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# Primary Care for the Poor

## The Potential of Micro-Health Markets to Improve Care

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Much of the primary curative care provided to the poor by the private sector occurs not at large hospitals but at small, single-person clinics. While such "micro-health" providers increase access, questions persist about quality. Some have argued that the micro-health sector needs to be better *regulated*. This note cites recent studies in arguing that the micro-health sector needs to be better *understood*. A more evidence-based approach may enable the World Bank Group to better target investments and interventions and help these providers fulfill an important role serving the poor.

### Micro-Health Transforms Primary Care for the Poor

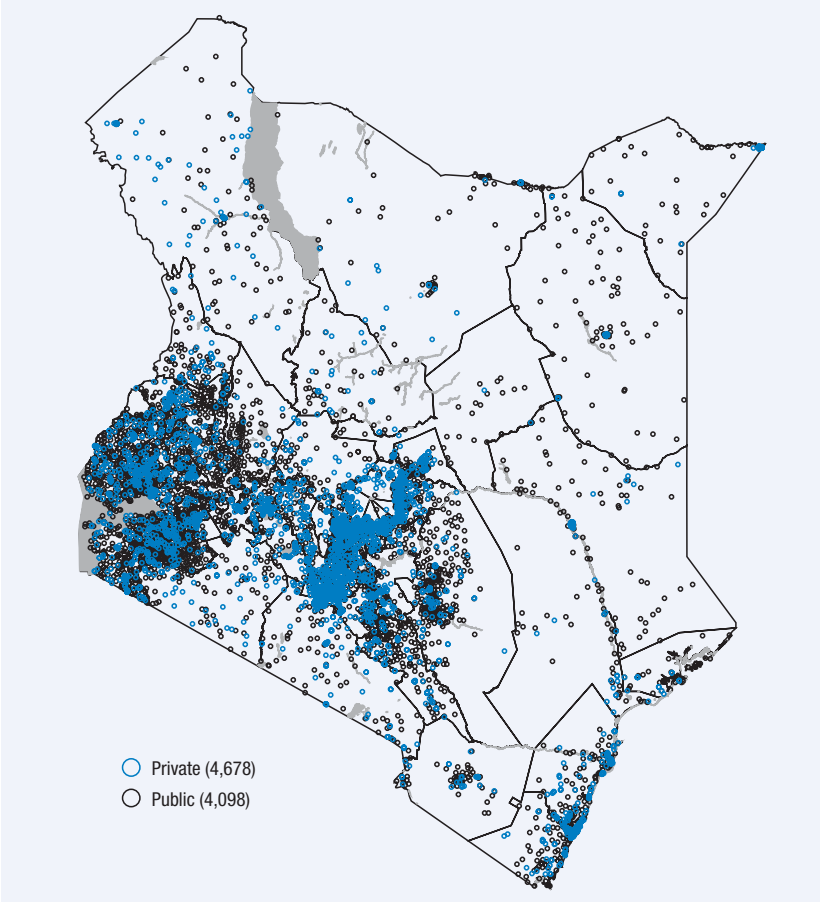
In many low-income countries, the private sector is the predominant source of primary curative care, which refers to the health system's first interaction with an ill person. Demographic and Health Surveys ask household members where they sought care when a child had a fever or diarrhea. Between 1990 and 2013 (across 224 surveys in 77 countries) half the population sought care in the private sector, and between 1998 and 2013, even among the poorest 40 percent of the population, two-fifths sought care in the private sector (Grepin 2014). For adult and childhood illnesses combined, private sector use in the early 2000s (the latest data) ranged from 25 percent in Sub-Saharan Africa to 63 percent in South Asia (Wagstaff 2013). Private providers typically used by the poor tend to be micro-health providers operating out of small, single-person clinics that offer low-cost curative services. The average Indian village has 4.4 health care providers and the cost of a single interaction with a private primary care provider in India ranges from 50 cents to $2 (Das, Muralidharan, et al. 2014). That would be anywhere from 10 percent to 40 percent of the minimum daily wage of an unskilled urban worker, or between 11 percent and 80 percent of the daily wage of a rural unskilled worker.[1] At the high end, these costs are similar to those in the United States as a percent of daily wages.[2]

