Is there a case for privatising reproductive health? Patchy evidence and much wishful thinking

Paulo Ferrinho[1], Ana Margarida Bugalho[2] and Wim Van Lerberghe[3]

Summary

There are a number of more or less explicit assumptions that provide a seemingly "rational" basis for the appeals to complement or substitute the provision of maternal health care by governmental services with services offered by "private for profit sector" (PFP) and "private not for profit non-governmental organisations" (PNFP-NGO). This paper reviews the evidence-basis of these assumptions.

The first assumption has it that private providers capture a significant and growing share of the service delivery market for maternal health care. With the notable exception of China, PNFP-NGO play an important role in health care in general. To a varying degree these services also include reproductive health services. For many populations, especially in rural areas, PNFP organisations are the main if not the only providers of reproductive health care. In urban areas PNFP-NGO usually share the work with PFP providers and government services. PNFP organisations seem to have an important role in the diffusion and adoption of fertility control. PNFP-NGO provide a wide range of services and their intervention strategies take multiple forms. PFP health providers are also an important source of ambulatory care throughout the developing world. These private practices in most developing countries are notoriously unregulated.

The second assumption claims better quality of care and greater efficiency. Relevant evidence on differences in quality of care and of other determinants of health-seeking behaviour is hard to come by. Common wisdom has it that patients would prefer private providers for reproductive health problems since these are supposed to dispense better quality care. Perhaps their most visible comparative advantage is their client-friendliness. Supply induced demand has resulted in a problem of iatrogenesis, exemplified in the epidemic of caesarian sections. Over-intervention is compounded by the

[1] President of the Associaçao Garcia de Orta, Lisboa, Portugal. Email: nop05938 @ mail. telepac .pt (correspondance should be addressed to this author)
[2] Associaçao para O Desenvolvimento e Cooperaçao Garcia de Orta, Rua Frederico Perry Vidal, Bloco 9, 1°piso, P-1900-275 Lisboa. Email : anabugalho@fm.ul.pt
[3] Professor at the Department of Public Health, Institute of Tropical Medicine, Antwerpen, Belgium. Presently working at the Office of Health Care Reform, Ministry of Public Health, Thailand. Email : wlerberghe@itg.be

tendency of PFP providers to specialise and deliver only part of reproductive health packages. The lack of integration automatically leads to sub-optimal care.

The claim for greater efficiency is not based on empirical evidence. It often merely refers to a higher efficiency per output unit, not per outcome unit. At times, one definitely gets the impression that efficiency is defined, not in terms of getting most value for money, but in terms of the possibility of running a service on basis of cost-recovery.

Obviously resources make a difference. An under-funded public service without drugs, equipment and adequately trained and paid staff will not provide as a good a service as a well capitalised private one. If resources are adequate and the range of services comprehensive, the quality and efficiency comparison hinges on the (visible) productivity and client-friendliness of the staff, and on the (less evident, at least to the patient) justification of the care. Some of the evidence presented justifies a cautious claim that PFP providers may be less efficient than PNFP or public providers, in as much as they can shift the risk and the consequences of their inefficiency to the client. On the other hand, the evidence does not allow for conclusions regarding the efficiency of PNFP providers.

The third assumption claims that by ensuring uptake of services PFP and PNFP providers complement government services and ensure a more comprehensive and equitable distribution of the uptake of services. The private sector would indeed contribute most to equity in situations where public sector would act as the first mover and choose its level of investment in the health sector. The private sector would then observe the level of public investment and would invest to meet the residual demand. This in turn would allow the public sector to make the most of its limited resources, whilst still responding to its political responsibility of delivering care to its population. But the empirical evidence suggests a scenario of substitution rather than complementary. In the best of cases this means filling the void left by failing public services. Often, however, it becomes a reality of competition and poaching.

No blanket recommendations. It may be a seductive solution to have reproductive care provided through PNFP – or even PFP –organisations, when the weight of history and public perception of government failure is so strong as to make recovery of failing public services unlikely. However, the fragmentary evidence shows that blanket recommendations are inappropriate. The problem is to specify the conditions under which this can be done without loss of quality, efficiency and equity. In this context six issues needing the policy maker's attention are addressed in the paper.

The most pressing problem is the lack of regulation of service provision by the private sector. Clients are not protected against the consequences of the asymmetry of information they face – with health- and financial consequences. As the recent evolution in a number of middle income countries points out, perhaps the most effective way to

help the State to regulate the private sector is to increase pressure from civil society. From a public health point of view, privatisation only makes sense if the State and civil society are strong enough.

Introduction

In many developing countries, and particularly in Africa, maternal health care was not particularly high on the list of public health priorities in the first three quarters of the XXth century. *"For many years colonial medicine had but few obstetrical problems to resolve"* (Amy 1992). That did not mean there were no problems, but these were grossly underestimated and disregarded (De Brouwere & Van Lerberghe 1998). Maternal health care most often was a mere sideline in childcare programmes (Rosenfield & Maine 1985), and essentially provided in the clinics and maternities of missions, foundations and charitable voluntary groups. In contrast, maternal health care today has become a priority of its own in a context of reproductive health.

Perhaps more important, it has become a legitimate and explicit concern of many governments. This is in line with the emphasis on the development of the government–owned health services after the colonial period. The various crises developing countries underwent have led to conspicuous failures of governments to provide good coverage with care of adequate quality (Van Lerberghe 1993, Van Lerberghe & De Brouwere 2000). This has paved the way for appeals to "privatisation". Privatisation has, for two decades, been a major item on the agenda of structural adjustment programmes in poor countries (Alubo 1990, Evans 1995). The World Bank, the World Health Organization and the United Nations Population Fund, all participated in developing recommendations on the role of the private sector in general and in reproductive health care provision (World Bank 1993, UNFPA 1999 a & b): governments had failed, as the Safe Motherhood Programme pointed out, to address maternal health effectively.

Current conventional wisdom is nicely summed up in a paper in the World Report on Women's Health 2000, a special issue of the International Journal of Gynecology & Obstetrics. Following the observation that programme approaches after the Cairo Conference on Population and Development in 1994 has shifted from largely government provision to *"significant involvement of non-governmental organisations including the private sector"*, the paper states that "*NGOs have proven their capability to complement the efforts of government and to implement innovative approaches. NGOs have the following special advantages: flexibility of operations, relevance to the broader context of development,*

ability to innovate, and effectiveness at the grassroots for targeting services to disadvantaged groups, such as the poor" (Edouard *et al.* 2000).

There are a number of more or less explicit assumptions that provide a seemingly "rational" basis for the largely ideological blanket appeals to complement or substitute the provision of maternal health care by governmental services with services offered by "private" "non-governmental" providers and organisations.

First, private services are said to capture a significant and growing share of the service delivery market for maternal health care.

Second, they are assumed to provide their clients with more accessible and better services in terms of quality, effectiveness and efficiency.

Third, by doing so they are said to complement government services resulting in a more comprehensive and equitable distribution of the uptake of services.

