THEMES AND DEBATES

The Rockefeller Foundation's "Public Stewardship of Private Providers in Mixed Health Systems": A Point-by-Point Critique

After 20 years, the evidence supporting public stewardship of the non-state health sector in lower and middle income countries remains elusive.

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Abstract:

The 2010 World Health Assembly (WHA) tabled, but did not manage to discuss, a resolution on regulating the private health care sector.[1] With hindsight, it seems fitting to thoroughly review an earlier 2008 Rockefeller Foundation (RF) report on the same issue: "Public Stewardship of Private Providers in Mixed Health Systems." The key weakness of the RF document – and also of the above WHA draft resolution – is that both fail to provide the necessary empirical evidence to show that better "stewarding" regulation in low and middle income countries (LMICs) has worked to provide quality, accessible, and affordable health care for all in mixed public-private health systems. In this article, we voice our skepticism about whether public stewardship can work in mixed systems in LMICs. Moreover, the RF report does not address the access to quality health care from a human rights perspective. The right to quality health care is simply overlooked. The report prescribes "new solutions" to well known regulatory problems and fails to offer any evidence of their benefit. It argues that regulation of mixed public-private health systems can be successful without providing any evidence even at the local level. This lack of evidence is striking since we have a good 20 years of experience with such regulation. We conclude that a) private providers will never be effectively controlled in LMICs with regulation alone and b) that the report reflects RF's ideological bias against single payer, universal coverage public health care systems. We argue that the "regulation alternative" is simply not a substitute for strengthening the public sector. Many of the measures proposed by the Rockefeller Foundation report are not necessarily wrong but they are applied to a private sector enjoying an established position that has given it access to deliver health care as a privilege and not as a right. Indeed, we remain convinced that if some of the proposed measures were applied to the public health sector with adequate long-term government and donor financing, they would go a longer way to achieve Health Care For All. The past experiences of Costa Rica and Sri Lanka suggest that LMICs private health markets have only been truly controlled in countries where the public sector was effective in competing with the private sector. A well organized and funded public health system, delivering comprehensive health care (not restricted to vertical disease control programs and not treating health as a commodity) is the only alternative to reign in the excesses of LMIC private providers in mixed health systems.

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Introduction

The 2010 World Health Assembly was expected to pass a motion on the need to regulate private health providers in low and middle income countries (LMICs).[1] Although such a regulation has been an issue for at least 20 years,[2,3] empirical evidence supporting its positive effects remains meager. The lack of evidence suggests that regulation of private providers in LMICs may be an inherently flawed project.

The role of the private sector in health systems in developing countries and its regulation were the subjects of a 2008 Rockefeller Foundation report entitled "Public Stewardship of Private Providers in Mixed Health Systems."[4] The report included a survey of regulatory models; an overview of private sector financing and delivery models, a survey of

attitudes towards the private health sector, and a review of evidence on where people receive health services. The executive summary of the report recognized that the topic is not devoid of controversy. Nonetheless, it clearly took sides in its conclusions by throwing the RF's prestige behind its recommendations for state regulation of mixed public-private health care systems. The WHO Executive Secretariat's March 2010 publication of a draft resolution for consideration by the 63rd World Health Assembly (WHA) on regulating the private health care sector prompted us to go back and review the RF inquiry documents in order to clarify the state of affairs on this matter. We felt there were three reasons for such a critique:

1. The authors of the report have a historical record of bias towards privatizing the health sector. The arguments they present in this report are likely to be the best they can find to plead their case. A critique of the report is thus a critique of the "best available evidence."
2. Rockefeller Foundation reports are generally influential in the international health community.
3. The report is written very professionally and a superficial reading could make one think it is even-handed.

We base our critique of the report on three key documents: The executive summary of the report,[4] the WHO draft resolution,[1] and one of the RF research papers that served as background for the report and reviewed existing regulatory models.[5]

The Rockefeller Report

The key arguments set out by the report can be summarized as follows:

- It normalizes the private sector delivery of health care services;
- It accepts that there are multiple problems with private health care delivery;
- It advocates for the role of the state as the appropriate regulator/steward of the health care market while acknowledging that, so far, government regulation of the private sector has failed;
- It suggests models, some innovative, for the ways in which states can better regulate the health care market.

