

PUBLICLY-PROVIDED HEALTH CARE:
INCENTIVES DO MATTER

POLICY BRIEF

The evidence is accumulating that consumers of health care services in many low- and middle-income countries have turned away from poor quality, publicly-financed services to private providers. At the same time, many services effectively have been privatised as low-paid government health workers have come to rely increasingly on fees for their income. This unplanned and unregulated process was accelerated by the introduction of cost-recovery policies which legitimised the charging of fees for services and for pharmaceuticals. Its roots lie in well-meaning attempts to provide comprehensive publicly-financed health care with insufficient resources and insufficient attention to provider incentives and regulation. The outcomes have been both inefficient and inequitable. Solutions will be elusive, but probably lie in new, more selective and affordable public roles, and different incentives for health care providers.

The erosion of public health services

There is great pressure to extend basic health services to the population at large, particularly to the poorest in poor countries. In many countries, however, the macroeconomic consequences of large budget deficits have demonstrated that health systems based on the United Kingdom's national health service (NHS) model cannot be financed from domestic tax revenues alone.

As a result, governments have turned increasingly to two additional sources of financing in their attempts to bridge the gap between public means and health needs. These sources are:

- Financial and technical resources from international donors and charities. In many African countries, for example, external finance now accounts for well over half of all recurrent health-sector expenditure, and an even greater share of public investment in health care.
- Fees – variously called user charges, cost-sharing and cost recovery – for government-operated facilities. Some schemes exempt preventive and other strategic health

interventions from charges; some schedule different charges for different services; and some levy flat fees.¹

Although individual facilities may have benefited from the introduction of fees, the charging strategy has not delivered its promised financial benefits to the sector as a whole. Typically, fee revenues contribute 10 per cent or less to government resources. Moreover, despite improvements in the quality of the services being offered,

there is evidence that access to health care for the poorest has been compromised.

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The growing privatisation of health services

A more startling outcome has been the wholesale, unplanned and unregulated privatisation of health services, accompanied by a switch in consumer preferences away from inferior, publicly-financed services to the private sector. Typically, public sector clinicians in low- and middle-income countries now work only part-time for the government: the greater part of their time is spent on private fee-earning work, or on managing private pharmaceutical (or other) businesses.

Some might argue that these trends are part of a

¹ For an account of alternative fee structures, see Carrin, Guy & Kodjo Evlo (1995), 'A methodology for the calculation of health care costs and their recovery', in *Macroeconomics, Health & Development*, Series No 2, WHO, Geneva.

desirable transition towards more pluralistic health systems, possibly even offering some efficiency gains and, from an equity point of view, increased access for groups who would otherwise be excluded. Solid empirical evidence on these issues is still patchy and requires to be confirmed by more research. Nonetheless, there is already substantial theoretical and anecdotal evidence that, where unregulated private provision replaces publicly-provided services, both efficiency and equity losses may ensue. The long term outlook, moreover, is less than optimistic.

Efficiency losses

In an unregulated health market, efficiency losses on the supply side arise from the exploitation of superior knowledge by providers. The outcomes include declining quality, unnecessary treatments and high prices. These inefficiencies are aggravated when – as is common practice in developing countries – clinicians are allowed to sell the pharmaceuticals they prescribe. This leads to over-prescribing for pecuniary gain, with few (if any) individual health benefits and, frequently, with public harm. Over-prescription of antibiotics is particularly worrying. At the same time, consumers – who are in no position to judge the cost-effectiveness of alternative interventions – frequently expect to receive injections and pills even when these make no significant difference to health outcomes.

These ‘market failures’ result in under-consumption of preventive health care and over-consumption of less beneficial interventions. By some accounts, 80 per cent of encounters between public sector clinicians and consumers at the primary level result in costs of this kind being incurred with no discernible health gains.² Such encounters, moreover, increasingly are being subsidised from scarce government resources and/or by international donors.

Equity losses

Equity is compromised in unregulated private health markets in two distinct ways:

1. Unnecessarily high costs of interventions exclude low-income consumers from access to health services.
2. Public sector resources, intended to finance health services for poor people, are diverted to provider income, when poorly-paid government clinicians charge fees.

The problem is complicated by the fact that clinicians employed in the public sector have substantial opportunities for economic rent-seeking:

- They can use public facilities for private practice at less than their full cost.
- They have access to publicly-financed pharmaceuticals that they can sell for their own account.³
- They can ration their time such that their private practice takes precedence over their government duties: consequently, government health clinics are open only for a few hours each week, and hospital doctors spend only a small proportion of their time at their place of work.⁴

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These practices divert resources from health services intended to provide access according to need, rather than according to means. Moreover, insofar as services for the poor would lengthen their lives or improve their productivity by

reducing the incidence of illness, the distortions have further adverse effects on efficiency.