This paper reviews the evidence-basis of these assumptions. Before doing so, however, it is necessary to revisit the notions of "private sector" and "non-governmental organisations". Putting both in the same bag obscures the whole debate on privatisation, the supposed advantages of the latter becoming justification for the deregulation of the former.

Private for profit and private non for profit

Not until the 1990s was it possible to discuss these problems in other terms than thatcherite or statist ideological statements. However, there is no such thing as a pure dichotomy between public and private sector. A first step that has helped was the public/private mix framework of the early 1990s (Table 1), that distinguished the functions of provision and financing of care.

Table 1. The 1990's framework for analysing the public/private mix

		FINANCING	
		Public	**Private**
PROVISION	**Public**	ex: Classic "free" national public health care systems	ex: Cost-recovery systems in public facilities; Private beds in public hospitals
	Private	ex: Contractual arrangements; district designated hospitals	ex: Private health care with fee for service and private health insurance

A further distinction has to do with the mission of the non-state health care provision organisations (Giusti *et al.* 1997). Some have an administrative stewardship and/or institutional identity that results in a social perspective:

non-discrimination, population-basis, guidance by government policy, non-lucrative goals, social advocacy (Box 1). These are what one indicates by "NGOs" *strictu sensu*. Others have profit as their *raison d'être*, rather than an agenda of public service. These are what one indicates by private sector *strictu sensu*.

The distinction is not always clear-cut (Van Lerberghe *et al.* 1997) and often a matter of judgement. In Dar Es Salaam, Tanzania, for example, a number of such NGOs providing reproductive health services are owned by private entrepreneurs whose affiliation with religious groups allows them to register as voluntary, and to benefit from favourable tax concessions. For all due purposes they function as for-profit organisations, NGO status notwithstanding (Kanji *et al.* 1995).

The blurring of the distinction between for-profit and non-for-profit is compounded by the different hats worn by individual providers. Private and non-governmental providers include large numbers of (on- or off-duty) government officials. This results in formal or informal sharing of human (Asiimwe *et al.* 1997, Ferrinho *et al. 1998,* Backström *et al.* 1997, Roenen *et al.* 1997, Damasceno *et al.* 2000, Mcpake *et al.* 2000), pharmaceutical (Asiimwe *et al.* 1997) and other resources between different "sectors" of health care provision, including, sometimes, "traditional" health care (Adam *et al.* 1997, Backström *et al.* 1997). Whether regulated and controlled or not officially acknowledged and "wild", passive privatisation over the last decades has changed the picture of health care provision.

Even if it is difficult to make, this distinction has such consequences for service delivery that it is necessary to specify what we talk about. In this paper we use the terminology of private-for-profit (PFP) and private-non-for-profit (PNFP) organisations to distinguish those for whom profit is a dominant *raison d'être* from those for whom the accent is on delivering a service to the public. PFP then corresponds to the entrepreneurial private sector *strictu sensu*, and PNFP to what commonly goes under the label of NGOs, and may include family planning institutions, medical associations, universities and research institutions, solidarity groups, religious, international or locally based welfare groups, unions, professional associations and the proliferation of organisations in rather small communities.

A large and growing share of the market

The first assumption has it that private providers capture a significant and growing share of the service delivery market for maternal health care, and ensure an important part of the uptake of services. This is certainly correct for health care in general. For a sample of 40 developing countries, a sample average of 55% of physicians worked in the private sector and a sample average of 28% of health care beds were private beds (21% private for profit) (Hanson & Berman, 1998). In Asia, for example, the percentage of private hospital beds ranges from 22 to 77% in six countries, and their share is growing (Newbrander & Moser 1997). The assumption is probably also basically correct for maternal health care. Nevertheless, actual documentation supporting this statement is scanty and patchy. There are wide differences between and within countries. Also, much depends on what maternal or reproductive health activities one considers: overall the market share is smaller for inpatient than for ambulatory care, and limited for preventive and public health services (Hanson & Berman 1998).

Moreover, the few data available usually fail to distinguish between PFP and PNFP. For example, the analysis of the data from the 1988-90 Demographic and Health Surveys programme in 11 countries could only classify providers in public, private (including pharmacies) or others (traditional healers, schools, churches, families and friends). Even so, there were large variations: in Morocco and Tunisia 48,2% and 25% of ante-natal care was private, but only 4,6% and 4,2% of delivery care (76,5% and 31,7% were home based). Private sector providers were the source of family planning in 7% of cases in Botswana, 21% in Morocco, 22% in Tunisia, 28% in Kenya, 36% in Sudan and 44% in Uganda (Berman & Rose 1996).

PRIVATE-NON-FOR-PROFIT PROVIDERS

With the notable exception of China, *PNFP-NGOs play an important role in health care in general:* for example, they provide more than 10% of clinical services in India and Indonesia, and are very important in Africa (Table2).

Box 1. Setting up gender–sensitive practices (Doyal 1996)

At the heart of all feminist critiques of medicine is the recognition that women lack power in health care institutions, limiting their ability to determine priorities and allocation of scarce resources. In this context, in some countries women have set up their own health centres.

In Britain very few services have been created outside the mainstream. This reflects in part the limited market for private care when it is available in the National Health Service without direct cost. But there is also a political reluctance to offer services that many women could not afford to buy. In the United States, the 1970s and early 1980s saw a proliferation of women's health centres offering reproductive care and a range of other services. Women's health centres have been most successful in Australia. This reflects the priority they have been given within the Australian Women's health movement and their subsequent incorporation into the National Women's Health Policy. Though the women involved continue to grapple with the contradictions inherent in any attempt to use state funding for radical initiatives, health centres in Australia do offer important examples of gender-sensitive practice for other health care providers.

In developing countries, women's health centres are not an alternative to the formal system of health care but very often the only option for care. The Bangladesh Women's Health Coalition now runs ten projects providing both reproductive and general health services for women and children. In Peru, Centro Flora Tristan and Vaso de Leche have worked together to create an integrated health service for women living in Lima. In Brazil, an alliance between the Ministry of Health and activists in the Women's Movement led to the creation of the Comprehensive Program for Women's Health Care. In Colombia, women have been able to go to a stage further with the implementation of a national women and health policy.

Table 2. Health care provided by NGOs in Africa

Country	*Services*
Burundi	Missions (PNFP): 30% of PHC facilities
Cameroon	Missions (PNFP): 40% of PHC facilities
Ghana	NGO(PNFP): 35% of ambulatory 30% of beds
Kenya	NGO(PNFP): 35% of services
Malawi	Private Health Association: 40% of all services
Nigeria	NGO(PNFP): 30% of beds
Swaziland	NGO(PNFP): 30% of services
Tanzania	NGO(PNFP): 45% of hospital beds
Uganda	NGO(PNFP): 40% of services
Zambia	Missions(PNFP): 50% of rural and 35% of total population
Zimbabwe	Missions(PNFP): 35% of beds

SOURCES: Hecht and Tanzi (1993) and (Turshen 1999).