The key weakness of the document is that it fails to provide the necessary empirical evidence to back its suggestion that governmental stewarding/ regulation of private providers will fix the market deficiencies found in mixed health systems. Our critique can thus be summarized as follows:

1. Private health care foisted upon poor countries in good part by the international agencies, such as the World Bank, was generally welcomed by the medical establishments in LMICs. In many of these countries, the commercial health sector – already well established – competed with the public health system which had been progressively weakened by neo-liberal reforms. We see this, for example, in the increasing commercialization of the health care provided in public hospitals. As the borders between private and public provision become increasingly blurred, the public sector is invariably weakened.
2. We share the report's view that unregulated markets have not improved equity in access to health care in these countries where a relatively small middle class had already been seeking modern, "decent quality" health care in the private sector. We also share the report's view that market mechanisms alone do not and will not work to "steward" existing mixed health systems.
3. The State may successfully steward the private health market in places like Europe. But the states of LMICs have faced several decades of neo-liberal attacks through structural adjustment programs imposed by international financial institutions and have, at best, feeble regulatory capabilities. In LMICs, evidence suggests that professional medical associations are unlikely to carry out the regulatory functions of the State and that civil society is also unable to assume this task.
4. Recommendations that advocate for the stewarding of the private sector have been made for decades. Despite this, there is a lack of adequate empirical evidence to demonstrate success in LMICs. The call for *improved* regulation simply seems yet another weak argument in the campaign to justify the privatization of health care delivery in LMICs.
5. Evidence suggests that competition between the public and private sectors fosters commercial practices whose net effect is to reduce access to equitable quality public health services in LMICs. Needless to say, neo-liberal policies have not strengthened public systems, not even those public programs limited to the control of specific diseases.
6. The Rockefeller Foundation report does not offer credible solutions to the question of how the private sector should be harnessed because it ignores the fundamental political problem, namely the weak capacity of the state in

LMICs. We have serious reservations about whether and how the stewardship initiatives proposed in the Rockefeller Foundation report could be implemented in mixed health systems in LMICs. Evidence would suggest that in mixed systems the poor and marginalized have always fallen (and continue to fall) through the cracks.

The WHO proposal

The second document we reviewed was a draft paper outlining WHO recommendations on private health system regulation. This document recommends the strategic and systematic gathering of evidence to objectively assess the effectiveness of private sector health care delivery in LMICs. This is seen as an important preparatory step to inform the development of regulatory frameworks that prioritize a people-centered service delivery which incorporates universal access, social protection, and primary health care. The potential role and contribution of NGOs—including consumer protection agencies and patient groups—to the processes of health care regulation should be considered. Furthermore, in order to nurture the understanding of various forms of health service regulation, technical assistance to WHO member states should be provided to improve regulatory implementation and oversight. There should be a better effort to document and understand the consequences of private sector provision of health services with specific reference to cases of poor and inadequate regulation of health systems that perpetuate health inequities. There should be an effort to convene and facilitate technical consultations that promote discussion and development of research agendas plus inter-country exchanges of ideas and experiences of regulatory practices. Finally, the document states that, since effective oversight of private health-care providers is often constrained by imperfect strategic intelligence, limited financial influence, and a weak institutional capacity, it is ultimately the renewal of primary health care that has to provide the policy framework for good government regulation and oversight.

This draft still calls for regulation and is not really an open critique of the many shortcomings of private provision. Nonetheless, the language it uses is different from that of the RF. The recommendations mention universal access, social protection, primary health care, participatory processes, the consequences of private provision, and health inequities.

The Rockefeller Literature Review

The RF commissioned a literature review which informed the main report. This review was interesting reading for us as it contradicts the RF executive summary. The key points made in that review are summarized here:

- The engagement of the private sector in health requires more than just regulatory commands and controls; it requires governments to guide the roles and direction of private actors through a broad policy process. The government must realign its own health functions to effectively steer the private health sector towards attaining public health goals.
- Regulatory instruments cannot be implemented only through strict legal controls. Monetary incentives and penalties have proven themselves as viable methods to enforce regulations.
- The essence of accountability is transparency and sanctions. Private providers should report and explain what they have or have not done.
- Regulation alone is not sufficient to assure that private providers support the goals of the national health system; other contextual factors must be addressed.
- The challenge of increasing governmental capacity for effective regulation is a prerequisite to the delegation of increased responsibility to the private sector in health care provision; this includes self-regulation by professional bodies;
- Civil society and consumer protection agencies can and should play a significant role to ensure that public voices are heard and policy actions are taken accordingly.