Sources of decline

The roots of this decline lie in attempts in many developing countries to provide comprehensive publicly-financed care without sufficient financial and management resources, and with inadequate attention to incentives and sanctions for providers. With the wisdom of hindsight, the following sequence of events can be identified.

In the initial stages, both newly independent governments and their donor partners invested heavily in the expansion of public health-service

² Bennett, Sara, Barbara McPake & Anne Mills (eds) (1997), *Private Health Providers in Developing Countries*, Zed Books, London.

³ This reduces the start-up costs and the costs of working capital compared with a private sector pharmacy.

⁴ See for example, Asiimwe, D E *et al* (1997), 'Informal health markets and health financing policy in Uganda', in Bennett, McPake & Mills (eds), *op cit*.

infrastructures and staff. The aim – based on the NHS model – was to provide comprehensive health care for everyone, free at the point of delivery. Little thought was given, however, to the implications of these investments for recurrent costs, and budgetary pressures subsequently emerged. Efforts were made to keep wages low in order to maintain the large work force thought to be essential for comprehensive coverage. In due course, however, pressures for higher wages began to squeeze out non-wage recurrent expenditure. As a result, the financial resources for pharmaceuticals, diagnostic materials, surgical supplies and building and equipment maintenance increasingly grew inadequate. Donors responded by making larger contributions to non-wage recurrent costs. Even so, the wage rises permissible within the government budget were insufficient to maintain parity with rising earnings in the private health sector.

As public sector clinicians sought to augment their income from fees, government not only became a residual employer but also lost effective management control. Finally, rising middle-class demands for better and more sophisticated treatments increased the costs of government-financed services still further, and resulted in an increasing share of the government budget going to tertiary, urban services at the expense of primary and rural health care.

Policy responses

As the need for reforms became increasingly apparent, attempts were made first to re-finance government health sectors from donor contributions and from fees paid by households for selected services. Donor assistance, delivered primarily in the form of project financing, was successful in augmenting government resources. But it also generated costs in terms of deteriorating co-ordination and coherence. More fundamentally, in many cases, foreign aid proved insufficient to provide a sustainable financial basis for the long-term development of public health services. The levying of fees also failed to generate a significant increase in the resources available to the sector as a whole,

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although individual service units were able to retain staff and purchase more supplies.

More significantly, the introduction of fees legitimised the practices of charging for services and for pharmaceuticals. In turn, given the low levels of government pay, fee-charging rendered the widespread privatisation of government-funded health services inevitable. At the time, however, this outcome was not anticipated, with the result that no regulatory framework was put in place.

More recently, reforms have concentrated on improving public sector efficiencies through introduction of better budgeting and management practices.

Designing incentives for health service providers

A central issue, not yet addressed fully in the design of health sector reform, is how to deal with the distortions that have been created in the incentives faced by health workers in countries where the public sector is in decline. A useful framework for analysis of conflicts between self-interested and socially-desirable outcomes is afforded by Oliver Williamson⁵. Williamson uses a hierarchy of institutions ('rules of the game') to analyse the strengths and weaknesses of the incentives and sanctions that interact to govern provider behaviour in different settings and to suggest strategies for the future.

'Embedded' incentives. The key task is to identify the 'embedded institutions' – the unwritten codes of conduct and rules that define acceptable social behaviour – within which providers operate. In health care, the codes of caring, trust and social responsibility are most famously embodied in the Hippocratic Oath. Under this institution, which places patient welfare ahead of pecuniary reward, the incentives for abiding by the rules include the rewards of professional pride, patient gratitude, prestige, altruism and social solidarity, as well as the fear of censure, gossip, shunning and the withdrawal of trust.

5 Williamson, Oliver E (1998), 'Transaction cost economics: How it works; where it is headed', *De Economist*, 146/1

Although health provider incentives clearly also include financial rewards, the underlying assumption driving the expansion of publicly-financed health services in low-income countries was that altruism and the narrowly-defined medical ethics of Anglo-Saxon societies would prevail. It was taken for granted that these motivations, which placed more emphasis on addressing need than on the means to pay, would ensure that health care resources would be used productively, even if pay was low.