To a varying degree these services also include reproductive health services. For example, in a mail survey of 88 non-governmental hospitals in sub-Saharan Africa at the end of the 1980s, 82 provided ante-natal care. All had maternities (with a median of 24 beds and 3 to 6 midwives). They ensured institutional delivery care for a median of 5,8 deliveries per 1 000 inhabitants per year in their districts – probably less than one fifth of the deliveries, but by and large nearly all the professional assistance to deliveries in those areas. Many of these hospitals also conducted major obstetric interventions: all but one performed caesarean sections and curettages, 85% did hysterectomies and 55% repair of vesico-vaginal fistulae (Van Lerberghe & Lafort 1990; Van Lerberghe *et al.* 1992).

For many populations, especially in rural areas, these PNFP organisations are the main if not the only providers of reproductive health care. In the hospital survey mentioned above, 39 were the only service provider in their district. It is also the case, for example, of rural Congo in the 1990s where only NGO supported districts continued working (Porignon *et al.*, 1994). Following the reforms of the early 1990s in Mali most ambulatory reproductive health care – nearly all in rural areas – is now provided by community-owned NFP health centres organised in a non-governmental federation (Maiga, Traoré Nafo, & El Abassi 1999). But these are mainly rural situations.

In urban areas PNFP-NGO usually share the work with PFP providers and government services. In a poor peri-urban township, in South Africa, Alexandra, for example, a PNFP University Clinic, a municipal clinic, and PFP "general dispensing cash practices" or "GP" worked side by side. GP covered 13% of the population receiving ante-natal care, 4% of post-natal care, 9% of family planning and 78% of treatments for sexually transmitted diseases (STD). The balance, including all delivery care as well as activities such as counselling for rape victims, was provided by the PNFP University clinic (Frame *et al.* 1991, Ferrinho 1995). Elsewhere the market share of PNFP is more limited: in Pakistan, for example, 15% of caesarean sections for absolute maternal indications are carried out in the PNFP- NGO hospitals (UON, 1999); and in Lebanon, health care provision, including maternal health, is for more than 80% in the hands of PFP providers (Van Lerberghe *et al.* 1997).

PNFP organisations seem to have an important role in the diffusion and adoption of fertility control (Montgomery & Casterline 1998), particularly through community-based programmes and social marketing (Box 2). In Egypt at least 9% of current family planning users obtain their contraceptive method from the PNFP-NGO sector (UNFPA 1999 b). They have had significant successes

in increasing the uptake, particularly in areas with very low contraceptive prevalence initially (Phillips *et al* 1999).

PNFP NGO provide a wide range of services and their intervention strategies take multiple forms (Box 2). PNFP providers – with different profiles - are found in urban as well as in rural areas. Obviously PNFP are far from homogeneous in their motivations (e.g. religious, feminist activism, serving the public) and in the range of services they provide. Consequently, they may be focused on family planning, or provide comprehensive ambulatory and hospital care in districts, and *often support government policies and services*.

PRIVATE-FOR-PROFIT PROVIDERS

PFP health providers are no doubt an important source of ambulatory care throughout the developing world. The development of private practice in most developing countries is notoriously unregulated. Private practices are not easily forthcoming with information, at times for fear of tax-implications, at times because existing regulations are both accepted, often because of a lack of respect for discredited MOPH and not infrequently because of the non-existence of information systems. In transitional countries, such as Tunisia, Mexico or Thailand, the growth of the entrepreneurial sector is well documented. For example, in Thailand, the number of private clinics doubled from 7,100 in 1984 to 15,700 in 1992; and they increased their share of outpatients from 10 to 23% in a context of overall growing utilisation (Mongkolsmai 1997). Household expenditure on private health care rose faster and overtook expenditure on public services between 1986 and 1996 (HFMSP 1999). This pattern is, however, unstable: after the economic crisis of the late 1990s private hospital utilisation dropped, whereas government health facility utilisation increased (Ministry of Public Health 2000). Although hard data are hard to come by for the poorer countries, it is sufficient to walk around Kinshasa or Dar Es Salaam, or to look at the ads sections of any newspaper in Maputo to see that private health care provision is a thriving growth industry.

If there are ever more private providers on the market, not all provide the whole range of reproductive health services. They tend to select niches in function of demand and the competition. In Egypt for example, private physicians provide family planning and ante-natal care but do not attend deliveries (Abu-Zeid & Dann 1985). That does not mean, however, that delivery care is the prerogative of the public sector or PNFP-NGOs: 80% of births are done by dayas in the mother's home, even when trained nurses are available (Roemer

1991). Two other examples of lucrative niches are STD treatment (also for traditional healers: STDs provide their largest group of clients in urban Nigeria (Okonofua *et al.* 1999)) and abortion. Private doctors and midwives (or moonlighting public sector staff) perform abortions at home (Asiimwe *et al.* 1997). This is particularly true in countries where the abortion law is most restrictive. Even in countries where most of the abortions are carried out by non-health practitioners, health professionals (doctors and midwives) are not insignificant providers in illegal private practices (Kamheang *et al.* 1981, Gallan 1982). These professional services are usually only available for the economically better off (Dixon-Mueller 1990).

All in all, PFP-providers are an important source of reproductive health care. In Indonesia 45% of ante-natal care in urban areas, and 36% in rural areas is provided by private midwives. These also assist about one delivery in three, one in two being assisted by traditional birth attendants and one in 10 by government services (Gani 1997). In the Philippines 33.8% of urban and 7.3% of rural deliveries were assisted by professional private providers (Schwartz, Akin, & Popkin 1993). In Mexico 32% of ante-natal care is provided by the private sector (Ramirez *et al.* 1997). In Brazil, data from five *favelas* in Rio de Janeiro in 1984 show that 85% of pill users bought them at private drug dealers. National household survey data from 1986 show that 66% of sterilisations were carried out in private institutions (Giggin 1994).
Egypt has also a long history of involvement of the PFP and the PNFP-NGO sector in reproductive health (Fox KFA 1988). A household survey found that 80% of women who had given birth during the last 10 years had not received ante-natal care, but that 21% of those who did obtained it from private physicians (Abu-Zeid & Dann 1985): the public sector thus carries the brunt of the (low coverage with) pregnancy care. For family planning, however, 54-63% (according to various estimations) prefer PFP-providers (UNFPA 1999b, Abu-Zeid & Dann 1985), a figure similar to that of the preferences for outpatient care. It seems that a significant proportion of family planning is bought directly from pharmacies (Letarte 1996).

In South Africa, private general practitioners are probably the most frequent source of care for STD (Frame *et al.* 1991, Schneider *et al.* 1999). For example, in Alexandra, a poor peri-urban community, general dispensing cash practices provided 78% of STD treatments (Frame *et al.* 1991, Ferrinho 1995). In Natal/Kwazulu, South Africa, 18% of 56% of peri-urban and rural men reporting a previous STD, declared that they received treatment from traditional healers (Karim *et al.* 1994).

Box 2. PNFP organisations and reproductive health

In **Bangladesh** NGO are important providers of many services to the communities. A recent panel study of the rise in contraceptive acceptance after the introduction of a micro-credit programme, suggests that, while programme members already differ from non-members to start out, the introduction of micro-credit in a village leads to a considerable increase in contraceptive use within a short time, suggesting that micro-credit may be contributing to a village environment that it is more open to innovative behaviour (Steele *et al.* 1998).

