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Effectively engaging the private sector through vouchers and contracting – A case for analysing health governance and context

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ABSTRACT

Health systems of low and middle income countries in the Asia Pacific have been described as mixed, where public and private sector operate in parallel. Gaps in the provision of primary health care (PHC) services have been picked up by the private sector and led to its growth; as can an enabling regulatory environment. The question whether governments should purchase services from the private sector to address gaps in service provision has been fiercely debated. This purposive review draws evidence from systematic reviews, and additional published and grey literature, for input into a policy brief on purchasing PHC-services from the private sector for underserved areas in the Asia Pacific region. Additional published and grey literature on vouchers and contracting as mechanisms to engage the private sector was used to supplement the conclusions from systematic reviews. We analysed the literature through a policy lens, or alternatively, a 'bottom-up' approach which incorporates components of a realist review. Evidence indicates that both vouchers and contracting can improve health service outcomes in underserved areas. These outcomes however are strongly influenced by (1) contextual factors, such as roles and functions attributable to a shared set of key actors (2) the type of delivered services and community demand (3) design of the intervention, notably provider autonomy and trust (4) governance capacity and provision of stewardship. Examining the experience of vouchers and contracting to expand health services through engagement with private sector providers in the Asia Pacific found positive effects with regards to access and utilisation of health services, but more importantly, highlighted the significance of contextual factors, appropriate selection of mechanism for services provided, and governance arrangements and stewardship capacity. In fact, for governments seeking to engage the private sector, analysis of context and capacities are potentially a more useful frame than generalizable outcomes of effectiveness.

1. Introduction

Countries in the Asia Pacific have achieved impressive population health gains in the last few decades, as demonstrated by progress towards the Millennium Development Goals (United Nations, 2013). However, these improvements in health outcomes are not equally distributed across populations. Heterogeneity by geography and socio-economic status has led to concerns about inequitable access to health services (Barros et al., 2012; Bauze et al., 2012). Some of the factors impeding equitable provision of health care are inequalities in the distribution of health care workers and facilities, financial barriers that fall more heavily on the poor, and under-investment in public health services (Efendi, 2012; Kanchanachitra et al., 2011; Meliala et al., 2012).

Health systems of most low and middle income countries (LMIC) in the region have been described as 'mixed' or 'pluralistic' (Lagomarsino et al., 2009; Meessen et al., 2011), terms which describe the public and the private sector operating in parallel and providing, and often also competing for, the same services. The private sector is not homogenous but rather encompasses different entities such as formally trained providers, informal providers like drug stores, spiritual healers and traditional birth attendants (TBA), and non-governmental and faith-based health care organisations (Basu et al., 2012; Berendes et al., 2011).

The role and extent of service provision by the private sector in the Asia Pacific has been categorised into three main geographic areas: (a) Southeast Asia, with a strong private sector providing substantial shares of primary health care (PHC) services and for-profit outweighing not-for-profit providers; (b) Countries of the Pacific where the private sector provides less than half of services

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and faith-based and not-for-profit organisations play a strong role; and (c) China and Mongolia where the private sector mainly provides some specialty services in a partnering role with government (Montagu and Bloom, 2010).

Given the inequities in access noted above, and the increasing contribution from the private sector, a key policy question that emerges is: what is the appropriate role of the private sector, and whether it has potential to contribute to addressing gaps in public service provision. This question has generated considerable debate (Oxfam, 2009; World Bank, 2009). Advocates for the private sector draw on theories of economic markets, claiming that increased competition will improve health service outcomes, such as increased utilization, efficiency, quality, or greater equity (Montagu et al., 2005; Smith et al., 2001). Opponents respond that only the public sector can warrant equitable and universal access (Oxfam, 2009) and that rapid privatization of health care is associated with worse patient outcomes (Basu et al., 2012). Two recent systematic reviews comparing publicly versus privately delivered care in LMIC found no evidence that one sector was clearly superior to the other (Basu et al., 2012; Berendes et al., 2011).