This proved not to be the case, however. Even in western countries, the Hippocratic Oath has been degraded from a formally-binding obligation to a less-rigorous social norm. In many other societies, this ethic had little relevance. In low-income

and strength of the incentives and sanctions associated with the embedded institutions are crucial to the design and costs of health sector reforms. If social incentives and sanctions are strong, moreover, the costs of financial, organisational and regulatory incentives are likely to be correspondingly lower.

Market incentives. Even when pay is not the only factor driving clinicians' behaviour, financial incentives still matter, particularly when government pay is too low to feed the family.⁶ Nurses and doctors operate in both public and private domestic health labour markets and, increasingly, in regional and international labour markets as well. They have scarce skills, valued – albeit by a poorly-informed market – at rates well

Potential incentives and sanctions in the health sector		
	Incentives	Sanctions
Markets	Employment Remuneration	Unemployment Loss of earnings
Organisational governance	Recognition, promotion Performance-related rewards Contracts	Withdrawal of confidence Loss of rewards Contractual sanctions
Institutional environment	Legal framework Bureaucratic rules Government regulations Formal rules of professional bodies	Fines, dismissal Censure Fines, censure Censure, de-registration
'Embedded institutions'	Trust Altruism Professional ethics Social recognition Social solidarity	Withdrawal of trust Loss of satisfaction Gossip, censure Loss of prestige Shunning

Adapted from Williamson (1998) *op cit*

countries, it was undermined also by the extreme degree of wage-compression that accompanied attempts to provide comprehensive health care coverage. Thus, the many problems that have emerged in seeking to expand government health services – and that threaten to undermine more recent management reforms designed to improve the sector's efficiency – can be explained by the failure to use more appropriate incentives.

The implication of this analysis is that the nature

above civil service pay. In many countries, the rewards of public sector employment now lie mainly in the opportunities it provides to pursue private business interests.

A great deal of attention has been focused recently on ways in which provider payments can be arranged to offer the best incentives for improved efficiency.⁷ Many of these incentives, however, cannot be applied when health services are delivered by civil servants whose only formal

6 Government doctors in Rwanda are paid US\$130 per month and, in Uganda, between US\$280 and US\$450 per month. At the same time, private health labour markets are supply-constrained, by rationing in training and accreditation, placing an upward pressure on health wage costs.

7 Barnum, Howard, Joseph Kutzin and Helen Saxenian (1995), 'Health reform: Incentives and provider payment methods', *HRO Working Papers*, Number 51, World Bank, Washington DC.

financial reward is an inadequate salary. This is because the agreements require that providers can be rewarded in return for specified services.

Organisational incentives. Employees who perform well can expect recognition, promotion and other rewards, as well as better pay. In return, employers can reasonably expect high productivity. Employees who fail to honour their part of an employment contract can expect employers to exercise the ultimate sanction of dismissal if other remedies fail. Service providers who do not honour their contracts can expect not to be contracted again. Until recently, the importance of such organisational incentives and sanctions was neglected, particularly in reforms based on cost recovery. There were few incentives available to encourage government-employed health staff to contribute fee revenues to the sector's resources, and few sanctions to restrain them from adding the revenues to their personal income or from spending most of their time on private practice.

Recent reforms have been aimed at improving organisational efficiency through better budget management and improved performance management techniques. The structures of organisational and managerial incentives and sanctions within the civil service, however, may still be too weak, low government pay undermining their effectiveness. Too often, pay levels are so poor that organisational rewards are not worth pursuing, and the ultimate sanction of dismissal has become so attenuated by bureaucratic procedures that management control has been rendered virtually ineffective.

Reforming the institutional environment. The implications of this analysis are that embedded, financial and organisational incentives and sanctions may need to be reinforced by formal regulation. The medical profession has a long history of self-regulation. This may have been satisfactory when other incentives, particularly reciprocal trust, were effective in compensating for health market failures. Although experience from around the world is still limited, it suggests that, with the weakening of self-regulatory procedures, health provider regulation needs to be backed by

legislation and supervised independently of both professional and political interests. Professional associations may still be useful intermediaries, but they are not sufficient in themselves.

The experience from other sectors, moreover, is that enforceable 'rules of the game' should be in place before the process of privatisation begins. Hitherto, this has not been the case in health care, where the privatisation of government services has been largely unexpected and unplanned. As a result, any attempt at regulation is now likely to be more costly than if enforceable rules governing provider conduct had been in place earlier. The longer the problem is left unaddressed, however, the higher the costs of regulatory reform are likely to be, quite apart from the continuing costs of existing inefficiencies in the sector. Regulation need not consist only of coercive measures; it should also include positive incentives to adopt best practice.