In **Nigeria** PSI was invited by USAID to enter the market following an earlier failed attempt at a social marketing programme based on a traditional manufacturer's model. PSI maintains that the manufacturer's model was not viable in the Nigerian market because Nigerians did not have sufficient purchasing power to create a viable commercial market. Rather than working exclusively with a local pharmaceutical manufacturer, the project joined with a local NGO, the Society for Family Health (SFH), which became responsible for managing the social marketing programme. SFH handles imports and sales to doctors, hospitals, NGO and wholesalers. SFH's sales representatives are responsible for product promotion. The project, with USAID and DFID support, succeeded in achieving national distribution of its products in both urban and rural areas, including low-income ones. By 1997, SFH was supplying 80% of all contraceptives used in Nigeria. In 1998, it was the largest social marketing programme in sub-Saharan Africa (UNFPA 1999 b).

The **Colombian** Association for the Well-being of the Family (PROFAMILIA) is a private not-for-profit organisation. It was established in 1965 to provide a broad range of reproductive health services. The nation-wide programme includes 40 clinics for women, 7 clinics for men, 13 youth centres and an extensive contraceptive distribution network (United Nations 1998).

In **Bolivia** PROFAMILIA included information, education and communication components as part of a reproductive health service. Started its work with only three clinics, one in each city; within a few years PROFAMILIA clinics were operational in every capital of every province. The major focus in creating awareness in a hostile environment was the utilisation of field workers called motivators. These motivators were backed up by radio support (United Nations 1998).

The Cancer Association of **South Africa** (CANSA) exists since 1931. It has three aims: to support research, to promote health education on lifestyles and advocate early detection of cancers and, lastly, caring and supporting cancer patients and their families. Reproductive health activities include: advocacy for the provision of early cervical cancer screening facilities; provision of mobile pap smear screening services, TV adds and guides for breast self-examination; self-help and support groups (Westaway 1994).

A particular niche is that of obstetrics, and particularly of technology assisted delivery care. In 1998 in Pakistan 48% of caesarean sections for absolute maternal indications were carried out in PFP hospitals (UON 1999). But their share was not limited to these justified caesarean sections. The role of PFP providers in promoting birth by caesarean section in Brazil is well known (Barros et al. 1991). Similar phenomena are occurring in other countries as well, such as in Mexico (Bobadilla & Walker 1991). In Thailand the chances of getting a caesarean section as a private patient are 5,8 times higher than as a public patient, and the total caesarean section rate increased from 15,2% in 1990 to 22,4% in 1996 (Hanvoravongchai et al. 2000). The problem has become so acute that in 1998 FIGO has issued ethical guidelines regarding caesarean delivery for non-medical reasons (FIGO 2000).

There are huge differences between and within countries. The (patchy and scarce) evidence confirms that both PFP and PNFP providers have a significant and growing share of the market of maternal health care. This statement however needs qualification. There are huge differences between and within countries, and these providers tend mostly to occupy certain market niches rather than providing comprehensive reproductive care.

Accessibility, quality, effectiveness and efficiency.

Surprising as it may seem, relevant evidence on differences in quality of care and of other determinants of health-seeking behaviour is hard to come by, even more so regarding reproductive health differentiated into the three segments being considered.

Two important determinants of treatment choices are the costs of health care alternatives (Young 1980) and distance from the health care provider. But regardless of distance to the provider, households in Africa or Asia chose their provider on the basis of the nature of the health problem and expectations of quality of care (Stock 1983, Colson 1971). These often counterbalance the effect of distance. Common wisdom has it that that patients would prefer private providers for reproductive health problems since these are supposed to dispense better quality care. This section reviews the patchy evidence for preference of private providers.

In urban areas, the reason to seek private healthcare is often one of accessibility and convenience. In Thailand, for example, opening hours are a major reason for people to choose private practitioners for ambulatory care. In rural Malaysia private services are more accessible in terms of their operating hours and the flexibility of their clinic schedules. All services are available during

opening hours while in the public sector some services, such as ante-natal care, are available only at certain days of the week (Aljunid and Zwi 1997). In Mexico the 32% of women who chose the private sector for ante-natal care do so according to physical accessibility and to economic and organisational reasons (Ramirez *et al.* 1997). In urban areas the distribution of private providers may be more capillary than that of public services, such as in Dar Es Salaam, where they are geographically more accessible to most people (Wyss *et al.* 1996). In Egypt, although there are 3700 state family planning outlets, the 63% of women prefer private services, because they consider them more accessible, physically and psychologically (Amin and Lloyd 1998). This greater physical availability of private services may, sometimes, be politically motivated, creating a niche that it is then filled by the private sector, as was the case in South Africa in the 1980s (Frame *et al.* 1991, Ferrinho *et al.* 1990, Ferrinho 1995).

Perhaps their most visible comparative advantage of PFP and PNFP providers is their client-friendliness. In Alexandra, South Africa, the staff of a PNFP University Clinic were made to use name tags while on duty to ensure a better rapport with patients (Ferrinho 1995). In Thailand patients almost always know the name of their private doctor, but the treating doctor in public facilities only in one case out of two. When patients feel treated like a client rather than like a number, and they assume that this also translates into better clinical quality. The latter, of course, is prey to asymmetry of information.

Supply induced demand has resulted in an, infrequently mentioned, problem of iatrogenesis. The question of supply induced demand – exemplified in the epidemic of caesarean sections mentioned above – is one of *a priori* reasons to question the supposed better quality of the private sector, especially in the case of PFP providers. Iatrogenesis is likely to be a real consequence. In Brazil the epidemic of caesarean sections is responsible for a not insignificant proportion of maternal morbidity and mortality (Cecatti, personal communication, May 2000).

Overintervention is compounded by the tendency of PFP providers to specialise and deliver only part of reproductive health packages. This represents a second reason to question the supposed better quality of the private sector. The lack of integration automatically leads to sub-optimal care, as in Brazil, where the separation between fertility control and health care for poor women leads to totally uncontrolled and incorrect use of oral contraceptives, resulting in unwanted pregnancies, illegal abortions and clandestine surgical sterilisation (Griffin 1994).

Infrastructural quality may be better in the private sector than in the public sector. In three districts of Tanzania, for example, infra-structural "quality was fair in the voluntary and private dispensaries but tended to be poor in the public ones". The private dispensaries also employed more doctors than the PNFP and the public sectors (Ahmed *et al.* 1996). But this does not mean that not-public does not always mean better clinical quality, even if one makes abstraction of over-medication and iatrogenesis.

