Developing strategies to engage the private sector and manage markets is essential to achieving policy goals. Here we provide an introduction to the rationale for the MM4H course, how the content is structured, and the key terms and concepts you will learn.
INTRODUCTION TO MANAGING MARKETS FOR HEALTH

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1. WHY LEARN ABOUT MANAGING HEALTH MARKETS?

Which policies for mixed delivery?

In most low- and middle-income countries, health services and products are delivered by a mix of public and private organizations. In many countries, private provision is growing (Agrawal, Campbell et al. 2014) (Konde-Lule, Gitta et al. 2010). When ill, large segments of the population consider their options, and choose to receive the healthcare they need in the private sector. An even greater proportion choose to do so when seeking medicines [Lu, Hernandez et al. 2011]. These interactions between care-seekers and providers are, in essence, health markets (See Box: ‘What is a health market?’ for a definition). Yet, in many countries, the ‘policy apparatus’ is equipped primarily to manage public sector entities. And, policy practitioners’ training and experience is likewise grounded in administering government health agencies and public sector networks. Many policy practitioners recognize the mixed nature of their health systems. More than likely, they recognize that the task of influencing service and product provision by a mix of public and private actors requires a different approach. But, what is this ‘other’ approach? Which strategies are effective? How do these strategies work to change the behavior of care-seekers and providers? And what do public agencies and officials actually do when they are implementing such strategies?

What is a health market?

A market consists of the interaction between all the buyers seeking something and all the sellers from whom they can get it. Accordingly, a health or health sector market consists of the interaction between all the buyers seeking a health-related service or product and all the sellers from whom they can get it. Although public sector employees may not view themselves as providers in a market, this definition places them in a market because, from a users’ perspective, they are choosing among all the options available, which includes public organizations.

Policy for mixed delivery and market management

Demand for learning. Many health policy practitioners are skilled in medicine, public health, or public administration. Yet few have training on the mechanics or operation of policies to guide mixed delivery, or about markets. As a result, most practitioners are ill-equipped to deploy policies to manage the highly complex set of markets present in their health systems. Practitioners often express frustration at the challenges of formulating and implementing policies in this area; and they express frustration at the lack of opportunities to learn about these topics (Hozumi, Frost et al. 2008). Practitioners often approach these challenges with their habitual mental frames and policy approaches. Results are often disappointing.

Learning from experience. Yet, across many middle- and high-income countries, public agencies, including health agencies, are, every day, using a range of regulatory and financial policy tools to manage mixed delivery of health and other social services in the public interest. Policy researchers from the fields of political science, economics, and public administration have analyzed these practices. And, some educational programs for public officials cover these topics (see for example, the Executive Master of Public Administration curricula at the Australia and New Zealand School of Government), as do some programs for health policy officials (see for example, the Pharmaceutical Policy course in the London School of Economics’ Masters of Health Policy curricula, and the Managing Healthcare Systems course in the Technical University – Berlin’s Masters of Health Policy curricula). Public policy, social policy and health policy literature and educational material thus contain considerable content that health policy practitioners would find relevant and useful for managing mixed delivery and health markets. However, the content is spread out, and, accessible only in programs requiring multiple years of study. The MM4H curriculum presents some of the content of most direct relevance for health policy practitioners seeking to manage mixed delivery.
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Tapping sources of distilled learning content. As later modules discuss, many countries have long relied heavily or exclusively on private distributors and retailers, as well as primary care providers. The policy apparatus and practices they deploy to manage these activities in the public interest are longstanding. Education on these topics is, as noted above, integrated into general curricula for policy practitioners. When countries or localities shift from public to mixed delivery however, the agencies and officials responsible for ensuring service provision goals typically lack this knowledge. And, unsurprisingly, many struggle with their new roles and responsibilities (Brown and Potoski 2004, Wanna, Butcher et al. 2010, Howlett and Ramesh 2014, Lægreid, Sarapuu et al. 2015). Because of the complexity of health markets, especially services markets, agencies that are tasked with managing mixed delivery in the health sector face a particularly difficult task (Nemec and Kolisinchenko 2006, Tynkkynen, Keskimaki et al. 2013, Lember and Sarapuu 2014, Sarapuu and Lember 2015). Agencies and their staff must establish new ways of interacting with providers (Tynkkynen, Keskimaki et al. 2013) (Nemec, Spacek et al. 2015). Staff must rapidly acquire a range of skills to deploy the new policy tools and processes (Chagin and Struyk 2004, Chagin 2005, DiMartino 2014). Special educational programs and materials often accompany such initiatives; indeed, they are often essential to success. Educational offerings strive to help practitioners quickly acquire the new skills they need. To accomplish this, they distill the most essential knowledge and content from the broader academic and operational literature dealing with policies and practices for managing mixed delivery of health and social services. They cover topics such as: collecting market intelligence; how to define and analyze health and social service markets; how to assess market structure; linkages between markets; how to use external policy tools to influence or “shape” market behavior in the public interest; and how to manage contracts.