We were puzzled as to why these important observations were not incorporated in the report's executive summary.

Four Assumptions

Our critique of the Rockefeller report stems from four assumptions:

- The private health sector is heavily used by the poor in LMICs. However, in an unregulated health market, catastrophic out of pocket and household expenditures on health are one of the main reasons people to fall into poverty.[6,7]
- In countries where the private sector is strong (in absolute terms), hospital utilization and hospital admission rates remain quite low; the stagnating maternal mortality ratio among the poor, particularly in Africa, is a direct consequence of this.
- There is probably an inverse relationship between expenditures on private health services and governments' capacity to regulate the pri-

vate sector; this is visible when we compare high-income countries and LMICs.
- When addressing access to quality health care, a human rights perspective should play a prominent and important role; technocratic solutions to well-known regulatory problems cannot be elaborated in isolation from the viewpoints of health care rights holders; if they do, they will remain fatally flawed.

We will now substantiate our critique of the RF report by offering a point by point rebuttal of key points made in the report's executive summary. The "points" are taken either verbatim or with close paraphrasing from the original text.

Point-counterpoint:

1. Point: The report begins by outlining the vital importance of public stewardship of the non-state sector. This is not new. The World Bank in 1993[8] and WHO in 2000[9] both placed special emphasis on promoting the regulatory function of governments. The report states that "many" – it should say most – governments are neither performing that stewardship role nor is there pressure from donors for them to do so. **Counterpoint**: The reality in most countries around the world is that the public sector – despite international policy and financial support – does not monitor the activities of the non-state sector. This situation calls into question whether the regulatory role proposed for the LMICs can ever be implemented in a serious way.

2. Point: In practical terms, regulation of the private sector requires a set of rules. But making rules, the report implies, is not necessarily a government function; rules can also be established through voluntary action. Contrary to conventional wisdom, the alternative to state regulation is not a regulatory void, but rather a range of voluntary arrangements. **Counterpoint**: The Code of Conduct on the marketing of breast milk substitutes is a sad reminder of how these voluntary guidelines do not work.[10] FAO also maintains voluntary guidelines on food security that have had a poor track record.[11] Are we supposed to be more optimistic when it comes to health care? The report actually suggests an answer to this question when it proposes regulating the system through professional associations. These associations have often tried to turn health policies and regulations to their own advantage; regulation by professional associations is fraught with conflicts of interest.[5] Indeed, the myth that self-regulation is somehow superior to governmental [12] has been shown false in cases documented long ago.[13,14]

The report itself later mentions several drawbacks of self-regulation, namely:

- Self-regulation by medical professionals has been prone to regulatory capture. Regulation is then misused to serve professional interests rather than those of the public.
- Medical associations have been anything but proactive in taking disciplinary action against medical malpractice or patient complaints; this is especially true when cases are so bad that they need to be taken to court. Professional associations have not publicized cases of malpractice for fear of damaging the medical profession's reputation.
- Registration and licensing of professionals and accreditation of medical facilities, although necessary, have been inadequate to reorient the private sector's contribution towards quality, efficiency, affordability, and equity in health care; even licensed practitioners misuse privileges and are responsible for medical malpractice and medical negligence.
- There is limited empirical evidence supporting the effectiveness of professional certification. Accreditation of private health facilities has had a mixed record of success in LMICs.
- Control over the behavior of private practitioners has been ineffective unless underlying financial incentives are corrected.

3. Point: The report stresses that many countries already have large private markets for healthcare and that these are unlikely to go away. It argues that existing institutional arrangements can be improved. Therefore, the report concentrates on barriers to stewardship and recommends stepwise reforms. **Counterpoint**: This emphasis unequivocally reinforces the bias set from the outset. The alternative paradigm of a single payer, universal coverage public health system is almost ignored. Also ignored is the fact that private health markets have only efficiently been tamed in LMICs where the public sector was effective in competing with it; Costa Rica and Sri Lanka are two places where this happened.

4. Point: The public-private mix greatly varies by country. Data to quantify this mix is hard to come by. **Counterpoint**: Some countries are known to have many private providers (India and Colombia, for instance) while others do not (Cuba, Costa Rica). The implications of these different mixtures have actually been studied in comparisons of Colombia and Cuba. The Colombian public-private reform has not been able to fulfill its promises of universal coverage, improved equity, efficiency, and better quality, while in Cuba, health

care remains free, accessible for everybody, and is of excellent quality.[15] Furthermore, the very difficulty of finding the basic information required to quantify the provider mix highlights that regulating individual private providers and organizations in LMICs is a non-starter.