In a large proportion of PNFP consultations care was potentially dangerous or outside established clinical practice. A study in Dar Es Salaam, Tanzania, suggested better clinical performance and interpersonal conduct and overall user satisfaction for PNFP providers as compared to government providers. Despite better performance, however, in a large proportion of PNFP consultations care was potentially dangerous or outside established clinical practice (Kanji *et al.* 1995). In urban Nigeria curative and preventive STD services provided by formal and informal health sectors were substandard. The informal sector (traditional healers and patent medicine dealers) was particularly problematic, as many of the practitioners in this sector provided inappropriate STD treatment and preventive services. By contrast, the formal treatment sector (private and public doctors, pharmacists and laboratory technologists) provided appropriate STD treatment, but they demonstrated substantial inadequacies in several areas. In particular, the private sector and public doctors lacked appropriate diagnostic tools. Many of these doctors were also not familiar with the appropriate treatment protocols, did not include counselling and contact tracing in their care procedures and lacked adequate channels of referral (Okonofua *et al.* 1999). In Alexandra, South Africa, many women booking for ante-natal care at a PNFP NGO providing comprehensive PHC, had previously booked at local GP in private cash practices. Most of the GP failed to conduct ante-natal laboratory screening. They kept patients as ante-natal care clients, only to refer them, near term, to the labour unit of the local PNFP provider, without any referral note (Frame *et al.* 1991, Ferrinho 1995). This type of predatory behaviour by the private for profit practices, is also not conducive to efficiency claims (Ferrinho 1995). Other data from South Africa suggest that PFP-GP offering STD care were providing a low standard of care. STD were a common reason for acute curative care but the management was mostly syndromic, little use was made of diagnostic resources which were readily available, and the therapies chosen were not the most correct considering the local epidemiological profile (Frame *et al.* 1991, Coetzee *et al.* 1994, Ferrinho 1995, Schneider *et al.*

1999). In rural Malaysia, in the public sector, new family planning clients were given a physical examination, a cervical smear and contraceptive advice. Oral contraceptives were given only to those below 35 years of age and their blood pressure was checked during follow up. In the private sector new clients were not usually screened and cervical smears were done only at the patients request. Women taking oral contraceptives could buy them without seeing a clinician. Although STD treatment was provided at the private providers, they were not equipped to handle an anaphylactic shock in reaction to administration of an antibiotic (Aljunid & Zwi 1997).

The claim for greater efficiency is not based on empirical evidence. This claim often merely refers to a higher efficiency per output unit, not per outcome unit. For example, contracted hospitals in South Africa have lower production costs than district public sector hospitals for caesarean sections and normal deliveries. But this was associated with higher perinatal mortality and more avoidable factors in the contractor hospitals than in the public sector hospitals (Broomberg *et al.*1997). At times, one definitely gets the impression that efficiency is defined, not in terms of getting most value for money, but in terms of the possibility of running a service on basis of cost-recovery. For example, Potts and Walsh *"organisations such as FEMAP in Mexico and Marie Stopes International in Asia, Africa, and Latin America, are developing comprehensive clinics for family planning, maternal and child health, the running costs of which can be wholly or largely recovered from user fees. Such clinics still require capital for start-up costs, but they have great potential, and non-governmental and international donors should explore provision of the needed capital as a cost-effective way of fulfilling the government mission to take services to the poor"* (Potts & Walsh 1999). Apart from the fact that this affirmation still *"needs to be explored"* (in three Tanzanian districts, for example, PFP dispensaries had a lower output of treated outpatients than PNFP and public dispensaries, although their equipment was superior (Ahmed *et al.* 1996) this defines cost-effectiveness in terms of shifting the burden to the client.

Obviously resources make a difference. An under-funded public service without drugs, equipment and adequately trained and paid staff will not provide as a good a service as a well capitalised private one. In Bolivia, injectables are only available in the private sector and access to public sector provided tubal ligation is difficult: this obviously drains people away from the public facilities (WHO 1998).

If resources are adequate and the range of services comprehensive, the quality and efficiency comparison hinges on the (visible) productivity and

client-friendliness of the staff, and on the (invisible, at least to the patient) justification of the care. Some of the evidence presented above justifies a cautious claim that PFP providers may be less efficient than PNFP or public providers, in as much as they can shift the risk and the consequences of their inefficiency to the client. On the other hand, the evidence does not allow for conclusions regarding the efficiency of PNFP providers. But it is not the public or non-public nature of service provision that makes the difference in quality and efficiency.

The "complementing"assumption: of filling gaps, occupying niches and poaching.

The third assumption underlying the calls for privatisation is that by ensuring uptake of services PFP and PNFP providers complement government services and ensure a more comprehensive and equitable distribution of the uptake of services.

The word complementarity is seductive. The private sector would indeed contribute most to equity in situations where public and private sectors are complementary. The public sector would act as the first mover and choose its level of investment in the health sector. The private sector would then observe the level of public investment and would invest to meet the residual demand. This in turn would allow the public sector to make the most of its limited resources, whilst still responding to its political responsibility of delivering care to its population (Hanson & Berman 1998). Such a planner's heaven assumes a rational, wise and well-meaning private sector, that makes the public agenda its own. This ignores institutional logic and conflicts of interest.

The empirical evidence suggests a scenario of substitution rather than complementary (Hanson & Berman 1998). In the best of cases this means filling the void left by failing public services. In South Africa, for example, private cash practices and PNFP services tend to emerge in areas of State neglect, namely the large sprawling peri-urban squatter areas (Ferrinho 1995) where, many times, they were the only providers of reproductive health care. Often, however, it becomes a reality of competition and poaching.

A two-tier health care system is emerging. This is true in some African countries, as for example in Tanzania, with private care for the wealthy and public services for the poor (Wyss *et al* 1996). The poor are more sensitive to price than the wealthy (Gertler *et al.* 1987). All this would not be so bad if this allowed the State to redirect its resources and the poor could then get good health care at an accessible price. In actual fact this happens only seldom.

Quality in public services does not improve readily, and the price of health care in public facilities is not so low as to compensate for the perceived differences in quality.

Although, in some countries like Kenya (Mbugua *et al.* 1995) and South Africa (Ferrinho 1995) antenatal services and family planning services are exempted, reforms have almost systematically introduced user fees for many health services, including reproductive health services. It is known that user fees may force low-income users out of the public health care system and even out of the modern health care system (Yoder 1989). For example, in Tanzania (Demographic and Health Survey 1991 and 1996) and Kenya (Mbugua *et al.* 1995), deliveries in health facilities dropped by at least 12% after cost-sharing measures were implemented. These fees, and most of all the informal charges demanded by health workers for delivery care, like in Uganda (Asiimwe *et al.* 1997), take away the main perceived comparative advantage of public services, their low price. One consequence is a shift of patients to commercial self-treatment. In Gaza reproductive health problems (infertility, urogenital problems and contraception) are the third most common (the first for women) reason for purchases in private pharmacies (Beckerleg *et al.* 1998). In some African and Asian countries unprescribed purchase of STD treatment in private pharmacies is quite common (Kloos *et al.* 1988, Crabbe *et al.* 1998, Okonofua *et al.* 1999, Phalla *et al.* 1998).

Some see difficulties of accessing the public sector as a necessary stimulus to ensure that the PFP sector gets more involved into the provision of reproductive health care. For example, encouraging commercial family planning services for people who are able to pay is said to be one way to improve services for those who cannot pay, releasing public resources to be used more effectively to serve lower-income clients (Anonymous 1998). Unfortunately, there is no hard evidence that this is a normal course of events, certainly not without a proactive policy.

