’s for them to work. The use of surrogate clients for intermittent monitoring may be a useful adjunct, although it may be necessary to obtain the agreement of provider organizations for this approach.

Multi-country studies, with descriptive and intervention components, are needed to distinguish context-specific, cross-cultural and generalizable lessons which can feed into policy development (Ross-Degnan 1992; Trostle 1996). These should include evaluations of different strategies for disseminating and implementing guidelines, the effectiveness of provider workshops and conferences, practice visits, audit and feedback, utilization of opinion leaders, local consensus networks, and combinations of different CME strategies. Strategies need to be evaluated in terms of changes in health care delivery processes, impact, efficiency, feasibility, acceptability to providers and patients, and likely sustainability. It is essential that PP’s, and where possible representatives of provider organizations, participate in the process of agreeing, implementing and evaluating interventions, which would increase the likelihood of them cooperating with, and sharing ownership of, such strategies (Harris 1990; DDM 1993). This would enable consideration to be given to practical issues such as the timing of CME training, so as not to clash with provider practice times, and the possible need for, and types of, incentives to encourage PP participation in CME (Swan and Zwi 1997).

As previously stated, the needs and agendas of a wider range of key stakeholders who influence treatment-seeking, provision and treatment-taking processes need to be taken into account. Where specific harmful practices are driven and partly determined by patient demand, and family and community expectations, reinforcing strategies directed at these key groups will be essential to achieving sustainable improvements and outcomes. The importance of involving patients’ families and communities in the care process has been recognized for certain key conditions, such as for HIV home care (McDonnell et al. 1994), and are being considered as an alternative to health workers for the supervision of directly observed treatment for TB patients (Volmink and Garner 1997). Strategies for educating patients and their families in appropriate treatment-taking might include providing counsellors to PP’s, and would complement training in communication skills for
providers. Patient support groups, e.g. by involving TB patients who have successfully completed treatment as peer educators, might also be evaluated. Community and service-user representative groups, and media education programmes, should be evaluated for promoting appropriate treatment-seeking behaviour in the community, which is especially important where a high level of competition between PPs exists; and such programmes could be linked to the programmes promoting the utilization of accredited providers.

Provider behaviour also needs to be considered in the wider commercial and regulatory contexts in which treatment delivery occurs, and should involve a wider range of players than providers, patients and their families alone. Important stakeholders include the different communities of potential service users and their organizations (e.g. women’s groups), the wider range of formally and informally recognized service providers – both public and private, policy makers, programme and health service managers, the research community, and pharmaceutical, health insurance and other commercial organizations, at the national and international level. Provider, patient and community-targeted interventions may be weakened or negated by the marketing strategies of pharmaceutical companies, directed at providers and consumers. By focusing more on key diseases of public health importance such as TB, malaria, and STDs, which require the appropriate use of drugs (rather than diseases such as childhood diarrhoea where drug-consumption needs to be reduced), it may be possible to forge linkages with pharmaceutical companies with a view to enlisting their support for strategies which promote evidence-based care and appropriate drug-taking. Such strategies, however, have potential dangers, in that some pharmaceutical companies may only wish to promote the use of their own products as part of recommended treatment regimes, rather than promoting cheaper generics or the complete essential care package.

To date, descriptive studies and anecdotal experience from many LMICs have reported the failures of regulation, partly due to the lack of capacity for enforcement (Kumararanyake 1997). The need to consider a shift in emphasis from regulation to provider incentives has therefore been suggested (WHO 1991). However, careful consideration needs to be given to finding the right balance, avoiding perverse and inefficient incentives, and taking account of local resource availability. Innovative strategies, such as provider self-regulation and accreditation, have yet to be evaluated, with service providers (especially PPs) participating with government decision-makers at key stages of this process. Processes, such as stakeholder analysis and political mapping (Reich 1993), may be useful in building consensus among the wide range of stakeholders whose subsequent behaviour will largely determine successes and failures. There are no ‘magic bullets’ which will transform the quality of care delivered by health care providers in LMICs. Evaluations of multi-faceted and synergistic combinations of strategies are needed, balancing incentives, controls and the education of providers, patients, and communities.

References


Private provision of public health care


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