These numbers, suggesting both ready availability and relative affordability of private care, call into question the longstanding assumption that single public providers at the village level are the dominant source of health care. In the emerging paradigm of micro-health markets, consumers can choose among multiple providers, even within small geographical spaces in

countries as diverse as Cambodia, India, and Kenya.[3]

In Figure 1, each circle represents registered health care facilities in Kenya as of 2011. The blue circles are private facilities; the black circles are public. More than half the registered health facilities (4,678 out of 8,776 in the country) are private, ranging from small, one- to two-person clinics to large, integrated service providers. The remote arid regions of the country in the north and northeast of Kenya are primarily served by public facilities. But although private facilities are more likely to locate in areas with higher population density and higher wealth, they are by no means found only in urban areas. Further, the Kenya data show only those facilities registered by the government and therefore almost certainly underestimate the number of private micro-health providers. According to one estimate, about a third of health care in Kenya, as measured by "health care interactions" or visits, is delivered by informal providers (Sudhinaraset et al. 2013).

Figure 1 **Formal health facilities in Kenya, by ownership**

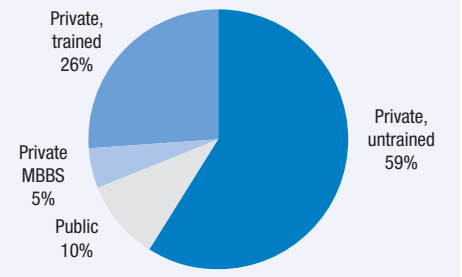



Source: authors' analysis of the Kenya Master Facility List (ehealth.or.ke).

Data from India (Figure 2) includes any provider to whom patients go for medical advice, regardless of the provider's registration status. The data come from mapping over 750 providers in the health markets of 100 villages in the state of Madhya Pradesh—one of the poorest states in a country with very poor human development outcomes (a measure combining health, education, and income indicators). The qualifications of these providers range from those with an MBBS (bachelor of medicine, bachelor of surgery—roughly equivalent to a medical doctor in the United States) to degrees from alternative systems of care to no formal qualifications at all. Those with no qualifications made up 60 percent of the providers surveyed; 10 percent of providers worked in the public sector; and only 5 percent were private sector MBBS doctors. Madhya Pradesh is not exceptional. Across India, the average village has more than four primary health care providers—the majority private—delivering care to households (Das, Muralidharan, et al. 2014).

The ready availability and affordability of private micro-health care does not, by itself, mean that micro-health is the right approach: If public care is cheaper and higher quality, the right response may be to limit micro-health markets in favor of an expanded public health sector. The first step, therefore, is to understand how these markets operate, the kind of quality they provide, and the choices that households make. Because the private sector operates in a mostly unsubsidized and lightly regulated fashion in many countries, with prices that are determined in market equilibrium, micro-health markets offer a lens into the fundamental determinants of demand and supply in the primary health care sector. Understanding the

Figure 2 **Distribution of all providers in Madhya Pradesh, India**



economics of these markets can provide crucial insights into how poor people access and pay for services and the responses of providers to these choices.

### From "access" to "access with quality"

An expanded understanding of the issue requires moving from measuring and thinking about access to measuring and thinking about access with quality. In many places, the problem is not whether people can access primary health care, but whether that care is of sufficient quality to be of any value to their health status. For example in rural India, only 4 in 10 people reporting chest pain to a health care provider would be correctly diagnosed as heart attack cases; 80 percent of children suffering from viral diarrhea would be incorrectly given antibiotics; and less than 25 percent of the poor who are suffering from hypertension even know that they have this condition (Lee et al. 2012). Similarly, in Kenya, one of the only low-income countries with a national survey on patient safety, only 1 percent of health facilities in 2012 achieved minimum compliance with international patient safety standards (Kenya Ministry of Health, IFC, WHO 2012). Poor health care quality and patient safety lead to poor health outcomes and inflated costs that impose unnecessary financial burdens on families, with economy-wide implications in terms of lost work and inefficient health care. Quality is the central pillar ensuring that health systems are fair, equitable and financially feasible, and improving the quality of care is a priority for many low- and middle-income countries today.