Privatising with conditionalities

No blanket recommendations. It may be an obvious solution to have reproductive care provided through PNFP – or even PFP –organisations, when the weight of history and public perception of government failure is so strong as to make recovery of failing public services unlikely. However, one thing that emerges from the fragmentary evidence is that blanket recommendations are inappropriate. There is a case for support of the private sector where this

serves the public's interest and allows redirection of scarce resources. If that is not the case, support has no rationale. The private sector should not be supported merely because that is a fashionable option in international development circles. Support, but also mere control, carries costs for the public sector administrative machinery. The costs of the "new" state responsibilities must be compensated for savings resulting from gains from efficiency improvements (Brugha *et al.* 1999, Mcpake and Hongoro 1995). In short, support of the private sector should be subject to conditionalities.

Conditionalities. If one wants to make sure that the private sector will not in fact siphon off resources from the public sector, the minimum is to make sure that it has infrastructural pre-conditions (Mcpake & Hongoro 1995), that it provides cost-effective interventions (Potts & Walsh 1999), that it has an adequate access to drugs and diagnostic facilities (Brugha *et al* 1999), and that information systems are adequate to monitor contractual obligations (Mcpake & Hongoro 1995). Preference should be given to private providers with a track record on managing resources efficiently and on tracking service data and finances efficiently and professionally (Potts & Walsh 1999). There are strategic considerations as well. Governments should guard against contracted private providers attaining powerful bargaining positions, if there are no viable competitors and the government does not itself retain capacity to offer an alternative service.

The problem is to specify the conditions under which this can be done without loss of quality, efficiency and equity. In this context six issues need to be addressed.

First, one has to find a way to encourage that PFP and/or PNFP providers provide the *full range* of priority services, preferably in an integrated way. Given the tradition of specialisation and niche-filling of both PFP and PNFP, and the lack of authority of Ministries of Health in many countries, this is no mean task.

Second, one has to find a way to ensure *access for those in need*, including the poor. Many would moreover be reluctant to see this happen in a two tier-system with a perceived quality of care that is different for the rich and the poor.

Third, adherence to *quality standards* has to be ensured, including mechanisms to avoid over-medicalisation and iatrogenesis.

Fourth, *conflicts of interests*, particularly in situations where one sector depends on another for some of its resources need to be acknowledged and explicitly addressed.

Fifth, all efforts should be undertaken to ensure multiple and independent channels of *accountability*, through penalties for not satisfying contractual obligations, through channels of accountability to professionals councils and associations, and to the public.
Lastly, all the effort of investing in the private sector is to *reinvest the gains* of complementarity. Whether this happens in practice is a matter of speculation: empirical evidence is just not available. A government would be expected to make sure that the evidence of real gains can be documented. This is not easy, and the paradox is that precisely those countries whose public services are dysfunctional– and thus are the first-hand candidates for a switch to PNFP or PFP – are also those where the state apparatus, research resources and competencies are in the worst position to make sure that the population actually gains from the switch.

Governments have a number of regulatory tools at their disposal that could be used more effectively. These include accreditation, independent quality assurance testing, but also the power to regulate payments and subsidies and to establish taxes and duties. Good legislation is not enough. The state must have the means to enforce it. In India, for example, private clinics and mobile teams promote pre-natal sex examination by advertising in local newspapers, in spite of government prohibition of the practice (United Nations 1998). There are experiences that point the way to financing schemes that ensure that the private sector has a complementary role to that of the state (Potts & Walsh 1999).

Counter-power. In the past decade the private care agenda gained momentum on the basis of rhetoric and wishful thinking. Nevertheless, it is a fact. The main issue now is that the private sector develops without control and supervision. Clients are not protected against the consequences of the asymmetry of information they face – with health- and financial consequences. The State cannot or does not take advantage of the "complementarity" to reallocate its resources to those most in need. Regulation is something more easily said than done. As the recent evolution in a number of middle income countries such as Thailand (National Forum on Health Care Reform 2000) – and from the history of the workers movement in Europe – points out, perhaps the most effective way to help the State to regulate the private sector is to increase pressure from civil society. From a public health point of view, privatisation only makes sense if the State and civil society are strong enough.

References

Abu-Zeid HAH and Dann WM (1985). Health services utilisation and cost in Ismailia, Egypt. *Soc Sci Med* **21**(4),451-461.

Adam Y, Gomes A, Cossa A, Naftal A, Conzo S, Coimbra H and Silva B (1997). Estratégias de sobrevivência do pessoal de saúde num hospital público em Maputo. Abstract Qi 32 *Revista Médica de Moçambique* **7**(1, 2) Suplemento 1: S62.

Ahmed AM, Urassa DP, Gherardi E and Game NY (1996). Capabilities of public, voluntary and private dispensaries in basic health service provision. *World Health Forum* **17**,257-259.

Aljunid S and Zwi A (1997). "Public and private practitioners in a rural district of Malaysia: complements or substitutes". Chapter 3, pp 40-53 *in* Bennet, S., McPake, B. and Mills A. (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Alubo SG (1990). Debt crisis, health and health services in Africa *Soc Sci Med* **31** (6),639-648.

Amin S and Lloyd CB (1998). *Women's lives and rapid fertility decline. Some lessons from Bangladesh and Egypt*. Research Division Working Paper no 117. New York: Population Council. http://popcouncil/pdfs/wp/117.pdf

Amy J (1992). "Obstétrique," pp. 825-848. *in* Janssens, G., Kivits, M. and Vuylsteke, J. (eds) *Médecine et hygiène en Afrique Centrale de 1885 à nos jours*, vol. 2 P. Masson: Paris.

Anonymous (1994) United Nations International Conference on Population and Development, 5-13 September 1994, Cairo, Egypt. http://www.iisd.ca/linkages/program/p07007.html.

Asiimwe D, McPake B, Mwesigye F, Ofoumbi M, Ørtenblad L, Streefland P and Turinde A (1997). "The private sector activities of public-sector health workers in Uganda". Chapter 9, pp 140-157. *in* Bennet S, McPake B, Mills A (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Backström B, Gomes ADC, Fresta E, Dias F, Gonçalves A, Lerberghe WV and Ferrinho P (1997). The coping strategies of rural doctors in Portuguese speaking African countries. Abstract Te 22. *Revista Médica de Moçambique* **7**(1,2) Supplement 1: S13.

Barros FC, Vaughan JP, Victora CG and Huttly SR (1991). Epidemic of caesarean sections in Brazil. *Lancet* **338**(8760),167-169.

Beckerleg S, Lewando Hundt G, Eddama M, el-Alem AE, Shawa R and Abed Y (1999). Purchasing a quick fix from private pharmacies in the Gaza Strip. *Soc Sci Med* **49**(11),1489-1500.

Bennet S, McPake B and Mills A (1997). "The public/private mix debate in health care". Chapter 1, pp 1-18 *in* Bennet S, McPake B and Mills A (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Berman P and Rose L (1996). The role of private providers in maternal and child health and family planning services in developing countries. *Health Policy and Planning* **11**(2),142-155.