Some conclusions

The embedded institutions that once may have provided the inducement for government health professionals, operating on low pay and without formal organisational incentives, to work hard for their patients, have been eroded. These trends may be regretted, but they also need to be accepted and other incentives sought to achieve the same outcome.

Consequently, an alignment of financial and non-financial incentives is required for increased health-sector productivity. These incentives need to be synergistic and to reinforce each other: no single incentive, operating alone, is likely to be effective. Adequate financial rewards for public sector health workers are now a necessary, though not a sufficient, condition for a reversal of the decline in health services that are publicly financed and delivered. In countries where the government health sector is too large to be financed adequately, poor pay has so eroded the effectiveness of management incentives and sanctions that the scope for efficiency gains by way of performance management and output-related budget management is limited. Unless government wage rates approximate market-

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clearing wage rates, these incentives are likely to remain weak and regulation will prove inordinately expensive. This raises further difficulties, however. In many low-income countries, market-related wage rates for health workers may be incompatible with civil service wage ceilings, unless the numbers employed by the government are reduced significantly and the majority of government health workers are moved into the private sector.

But 'bad habits' are unlikely to be reversed by an increase in government wages alone. Expectations may already have been formed of widely-available rent-seeking opportunities in the public health service. If so, higher wages may not reduce rent-seeking behaviour. Instead, income expectations may simply advance ahead of pay increases. At worst, there may be a wage-rent-seeking ratchet in place which will be difficult to reverse in the short run, and may be managed only by introducing a new cohort of public sector health workers to new pay, employment and management conditions. Changes in organisational and regulatory incentives, backed up by strong sanctions – including the possibility of job-loss, humiliation or legal action - may need to be in place before wage increases will generate productivity gains.

Thus, the strength of non-financial incentives will increase once the necessary condition of adequate pay has been met, and the job has been rendered worth keeping. Nevertheless, civil service incentive structures may still be too weak and inflexible to serve the needs of a health system which employs professionals who have highly marketable skills. There are now few countries, outside ex-British and French colonies and the former socialist countries of Eastern Europe,

where doctors and nurses are civil servants. Where they are, a first step to reforming health sector incentives may be to re-employ the staff required for core public functions outside the civil service, on new terms and conditions, including better pay and more powerful organisational incentives to perform well.⁸

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No incentive or sanction is costless, however. Low-income countries facing hard health budget constraints need to examine the least-cost mechanisms for producing the greatest health sector productivity gains.

Mechanisms arising from 'embedded institutions' are the most important as they impose the lowest cost on the state. But, important as they are, they are unlikely to be sufficient to generate high levels of professional productivity unless they are reinforced by financial, regulatory and organisational incentives, with matching sanctions.

How successful such reforms will be remains to be seen. The foregoing analysis suggests that radical changes may be necessary before significant returns will be forthcoming. In particular, where 'self-privatisation' has proceeded to the point at which public pay contributes only a small proportion of total provider income, governments could probably achieve the same coverage more cost-effectively by contracting the same staff as private providers to supply selected services, paid for by public financing. This would allow the public sector to concentrate on providing effective non-financial incentives to a smaller number of well-paid public employees.

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⁸ Ghana, Zambia and Jamaica are implementing this type of reform.



What's on at OPI

During the 1999-2000 academic year, Oxford Policy Institute is holding three series of public meetings. The first and second series – on Re-thinking Approaches to Government Reforms and International Relations and the Developing World – were held in October-December 1999 and January-March 2000 respectively. The third – on Issues in Health Sector Regulation – is scheduled for April-June 2000.

The provisional programme includes the following topics:

- Issues in health sector regulation: an overview
- Regulating quality and price in private UK health markets
- Health insurance regulation
- Rationing and regulation for a cost-effective NHS
- Regulation for cost-effectiveness in pharmaceutical markets
- Health sector regulation in developing countries
- Health service regulation in public health systems and the law
- The impact of financial incentives on the behaviour of GPs

The seminars will be held weekly on Fridays from 5-6.30 pm at Queen Elizabeth House, 21 St Giles, Oxford, starting on 5 May 2000. Material from some of these meetings will appear in future issues of OPI Issues Notes, or as OPI Policy Briefs.

Advance notice: Round Two of OPI's *Consultations on Best Policy Practice* will be held in autumn 2000 with a conference on 'Strategic Public Management in Pluralistic Health Sectors'

For further details about any of these events, contact the Administrator at OPI.



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