5. Point: In the most populous nations on earth, more than half of the total health expenditures are private out-of-pocket transactions and private providers outnumber public providers. **Counterpoint**: The level of household expenditure on health tells little about access to quality care. Data on private providers often includes the purchase of drugs and visits to non-professional providers. These factors tend to inflate the role of the private sector.

6. Point: The private sector offers patients greater convenience and access. **Counterpoint**: The latter claim (increased access) is certainly not true for rural areas and for the urban poor; this is where almost half of the world population live on less than 2.5 USD/day.[16] The private sector simply writes off these groups since they are not a source of potential profit (even in countries like Colombia where huge incentives are given to steer private health care delivery to the poor).[17]

7. Point: Without proper incentives for quality, equity, and affordability and without adequate monitoring, health markets can produce poor outcomes. Markets in health favor wealthier segments. Without a mechanism to intervene and control markets that are failing, the distribution of wealth and of disease perpetuates the inequitable delivery and financing of care. It is the government who bears responsibility for the achievement of both economic and social justice objectives. **Counterpoint**: We note here the *"can produce"* in the first sentence. We suggest it should read *"does produce"* (see point 15 below). We are left wondering, then, how does the RF think that more stewardship will tame health market? As we see it, *the mixed public-private health system is a prime example of a failing market progressively in crisis.* (We cannot avoid suppressing the thought that the report often indulges in the most unreasonable leaps of faith while using the most reasonable sounding of words).

8. Point: There are three stewardship mechanisms: regulation, risk pooling and purchasing. Combined, these mechanisms *can promote* (emphasis added) better health outcomes, better financial protection, higher quality and more equitable private health service delivery. Chile, Colombia and Thailand are given as examples. **Counterpoint**: Since these mechanisms are not adopted in most LMICs (no evidence available), the three cited countries are actually rather exceptional. This "*can promote*" statement represents another big leap of faith. A closer analysis of the three cited cases shows a different picture: the evidence is indeed weak,[18,19] and any replication of these experiences seems problematic.

9. Point: Most high income countries and some middle income ones have policy mechanisms to steward both public and private actors; their governments engage in stewardship through: i) regulatory policies that monitor quality and mitigate market failures; ii) financing policies that minimize out-of-pocket payments; and iii) purchasing policies that create incentives for the delivery of quality services to the poor. **Counterpoint**: Let us first set the record straight. As early as 1992,[17] several industrial countries acknowledged problems and even outright failure in regulating the non-state sector. The absence of evidence that such regulation is possible in LMICs is, as said earlier, the key weakness of the RF report. Evidence from high income countries (HICs) is of little relevance to the discussion on viability of regulation in LMICs where vested interests,[20] extortion,[5] policy capture,[21] and corruption[22-24] are widespread.

10. Point: Innovative models should be used as stepping stones to broader regulatory reforms. The report speaks of "harnessing private markets" and addressing their failures. Potential interventions include reducing provider fragmentation, creating incentives for quality, providing subsides for targeted populations, fostering high impact interventions, and using technologies that expand access. These goals can be achieved through fostering stronger professional associations and provider networks inputs, tendering franchises, giving selective vouchers, setting up community-based health insurance schemes, and using social marketing and telemedicine techniques. These are not necessarily systemic solutions, but they may provide some benefits and can stimulate more comprehensive government-led reforms. **Counterpoint**: As much as it would be great to "harness private markets" and address their failure in LMICs, we need to examine these innovative "models" one by one. What has been the experience with each model in terms of promoting equitable access to better services for poor people, i.e., the bulk of the LMICs' population? Unfortunately, that experience is far from promising. Community-based health insurance schemes have largely failed in Africa. On average, less than 2% of the African population joined such schemes and where they existed, they did not manage to improve quality of care.[25] Self-regulation by professional associations is a myth even in HICs. As early as the 1950s, professional organizations were active in countries like Ghana and had been

