

# Safe in their hands? Engaging private providers in the quest for public health goals

Phyllida Travis<sup>a</sup> & Andrew Cassels<sup>a</sup>

In many low-income countries, private providers have long been a significant source of health care.<sup>1–3</sup> Private providers include individual practitioners, both formal and “informal”, working alone and in groups;<sup>4</sup> national and international nongovernmental organizations; and private companies providing health care for employees and their dependants. In some countries, private (or more accurately non-state) practitioners provide over 50% of ambulatory care in rural and urban areas.<sup>5</sup> Despite their importance in delivering services to vulnerable populations, they received only limited attention from policy-makers and researchers until the late 1980s.<sup>6</sup> This neglect — particularly of informal providers — was often reinforced by active opposition from formal professionals. There is growing recognition of their importance, however, and signs of a shift in attitude. While concerns remain about quality, effectiveness and cost, there is also interest in their untapped potential to help meet public health goals.

Public sector managers, who are expected to ensure access to care and protect the public, have a duty to understand and engage with these various players. A number of governments have developed policies to define roles and relations with the private health sector, but these can prove difficult to put into practice. Funds for working with private providers are available from many international agencies. A wide range of approaches has evolved to influence consumers, providers and policy-makers. The scope of services targeted ranges from those for specific health priorities (e.g. HIV, tuberculosis, malaria, and reproductive health) to broader packages of essential services.<sup>3,7</sup> Many efforts exist on a relatively small scale, however, and are undocumented. Debate is often still “rich in opinion and short on facts”.<sup>8</sup> The following key questions remain.

- Do private providers help to expand access to care for the hard-to-reach groups?

- How can the safety and effectiveness of services be ensured?
- Can privately provided services be affordable, cost-effective and genuinely pro-poor?
- What does it take to sustain the involvement of private providers?
- How can greater mutual understanding and trust be promoted?

Two articles in this issue focus on some of these questions from the perspective of tuberculosis.<sup>9,10</sup> The article by Salim et al. (479–484), reports how informal village doctors in Bangladesh (a mix of semi-qualified and unqualified practitioners, drug vendors and traditional practitioners) became a resource in tuberculosis care on a large scale in rural areas. The article by Floyd et al. (437–445), reports on the cost-effectiveness of DOTS by private practitioners in two cities in India. Persuading private providers to deliver care for one disease is arguably easier than getting them involved in a larger bundle of services. Three essential points about what it took to get results are flagged here as they provide food for thought beyond tuberculosis care: organization; incentives, and the role of the public sector.

Firstly, individual practitioners are by definition not part of a formal organization. Engaging with them singly would be highly labour intensive. Both articles point to the important role played by intermediary organizations in creating “managed networks”. The government tuberculosis programme agreed Memoranda of Understanding with different intermediaries: a large nongovernmental organization implementing the DOTS strategy in a rural area covering 26 million people; a non-profit hospital; and an association of medical practitioners. Lack of formal organization also means that information and linkages between providers are often scarce. Creative ways were used to

identify informal providers, and a functional provider network was established with referrals in *both* directions between village doctors and formal services.

Secondly, non-financial incentives were effective. Factors thought to maintain involvement by informal practitioners include recognition from a reputed organization, which enhances their standing and credibility and is good for business, free training and refresher courses. Floyd and co-workers also make the point about incentives and look at costs from three angles: costs to the patient, the private provider and the public purse.

Lastly, the public sector retained key roles in all cases: in developing national standards and training materials, giving legitimacy to the intermediate organization, providing drugs and training materials, and, particularly, in exercising supervision.

Critics of greater engagement with the private sector often suggest that efforts such as these are a diversion from the prime task of strengthening public services. We would agree that private sector provision should not be a policy goal in its own right. The examples given here, however, demonstrate how to deal with urgent worldwide problems in a pragmatic way. They point out that, without engaging private providers, poor quality and sometimes harmful care will continue; they show that private providers can help expand access in rural as well as urban areas; and they point to the need for careful institutional design. Other analyses have found — and this is a critical point — some evidence that well-managed networks of private providers can offer a service that has a positive impact on the quality of the public sector.<sup>11</sup> More experimentation and documentation, such as is offered in these papers, is to be welcomed. ■

## References

Web version only, available at: <http://www.who.int/bulletin>

<sup>a</sup> World Health Organization, 1211 Geneva 27, Switzerland. Correspondence to Dr Travis (email: [travis@who.int](mailto:travis@who.int)). Ref. No. 06-032755