Against this background, we reviewed the available evidence from systematic reviews and the literature describing experience of engaging with the private sector in LMIC in the Asia Pacific to address gaps in public sector provision of PHC-services as a basis for the development of a policy brief for governments in this region (Asia Pacific Observatory, 2014). We used the systematic reviews to identify potentially effective mechanisms for government engagement of the private sector, and then conducted a purposive review of literature describing experiences with the selected mechanisms in the Asia Pacific region.

In recognition of the important role of social, economic and political context in understanding both outcomes and effectiveness of health system interventions in the literature (Sheikh et al., 2011) this review focuses on contextual factors and design features, particularly factors associated with health governance and stewardship, in examining the performance of these schemes and their potential engagement for the provision of PHC- services in LMIC in the Asia Pacific.

In this paper we summarise the evidence obtained from the literature on the selected mechanisms, and provide some recommendations for policy makers on issues that need to be considered in engaging the private sector to provide PHC-services for underserved populations. The first section summarises and discusses factors associated with voucher schemes. The second section focuses on contracting which is followed by a comparative analysis of contextual factors and design features most relevant to both mechanisms. We conclude with a discussion of governance issues common to vouchers and contracting and point out knowledge gaps for future research in this field.

2. Methods

Initially, a search for systematic reviews of purchasing arrangements with the private sector to provide PHC-services in underserved areas was undertaken, using the following definitions:

- Purchasing was defined as the provision of resources from government to private sector providers in return for services, or goods relevant to services. Publications were not excluded if the funding came from development partners rather than government.
- Private providers were limited to formal providers (for- and not-for-profit), i.e. recognized by a regulatory authority or having received training at a recognized institution.
- The definition of underserved areas followed an approach suggested by Patouillard et al. (2007) as either poor population groups or geographic areas with high proportion of poor with reduced access to essential health services.
- Services were limited to PHC-services, defined as the first point of contact with the health care system in a community, comprising promotion, prevention, and treatment services.

Using the definitions above, a search was undertaken of the Cochrane database, Pubmed, and CABI Global Health—limited to publications in English, with an available abstract, published from 2000 onward. This identified 56 abstracts. Abstracts were reviewed manually and reviews were excluded if (1) studies were not systematic reviews (2) did not provide information to distinguish between public and private providers (3) assessed other arrangements not directly including providers, such as conditional cash transfers (4) or reported on informal private providers only, leaving 15 systematic reviews for further analysis.

Vouchers and contracting were selected as purchasing mechanisms for further realist review based on the extent of experience in using these mechanisms in LMIC of the Asia Pacific, and on the systematic review conclusions that these mechanisms had been able to achieve improvements in service outcomes (particularly utilisation or access) in some situations.

We used a realist approach, which tries to elicit 'what worked in which context, for whom and why', for more in depth analysis of experience in using these mechanisms. The benefit of using a realist approach is that, as Pawson et al. (2005) formulate '[t]he results of the review combine theoretical understanding and empirical evidence, and focus on explaining the relationship between the context in which the intervention is applied, the mechanisms by which it works and the outcomes which are produced'.

The realist review focused on (1) social, economic and political context (2) design features of vouchers and contracting and (3) characteristics of delivered services and populations, and outcomes obtained by drawing on literature describing implementation of one or both of these mechanisms. The review used publications identified in the systematic reviews, complemented by identification of references and an additional search on Pubmed and Google Scholar for peer-reviewed and grey literature, using simple search terms for vouchers and/or contracting with location in Asia. Three reviewers identified the most relevant contextual factors with impact on health service outcomes for these schemes.

This study did not require ethics approval as no primary data collection or analysis was included. The authors did not deal with any kind of patient related data, the analysis was rather a review of previously published and grey literature.

3. Results

3.1. Effectiveness of purchasing mechanisms-results from systematic reviews

The included 15 systematic reviews were mostly of low (n = 4) to moderate (n = 10) quality according to the AMSTAR criteria (Shea et al., 2007). This section presents a summary of the effectiveness of identified mechanisms to deliver PHC-services to underserved populations.

There was some evidence that contracting can improve availability and utilization of services, especially by underserved populations (Liu et al., 2008). The public sector, however, seemed to deliver care of better quality at an overall lower cost (Patouillard et al., 2007). Nevertheless, out-of-pocket (OOP) expenditure at the household level was reduced for contracted services. The overall impact of contracting on health systems remained