given regulatory responsibilities.[14] The RF report itself has reservations on their effectiveness (see point 2 above). Providers' networks characterize the Colombian health reform which is currently in disarray due to the government's incapacity to effectively regulate the sector.[26] The recommendations on vouchers, telemedicine, and social marketing are of marginal – even anecdotic – importance with regards to access to care. Cash transfer programs have had mixed reviews especially in Latin America; their effectiveness depends, among other things, on the quality of available health care services.[27] Consumer associations have been around for decades,[28] but have lacked the knowledge and the power to effectively tackle health care delivery problems; they do not have the necessary political leverage to stop unethical behaviors in the context of public-private partnerships. The problems of delivering health care and managing it are much more complex than overseeing the quality of the goods and services sold in the local marketplace. We reiterate: there is evidence available on what works and what does not. Little of this evidence has found its way into the report. So what is the purpose of making these recommendations? It is as if marketeers were (re)packaging "new" modalities while ignoring the failures of their previous attempts at repairing a resiliently flawed system.

11. Point: The report cites call centers, telemedicine, mobile diagnostic devices and healthcare kiosks as examples of new technologies. **Counterpoint**: These technological magic bullets are for sure overrated. We prefer to think of processes by which beneficiaries and providers become involved in dialectically working out what is needed. Telemedicine has only a limited ability to solve the more complicated clinical problems at hand when compared to medical assistants/community health workers operating in publicly oriented health services and properly supervised. The literature on this issue is extensive.[29-31]

12. Point: Governments should consider direct contracts with successful programs and, at the same time, the private sector should be aware of national health goals and determine how their programs will contribute to them. **Counterpoint**: Is this the way the private sector operates? Or is this another example of wishful thinking? We see little altruism in the way the private health sector works in most parts of the world. Moreover, is the success of "successful programs" going to be measured as quality, equitable access and affordability for all? A caveat here: Contracts based on achieving minimal primary care utilization rates and minimal hospital admission rates, as well as achieving indicators of quality of care could be envisaged, but experience suggests that they have only been effectively implemented by not-for-profit organizations[32] and, even then, the contracts need to establish a long term relationship based on trust.[33]

13. Point: Donors should provide long term financing for privately implemented programs that improve health market functioning. **Counterpoint:** Why can't donors have a more open funding attitude towards improving the public health care delivery sector? The public sector generally remains in charge of delivering most disease-specific clinical interventions. Top-down disease control programs need a pool of patients to have even a chance of succeeding. We consider donor support to the private health sector – a profit seeking sector – to be contrary to the interests of the people in aid-recipient countries.

14. Point: Country level analyses have revealed a significant link between population health outcomes and health expenditure. Therefore, given high out-of-pocket payments, the ultimate challenges are to achieve financial protection and to ensure quality services from unmonitored providers. **Counterpoint**: The reported link may not be causal in nature, i.e., that high per capita health expenditure on health is often associated with improved health outcomes as is the case in Western Europe. This association is subject to several confounding factors such as the more genuine social aims of health policies. (Consider that *per capita* health expenditure in the US is nine times that of Costa Rica, but health outcomes are largely comparable).[34]

15. Point: The report presents a roadmap for mixed health systems stewardship which recognizes that any reform will be subject to political pressures. **Counterpoint**: Unfortunately, the report ignores the powerful private sector lobby and its ability to use corruption to benefit its ends. Political clout is heavily unbalanced in favor of the private sector especially where there is no social counterpower within government circles and where civil servants are poorly paid (and consequently easy to buy off). The roadmap is loaded with unrealistic expectations. It is unlikely that even half of the Rockefeller recommendations will ever be adopted since they would run against the interests of the private sector.

16. Point: The report concludes that there is a need to focus pragmatically on how to ensure that health markets are contributing to key health goals such as the MDGs and universal coverage. Aspects of health markets that detract from these key goals should be diminished through regulation. This de-

bate is legitimate at a time when the negative effects of unregulated health markets persist worldwide. **Counterpoint**: We cannot but underline that the MDGs represent a dramatic downscaling from previous international commitments. (Remember WHO's "Health for All by the Year 2000"?) Furthermore, will the "public stewardship of private providers in mixed health systems" eventually lead us "pragmatically" to achieve the health MDGs and universal coverage? This is neither the opinion of WHO – which has acknowledged a failure towards significant progress on the MDGs[35] – nor of PAHO[36] nor of the EC.[37] These organizations have advocated for a reorientation of health policies. We are intrigued by the faith the report places in regulation as a means to diminish the negative aspects of mixed health markets. The evidence is simply not provided.