### More evidence needed on quality of care

The discussion about micro-health providers almost inevitably centers on the need for greater regulation and punitive action based on the assumption that inferior quality of care among micro-health providers *must* be the major driver of poor quality in the health system. Based on qualifications alone, this is a reasonable conclusion, given the widely varying credentials of micro-health providers already noted. But while regulation and punitive action are legitimate strategies for addressing low quality care, there is little direct evidence that would justify basing such punitive action solely on suppressing practitioners who lack formal training.

The problem is twofold. First, there are large differences in the knowledge of providers with formal medical training since the quality of this training can itself differ substantially across institutions. Second, there is a large "know-do" gap in medical practice. Health care providers often do a lot less than they know they should, the result being that they practice below the frontier of their knowledge. The quality of care in practice responds to both knowledge and effort. Although micro-health providers in the informal sector typically have lower levels of knowledge than, for instance, providers in the public sector, their effort levels are often higher, bringing them closer to parity in the practice quality of their formally trained counterparts.

Consequently, the available evidence does not confirm a strong correlation between formal training and health care outcomes. It is important at the outset to resist simple comparisons. For example, while public facilities offer services delivered by licensed professionals, in many countries these trained doctors and nurses often delegate health care delivery to unlicensed subordinates (Das et al. 2012).[4] Recent work comparing providers with and without training and those in the private versus the public sector shows that while training increases diagnostic accuracy, the increases are relatively small and in many cases, providers without formal medical training deliver care equivalent to what is available from providers with formal medical training and those in the public sector (Das et al. 2012). In such cases, a blanket requirement that all practitioners have formal degrees would bar many good (unlicensed) providers and maintain many poor quality (licensed) providers. While on its face the logic of this type of regulation seems sound, a closer look at the evidence raises questions about whether it serves the intended purpose of improving the quality of care. In extreme cases, the evidence suggests, blanket enforcement of such regulations could actually reduce both the quality and availability of care for poor populations.

A second prevailing assumption in the health care field has been that poor quality of care stems from a lack of hardware that prevents doctors and other trained professionals from achieving their technical knowledge frontier. Here again, recent research has demon-

strated this position to be largely incorrect. A number of studies have found that, in primary care settings, improvements in infrastructure and supply of materials including drugs may be necessary but are not sufficient to improve quality (Das and Hammer 2014).

## Recommendations

### 1. Effort, rather than hardware or training, may count the most.

There is a need to go beyond regulation and infrastructure improvements in the quest for quality. One consistent finding from new research across many settings, ranging from India to Rwanda to Uganda to the United States, is that large improvements in quality can result from changing the level of effort that providers exert in their interactions with patients. Effort, in turn, is sensitive to interventions that change the financial, non-financial, and intrinsic incentives that providers face. For example, a doctor working in his private clinic in Madhya Pradesh is 23 percentage points more likely to give the right treatment for unstable angina than the same doctor working in his public clinic (Das, Holla, et al. 2014). The clear financial incentive for greater effort represented by working in a fee-for-service model rather than for a fixed salary is only one way to achieve better outcomes. Similar results can be obtained by improving community or administrative accountability, or even by playing on the intrinsic motivation of health care providers. For instance, recent research shows that effort levels can be improved through better peer monitoring or increasing providers' pride in their own work (Brock, Lange, and Leonard 2014).[5]

These observational and experimental studies provide important "proof-of-concept." Moving from the conceptual to the scale-up stage requires a different investment approach. It is increasingly evident that improving the quality of primary health care requires interventions at the market-level. These are interventions that do not "pick winners" in the sense of mobilizing public and private funding to individual clinics or hospitals. Instead, they improve the overall functioning of *markets,* allowing different clinics to improve under new policy environments according to their own capabilities and constraints. In other words, a new approach requires moving from "fixing the pipes" to "fixing the institutions that fix the pipes."