Bobadilla JL and Walker G (1991). Early neonatal mortality and Caesarean Delivery in Mexico City. *Am J of Obstetrics and Gynecology* **164**(1),22-28.

Broomberg J, Masobe P and Mills A (1997) "To purchase or to provide? The relative efficiency of contracting out versus direct public provision of hospital services in South Africa". Chapter 13, pp 214-236 *in* Bennet S, McPake B, Mills A (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Brugha R, Chandramohan D and Zwi A Viewpoint: management of malaria – working with the private sector. *Tropical Medicine and International Health* **4**(5), 402-406.

Coetzee N, Ahmed N and Kagee M (1994). Sexually transmitted diseases in general practice. S Afr Med J **84,**237-238.

Colson AC (1971). The differential use of medical resources in developing countries *J Hlth Soc Behav* **12,**226.

Crabbe F, Tchupo JP, Manchester T *et al.* (1998). Pre-packaged therapy for urethritis: the “MSTOP” experience in Cameroon. *Sexually Transmitted Infections* **74**, 249-252.

Damasceno A, Van Lerberghe W and Ferrinho P (2000). "Coping through private practice. A cardiologist in Maputo, Mozambique". pp 157-162 *in* Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) *Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies.* Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.

De Brouwere V and Van Lerberghe W (1998). Les besoins obstétricaux non couverts. *L'Harmattan* Paris Montréal. 1-237.

Dixon-Mueller, R. (1990) Abortion policy and women’s health in developing countries. *In J Hlth Serv* **2**,297-314.

Doyal L (1996). The politic´s of women's health: setting a global agenda. *In J Hlth Serv* **26**(1),47-65.

Edouard L, Dodd N and Bernstein S (2000). The implementation of reproductive health programs: experiences, achievements and challenges. *Int J Gyn Obs* **70,**25-34.

Evans I (1995). SAPping maternal health *Lancet* **346,**1046.

Ferrinho P (1995). *Primary Health Care in Alexandra. A contribution to the Methodology of Primary Health Care*. PhD Thesis, Department of Community Health, Faculty of Medicine, Medical University of Southern Africa.

Ferrinho P, Barron P, Buch E *et al.*(1990). Some aspects of primary health care in Oukasie *SA Family Practice* **11**(9),447-450.

Ferrinho P andVan Lerberghe W (editors) (2000). *Providing health care under adverse conditions: Health personnel performance & individual coping strategies*. Studies in Health Services Organisation & Policy, 16. Antwerp: ITG Press.

Ferrinho P, Van Lerberghe W, da Cruz Gomes A (1999). Public and private practice: a balancing act for health staff [editorial] *Bulletin of the World Health Organization* **77**(3),209.

Ferrinho P, Van Lerberghe W, Julien MR *et al.* (1998). How and why public sector doctors engage in private practice in Portuguese-speaking African countries *Health Policy and Planning* **13**(3),332-8.

FIGO (2000), Recommendations on ethical issues in obstetrics and gynecology by the FIGO committee for the ethical aspects of human reproduction and women's health. FIGO, London.

Finger WR (1998). Commercial sector can improve access. *Network (Family Health International)* **18**(2),12-15.

Fox KFA (1988). Social marketing of oral rehydration therapy and contraceptives in Egypt. *Studies in Family Planning* **19**(2),95-108.

Frame G, Ferrinho P and Wilson TD (1991). The care of STDs in Alexandra: review of previous research and a survey of General Practitioners. *S Afr Fam Pract* **12**, 87-92.

Gallan M (1982). Abortion in the Philippines: a study of clients and practitioners. *Studies in Family Planning* **13**,35-44.

Gani A (1997). "Improving Quality in Public Sector Hospitals in Indonesia," pp. 197-217. *in* Newbrander W. (ed.) (1997) *Private Health Sector Growth in Asia. Issues and implications*. Wiley: New York.

Gertler P, Locay L and Sanderson W (1987). Are user fees regressive? *J Economet* **36**,67-88.

Giffin K (1994). Women's health and the privatization of fertility control in Brazil. *Soc Sci Med* **39**(3),355-360.

Gilson L, Adusei J, Arhin D, Hongoro C, Mujinja P and Sagoe K (1997). "Should African governments contract out clinical health services to church providers?" Chapter 17, pp 276-302. *in* Bennet, S., McPake, B., Mills, A. (eds.) (1997) *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Giusti D, Criel B and de Béthune X (1997). Public versus private health care delivery: beyond the slogans. *Health Policy and Planning* **12**(3),193-198.

Hanson K, Berman P (1998). Private health care provision in developing countries: a preliminary analysis of levels and composition. *Health Policy and Planning* **13**(3), 195-211.

Hanvoravongchai P, Letendumrong J, Teerawattananon Y, and Tangcharoensathien V (2000). Implications of private practice in public hospitals on the cesarean section rate in Thailand. *Human Resources for Health Development Journal* **4**(1), 2-12.

Hecht RM and Tanzi VL (1993*). The role of NGO in the delivery of health services in developing countries*. Background paper for the World Development Report. Washington, DC: World Bank.

HFMSP (Health Financing and Management Study Project)(1999). Health Financing in Thailand. Technical report. Mimeo, 146 pp.

Huber SC and Harvey PD (1989). Family planning programmes in developing countries: cost-effectiveness by mode of service delivery. *J Biosoc Sci* **21**,267-277.

Kamheang C, Tangtrakul S, Pongthai S *et al.*(1981). Abortion: an epidemiologic study at Ramathibodi hospital, Bangkok. *Studies in Family Planning* **12**,257-262.

Kanji N, Kilima P, Lorenz N, Garner P (1995). Quality of primary outpatient services in Dar Es Salaam: a comparison of government and voluntary providers. *Health Policy and Planning* **10**(2),186-190.

Karim QA, Morar N, Zuma N, Stein Z and Preston-Whyte E (1994). Women and AIDS in Natal/Kwazulu. Determinants of the adoption of HIV protective behaviour. *Urbanisation and Health Newsletter* **20**,3-9.

Kloos H, Getahun B, Tefari A, Tsadik K, Belay S (1988). "Buying drugs in Adis Ababa: a quantitative analysis" *in* van der Geest, S., Whyte, R.S. (eds.) *The Contest of Medicines in Developing Countries*. Kluwer Academic Publishers, Autrecht, London and Boston.

Koivusalo M and Ollila E (1997). *Making a Healthy World. Agencies, Actors and Policies in International Health*. Zed Books Ltd: London and New York.

Letarte C (1996). Health Situation In Egypt. Cairo, Draft, Mimeographed Document.

Maiga Z, Traoré Nafo F and El Abassi A (199). La Réforme du Secteur Santé au Mali, 1989-1996. *Studies in Health Services Organisation & Policy* **12**,1-132. Antwerp, ITG Press.

Mbugua JK, Bloom GH and Segall MM (1995). Impact of user charges on vulnerable groups: the case of Kibwesi in rural Kenya. *Soc Sci Med* **41**,829-835.