17. Point: The report offers a series of recommendations which are accompanied by the following assertions:

Private health care providers create supplier-induced demands.

1. There are unqualified health practitioners in the private sector.
2. Misuses of public resources by the private sector are often reported.
3. There is an overuse of high-technology in the private sector.
4. Concierge care is promoted by the private sector (leading to an escalation of total healthcare costs).
5. There are widespread reports of inequalities of access to health care and to health insurance.
6. There are many reported cases of poor drug prescribing and dispensing practices, misuse of antibiotics, insufficient use of oral rehydration therapy, under-dosing of anti-malarials, over the counter sales of HIV medications, and non-adherence to TB treatment guidelines.
7. Consumers universally lack information about the problems with private providers in their area. The major limiting factor in the involvement of consumers and civil society has been their inability to judge clinical quality.
8. Conflicts of interest and corruption abound in the private sector.
9. The public has been excluded from rules setting even where regulation exists and is enforced.
10. Legislative efforts to regulate the private health sector often have insufficient impetus.
11. It has been a problem to enforce contracts and to catch and close the loopholes used by private providers and suppliers.
12. Abuse has been widely reported in contracting procedures (especially in drug procurement); in the management of user fees; and in informal under-the-table payments.
13. Fraud is rife in different insurance schemes.
14. Dual practice by health practitioners (i.e. working simultaneously in the public and private sectors) has led, at best, to absenteeism in the public sector and, at worst, to ghost workers in the same sector.
15. The overwhelming majority of health professionals do not have an ethical commitment to serve the rural population.
16. The interest of the private health sector is normally dominated by the profit motive.
17. Almost no financial resources are committed by the private sector to the priority public health issues of the country.
18. A commitment to equity and solidarity is lacking. Also lacking are a focus on PHC and the use of government co-payments as financing mechanisms for the poor.
19. Self-regulation of medical professionals has been prone to regulatory capture; professional groups serve the interests of their members rather than that of the public.
20. Medical associations have been anything but proactive in taking disciplinary action against medical malpractice or patient complaints; they have also not publicized malpractice cases for fear of damaging the reputation of the medical profession.

Counterpoint: Fixing so many of these shortcomings seems nothing short of impossible. We are thus left with two key questions: i) On what basis can we reasonably think that regulation will possibly play an enabling role in controlling the non-public service motivation of private health providers in LMICs?, and ii) Is there enough concrete evidence that suggests that regulatory mechanisms can indeed constrain the mostly profit-motivated drive that guides private health practice in mixed system environments? As can be seen, the list of problems is rather long. Simply put, problems loom at every corner of mixed systems and they are compounded by large scale regulatory problems. We remain of the opinion that when the state contracts out services in LMICs, it uses public money that actually strengthens the private sector, thereby creating a cycle whereby the private sector grows ever larger at public expense.

A caveat

We would be the first to acknowledge that some of the above problems and shortcomings are also found in the public health sector. This occurs espe-

cially when i) a market rationale is introduced in public hospitals, ii) governments are not willing to decently finance public services, and iii) cash flows from disease control programs are directly allocated to district officers thus creating inequity in civil servants salaries. In all continents, success stories have only come from well organized and acceptably financed public services. Costa Rica, Cuba, Chile, Sri Lanka, Kerala, Spain, and Sweden offer examples of this, although some of these systems are now in jeopardy.

Conclusion

Market fundamentalism, as an argument for private health care and its alleged regulation, offers not just a system of ideas, but also an algorithm for restructuring state health institutions and an ideological cover for investors interested in acquiring a key stake in health care delivery in LMICs. This shifts responsibility for health provision away from the state and towards individual households; this is antithetical to health equity. The concept of health as a human right becomes meaningless if its realization depends upon income or purchasing power or – in the case of LMICs – on the private provision of services, whether "regulated" or not. The ultimate issue is whether health care should be delivered with a social or a commercial goal and whether health care organizations should be managed with a public-oriented mission or not.

The evidence offered by the RF report does not convincingly suggest that the private sector can be harnessed in low and middle income countries. "New" regulatory approaches are *not* a substitute for actions that directly strengthen the public sector. Rather, regulations should be seen as a secondary—mostly transitional—measure while the "space" of the public sector is enlarged.