### 2. Scaling up interventions to improve quality requires understanding and addressing market failures.

As with the design of policies and regulations to improve quality, market-level investments will have to be grounded in a robust understanding of the causes underlying market failures. This idea is nascent for primary health care, but the approach has already been tested in recent research. For example in Uganda, after noticing that pharmacists often sold counterfeit drugs at prices identical to those of real drugs, researchers worked with a non-governmental organization (NGO) to introduce a new, high-quality option into the market. The NGO pharmacist sold only real drugs and had a strong reputation to back that claim. One year later, when the researchers went back to look at the other existing pharmacists, they found that the number of counterfeit drugs had fallen dramatically. Introduction of the high-quality option forced other pharmacists in this market to change their products and reduced the chances that a low-income household seeking medicine would be sold a fake (Björkman-Nyqvist, Svensson, and Yanagizawa-Drott 2013).

### 3. Changing the way impacts are measured will lead to smarter investments.

A new approach will be required to understand and measure the impact of public and private investments in primary health care markets. Traditional approaches like measuring how many users attended a private clinic or a new public health center may no longer be adequate. The problem is that an increase in the number of users of a new facility does not necessarily mean that quality improved in the market where that facility operates. An accurate measure of how such a shift affected quality would require measuring the quality of the clinics that people no longer use. This was illustrated clearly in an experimental study of user fee reductions in Ghana. The study showed higher utilization of health care services following a reduction of fees, but no change in health outcomes (Ansah et al. 2009). The reduction increased demand for public clinics, but the private clinics that people no longer patronized were probably of equally high quality, so increased traffic at the public clinics did not improve the overall quality in the market.

## Conclusion

Most global health funding focuses on public providers. Investment in the private health sec-

tor is directed mostly towards large integrated providers that serve a predominantly urban, relatively wealthy clientele.[6] To the extent that the "other" private sector, composed of micro-health providers, enters policy discussions, the emphasis is primarily on regulation. This note argues that although regulation is an important policy lever, there is a need to broaden the set of interventions to supportive measures and institutional responses that can influence consumer and provider behavior. Accomplishing this requires a better understanding of the way private providers operate and the drivers of consumer choice in a market context. A comprehensive view of health systems would include better understanding all types of providers, their interactions, and how their behavior mediates the impact of potential interventions. This task requires a major effort, particularly in countries with many widely dispersed villages. But it can be done; indeed, it has been done. Teams working in India and Cambodia have completed major regional and national surveys mapping out the availability and quality of public and private providers in representative village samples. The commitment of resources should be measured against the potential benefits for improvements in the overall quality of health care in the very facilities that a majority of the poor use.

## Notes

1. Current Minimum Wage Rate data, Labour Department website, National Capital Territory (NCT) Delhi, India. http://www.delhi.gov.in/wps/wcm/connect/doit_labour/Labour/Home/Minimum+Wages/.
2. Doctor Visit Costs, Debt.org website, http://www.debt.org/medical/doctor-visit-costs/.
3. Based on experiences of World Bank's Human Development Unit, East Asia and Pacific Region, in Cambodia's Rural Health Markets.
4. When standardized patients were sent to public primary clinics, in 64 percent of interactions they were attended to by a subordinate who was not the doctor in charge. These ranged from compounders, or pharmacists, to janitors.
5. Refers to separate articles by same authors in 2014 and 2013 as noted in References.
6. Sixty-three percent of IFC investments in health in FY12–13 were in integrated service providers.

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