McPake B, Asiimwe D, Mwesigye F, Ofumbi M, Streefland P and Turinde A (2000) "Coping strategies of health workers in Uganda". pp 157-162 *in* Ferrinho P and Van Lerberghe W (eds.) (2000) *Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies.* Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.

Mcpake B and Hongora C (1995). Contracting out of clinical services in Zimbabwe. *Soc Sci Med* **4**(1),13-24.

Ministry of Public Health (2000). Thailand Health Profile 1997-1998. Bangkok: ETO.

Mongkolsmai D (1997). "Private Health Sector Growth and Social Security Insurance in Thailand" *in* Newbrander W. (ed.) (1997). *Private Health Sector Growth in Asia. Issues and implications.* Wiley: New York. pp. 83-107.

Montgomery MR and Casterline JB (1998). Social Networks and the Diffusion of Fertility Control. Research Division Working Paper no 119. New York: Population Council. http.//popcouncil/pdfs/wp/119.pdf

Mwabu G, Mwanzia J and Liambila W (1995). User charges in government health facilities in Kenya: effect on attendance and revenue. *Health Policy and Planning* **10**, 164-170

Newbrander W and Moser P (1997). "The Future of Health Sector Reform in Asia," *in* Newbrander, W. (ed.) (1997) *Private Health Sector Growth in Asia. Issues and implications*. Wiley, New York, pp. 221-234.

Okonofua FE, Ogonor JI, Omorodion FI, *et al.*(1999). Assessment of health services for treatment of sexually transmitted infections among Nigerian adolescents. *Sexually Transmitted Diseases* **25**(3),184-190.

Pannarunothai S and Mills A (1997). "Characteristics of public and private health-care providers in a Thai urban setting". Chapter 4, pp 54-70 *in* Bennet S, McPake B and Mills A (eds.) (1997). *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Pannarunothai S and Mills A (1998). Researching the public/private mix in health care in a Thai urban area: methodological approaches. *Health Policy and Planning* **13**(3),234-248.

Phalla T, Leng HB, Mills A, Bennet A, Wienrawee Gorbach P and Chin J (1998). HIV and STD epidemiology, risk behaviors, and prevention and care response in Cambodia. *AIDS* **12,** S11-S18.

Phillips JF, Greene WL, Jackson EF (1999). Lessons from community-based distribution of family planning in Africa. Research Division Working Paper no 121. New York: Population Council. http.//popcouncil/pdfs/wp/121.pdf

Porignon D, De Vos P, Hennart P, Van Lerberghe W, and Laurent A (1994). [The health sector in Zaire: towards a new strategy for co-operation] La problématique du secteur santé au Zaïre: vers une nouvelle stratégie de coopération. BADC, 1-145. Report

Potts M, Walsh J (1999). Making Cairo work. *Lancet* **353**,315-318.

RamirezT, Zurita B, Cruz C, Recio M and Vargas C (1997). "The role of an NGO in the market for maternal and child health-care services in Mexico City". Chapter 11, pp 174-187 *in* Bennet S, McPake B and Mills A (eds) (1997). *Private Health Providers in Developing Countries. Serving the Public Interest?* London and New Jersey: Zed Books.

Roemer MI (1991). National Health Systems of the World. Volume I. The Countries. New York: New York University Press.

Roenen C, Ferrinho P, Van Dormael M, Conceição MC and Van Lerberghe W (1997). How African doctors make ends meet: an exploration. *Tropical Medicine and International Health* **2**(2),127-135.

Rosenfied A and Maine D (1985). Reproductive mortality- A neglected tragedy: Where is the M in MCH? *Lancet* 83-85.

Schneider H, Blaauw D, Magongo B and Khumalo I (1999). "STD care in the private sector". Chapter 7 *in* (falta editor) *SA Health Review* (1999). Durban, Health Systems Trust.

Schwartz JB, Akin JS, and Popkin BM (1993). "Economic determinants of demand for modern infant-delivery in low-income countries: the case of the Philippines." *in* Mills, A. and Lee K. (eds.) *Health economics research in developing countries*. Oxford University Press: Oxford. pp. 165-192.

Steele F, Amin S and Naved RT (1998). The impact of integrated micro-credit program on women's empowerment and fertility behavior in rural Bangladesh. Research Division Working Paper no 115. New York: Population Council.http.//popcouncil/pdfs/wp/115.pdf

Stock R (1983). Distance and the utilization of health facilities in rural Nigeria. *Soc Sci Med* **17**,563.

Turshen M (1999). *Privatizing health services in Africa*. Rutgers University Press: New Brunswick, New Jersey and London.

UNFPA (1999a). Expert Group Meeting on Reproductive Health. Implementing the ICPD Programme of Action in Central and Eastern Europe: Lessons Learnt Post-Cairo. UNFPA/WHO Meeting, Copenhagen, Denmark, 28-30 September 1998.

UNFPA (1999b) The UNFPA private-sector initiative. Exploring ways to facilitate co-operation between governments and the commercial sector to expand access to reproductive health commodities. A project of the UNFPA Global Initiative on Reproductive Commodity Management. United Nations Population Fund, Technical and Policy Division, Technical Branch.

United Nations (1998) World Population Monitoring. Selected Aspects of Reproductive Rights and Reproductive Health. Population Division, United Nations Secretariat, New York.

UON (1999) Unmet Obstetric Needs Network, unpublished report.

Van Lerberghe W and De Brouwere V (2000). Etat de santé et santé de l'Etat en Afrique subsaharienne, *Afrique Contemporaine* **135**,175-190.

Van Lerberghe W (1993). Les politiques de santé africaines: continuités et ruptures. *Bull Séances Acad R Sci Outre Mer* **39**,205-230.

Van Lerberghe W and Lafort Y (1990). The role of the hospital in the district; delivering or supporting primary health care? Current Concerns SHS Papers: 1-36.

Van Lerberghe W, Van Balen H and Kegels G (1992). [Typology and performance of first-referral hospitals in sub-Saharan Africa] Typologie et perfromances d'hôpitaux de premiers recours en Afrique sub-Saharienne. *Ann.Soc Belg.Med Trop* **72** Suppl 2,1-51

Van Lerberghe W, Ammar W, el Rashidi R, Sales A and Mechbal A (1997). Reform follows failure: I. Unregulated private care in Lebanon. *Health Policy and Planning* **12**, 296-311.

Westaway M (1994). An interview with Sonja van Oudtshoorn, the Director: Education and Training of the Cancer Association of South Africa (CANSA). *Urbanisation and Health Newsletter* **20**,69-78.

WHO (1998). Reproductive Health Research: The New Direction. Biennial Report 1996-1997. UNDP/UNFPA/WHO/WB Special Programme of Research, Development and Research Training in Human Reproduction. Geneva.

World Bank (1993). *Investing in Health*. Oxford University Press: Oxford.

Wyss K, Whiting D, Kilima P *et al.* (1996). Utilisation of government and private health services in Dar Es Salaam. *East African Medical Journal* **73**(6),357-363.

Yoder R(1989). Are people willing and able to pay for health services? *Soc Sci Med* **29**(1),35-42.

Young JC (1980). A model of illness treatment decisions in a Tarascan town. *Am Ethnol* **7**,106.