A more radical position would suggest that, based on available evidence, regulation of the private sector in LMICs is a mirage of sorts that attempts to bring a modicum of justice within the framework of excessive market freedom. Regulation attempts to avoid the excesses and imperfections of the health market. But, in reality, regulation incorporates purported justice considerations into mixed health systems only in a piece-meal and unwilling manner, all the while promoting the further commoditization of health care in LMICs.

Many of the measures proposed by the Rockefeller Foundation report are not necessarily wrong, but are applied in isolation and are financially backed by the WB and many bilateral donors. But individual measures are not enough. The multiple failures of mixed markets in health are simply too many and we contend that they cannot be fixed by regulation. We continue to believe that a competitive, well organized, and well funded publicly oriented health system, possibly multi-institutional, delivering comprehensive health care (not restricted to vertical disease control programs) is the only alternative to reign in the excesses of private providers in mixed health systems.

Some of the same measures proposed by the RF summary report applied to the public health sector *with* adequate long-term government and donor financing will go a long way to achieve "Health For All" through a single-payer, universal access public health service.[38]

References

1. WHO, Sixty-third World Health Assembly A63/25, provisional agenda item 11.22, 25 March 2010. Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services, Report by the Secretariat.
2. Asiimwe D, JC Lule. 1993. The public private mix in financing and provision of health services in Uganda. and Mujinja P, Urassa D, Mnyika KS. The Tanzanian public/private mix in national health care. In proceedings from the workshop on the public/private mix for health care in developing countries, ed. S Bennett and A Mills, London (LSHTM).
3. Yesudian CAK. 1994. Behaviour of the private health sector in the health market of Bombay. Health Pol Plann 9 (1): 72-80.
4. Lagomarsino G, Nachuk S, and Kundra SS. 2009. Public stewardship of private providers in mixed health systems: Synthesis report from the Rockefeller Foundation—sponsored initiative on the role of the private sector in health systems. Washington, DC: Results for Development Institute. Available at: http://www.rockefellerfoundation.org.
5. Tangcharoensathien et al. 2008. Regulation of health service delivery in private sector: challenges and opportunities. International Health Policy Program, Thailand. Rockfeller Foundation.
6. Kawabata K., Xu K., & Carrin G. (2002). Preventing impoverishment through protection against catastrophic health expenditure. Bulletin of the World Health Organization, 80 (8), p. 612.
7. Van Doorslaer E., O'Donnell O., Rannan-Eliya R. P., Somanathan A., Adhikari S. R., Garg C. C., Harbianto D., Herrin A. N., Huq M. N., Ibragimova S., Karan A., Lee T. J., Leung G. M., Lu J. F. R., Ng C. W., Pande B. R., Racelis R., Tao S., Tin K., Tisayaticom K., Trisnantoro L., Vasavid C., & Zhao Y. X. (2007). Catastrophic payments for health care in Asia. *Health Economics*, 16 (11), pp. 1159-84.
8. The World Bank. Investing in Health. 1993, Washington DC
9. WHO. World Health Report. 2000, Geneva.
10. IBFAN. The International Code. International Baby Food Action Network. Available at: http://www.ibfan.org/issue-international_code.html. See also:

http://www.ibfan.org/code_watch.html and www.babymilkaction.org
11. FAO (Food and Agriculture Organization of the United Nations) 2005. Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food in the Context of National Food Security. Rome: FAO. http://www.fao.org/docrep/meeting-/009/y9825e/y9825e00.htm
12. Baldwin R and M Cave, 1999. Understanding regulation: theory, strategy and practice. Oxford, Oxford University Press.
13. Bennett S, Ngalande Banda E, 1994. Public and private roles in health: a review and analysis of experience in Sub-Saharan Africa. Geneva, WHO.
14. Bennett S, Dakpallah G, Garner P, et. al. Carrott and stick : state mechanisms to influence private provider behaviour. Health Pol Plann, 9(1):1-13
15. Pol De Vos, Wim De Ceukelaire and Patrick Van der Stuyft. Colombia and Cuba, contrasting models in Latin America's health sector reform. Trop Med Int Health, volume 11 no 10 pp 1604–1612 october 2006
16. Anup Shah, Poverty Facts and Stats, Global Issues, Updated: September 20, 2010. Available at: http://www.globalissues.org/article/26/poverty-facts-and-stats
17. Rosenthal MM, 1992. Medical discipline in cross-cultural perspective: the US, Britain and Sweden. In Dingwall R and Fenn p (Eds). Quality and regulation in health care: international experiences. Routledge, London and New York. Quoted by S.Bennett, 1993, op.cit.
18. Unger J.-P., De Paepe P., Arteaga Herrera O., Solimano G., "Chile's Neoliberal Health Reform: An Assessment and a Critique", *PLoS Medicine* 2008; 5(4) e79: 0001-0006.
19. De Groote T., De Paepe P., Unger J.-P., "Colombia: in vivo test of health sector privatization in the developing world", *International Journal of Health Services* 2005; 35(1): 125–141.
20. Bennett S, K Hanson, P Kadama and D Montagu. Working with the non state sector to achieve public health goals. Making Health Systems Work, Working Paper 2, WHO, Geneva.
21. Soderlund N, V Tangcharoensathien. 2000. Health sector regulation: understanding the range of responses for government. Health Pol Plann 15: 347-48.
22. Tangcharoensathien et al.2008. Regulation of health service delivery in private sector: challenges and opportunities. International Health Policy Program, Thailand.
23. T Vian. 2008, Review of corruption in the health sector: theory, methods and interventions. Health Pol Plann 23: 83-94
24. Savedoff WD. 2006. The causes of corruption in the health sector: a focus on health care systems. In Global Corruption report 2006. Special focus on corruption and health. Ed J Kotalik and D Rodriguez, London, Pluto Press.
25. Criel B., Blaise P., & Ferette D. (2006). Mutuelles de santé en Afrique et qualité des soins dans les services: une interaction dynamique. In L' Assurance Maladie En Afrique Francophone. Améliorer L'Accès Aux Soins Et Lutter Contre La Pauvreté. Série: Santé, Nutrition Et Population, ed. G. Dussault et al., eds.. Washington, DC: Banque Mondiale, pp. 353-72
26. Arnio S. Government declares Social Emergency to face financial health crisis. 2009. Columbia News. Available at: http://colombiareports.com/colombia-news/news/6965-government-declares-social-emergency-to-face-financial-health-crisis.html (accessed April 24,2010)
27. Fiszbein A, Schady N, Ferreira FHG, Grosh M, Kelleher N, Olinto P, and Skoufias E. Conditional Cash Transfers: Reducing Present And Future Poverty. 2009 The International Bank for Reconstruction and Development / The World Bank; Washington DC 20433
28. Asiimwe and Lule, 1993, quoted by Bennett, G.Dakpallah, P Garner et al. Carrott and stick : state mechanisms to influence private provider behaviour. Health Pol Plann, 9(1):1-13
29. Kasongo Project Team (1981). Le Projet Kasongo; une expérience d'organisation d'un soins de santé primaires. Annales de la Société Belge de Médecine Tropicale, 60 (S1), pp. 1-54.
30. King MH. Medical Care in Developing Countries. Oxford University Press, inc. IBSN: 0196440181 / 9780196440187 / 0-19-644018-1
31. Lehmann U, Van Damme, W, Barten F, Sanders D. Task shifting: the answer to the human resources crisis in Africa? Human Resources for Health 2009, 7:49doi:10.1186/1478-4491-7-49
32. On privatization of disease control programs see: Jean-Pierre Unger, Pierre De Paepe, Patricia Ghilbert, Walter Zocchi, Patrick van Dessel, Imrana Qadeer, Kasturi Sen, Privatization (PPM-DOTS) strategy for tuberculosis control: how evidence based is it? In: International health and aid policies. Cambridge University Press, 2010.
33. Palmer N. The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries Bull World Health Organ vol.78 no.6 Genebra June 2000.
34. Unger J.-P., De Paepe P., Buitrón R., Soors W. Costa Rica: Achievements of a heterodox health policy. *American Journal of Public Health* 2008; 98(4): 636-643.
35. Chan M. (2008). Return to Alma-Ata. *Lancet*, 372 (9642), pp. 865-6.
36. Pan American Health Organization (2003). Primary health care in the Americas: Lessons learned over 25 years and future challenges. Washington DC: World Health Organization.
37. European Commission. Brussels, 31.3.2010. COM (2010)128 final. Communication From The Commission To The Council, The European Parliament, The European Economic And Social Committee And The Committee Of The Regions. The EU Role in Global Health
38. Unger J.-P., De Paepe J.-P., Ghilbert P., Soors W., Green A. 2. Integrated care: a fresh perspective for international health policies in low and middle-income countries. *International Journal of Integrated Care* 2006; 6. ISSN 1568 - 4156.