The Managing Markets for Health curriculum draws on these materials as well as the public and health policy literature on managing mixed delivery of services. The curriculum is a “crash course” on managing markets, especially health markets, in the public interest; and it aims to convey the concepts and tools that are of most use to practitioners striving to conduct private sector and/or market analysis and form sound policy approaches. It aims to cover these topics in a way that is useful for policy practitioners working in variety of contexts. The curriculum incorporates the core concepts and analytical frameworks together as the Managing Markets for Health Approach (MM4H). This comprises two distinct components: the Market Forces template for distinguishing the market forces and countervailing structuring forces operating in a particular market; and the Tools of Government in Health framework for characterizing the policy tools used to structure health markets and for characterizing the most common policy tool “packages”, which countries’ policy frameworks deploy to manage particular health markets in a directed fashion. Practitioners can use these frameworks to organize market analysis and inform policy decisions and implementation toward the private sector in health.

Improving child health in Bangladesh

In 1999, Bangladesh’s child mortality, at 44 per 1000 live births, was quite high by the standards of other countries at a similar level of development. Health officials, explored the situation, seeing to understand what was driving these unnecessary deaths. Quality of health assessments and case management of sick children was poor in public clinics. Most child deaths were attributable to only a few causes [pneumonia, diarrhea, measles, malnutrition]; many of these deaths could have been averted with better quality care (Arifeen 2004). The World Health Organization [WHO] helped authorities to launch the Integrated Management of Childhood Illness (IMCI) initiative, to improve how clinic staff dealt with these illnesses. The initiative deployed three distinct components to improve care in public facilities: (i) Training staff on what to do when attending to children with diagnosed priority illnesses – to improve healthcare quality; (ii) Improved management of drug inventory and distribution to assure availability of medicines; and (iii) Enhanced supervision to reduce absenteeism and increase operational effectiveness. These efforts succeeded in improving public clinic’s care for sick children. Nevertheless, it did not reduce the overall rates of child mortality (Arifeen, Hoque et al. 2009).
Common pitfall: missing the markets

When practitioners first become involved in managing mixed public and private provision, one of the most common stumbling blocks they encounter is the lack of basic information about private provision and individuals’ care-seeking behavior. Officials cannot possibly identify and successfully deploy policies to influence private providers’ contributions to sector objectives without this basic information. A story showing how this can unfold within the health sector follows.

Why were the results so disappointing? The problem is grounded in a misunderstanding of the mixed nature of the country’s primary care services suppliers (Bryce, Victora et al. 2005). In 1999, only 13% of caregivers with sick children, who sought care outside of the home, took their child to a public facility after examining the available options. The rest sought help from a range of informal and formal private providers. The frontline delivery network was largely private (see Figure 1), while the program’s implementation network was limited to public clinics. Health decision makers didn’t reflect these care-seeking patterns in their situation analysis, nor in program design (Bryce, Victora et al. 2005).

Improving quality of care in public clinics, even significantly, could achieve only a small impact in child health at the population level, because this clinic network reached only a small portion of sick children. How did decision makers come to select a strategy that would work through such a small part of the delivery network (see Figure 1)? Observers attributed this to two key factors: decision makers’ lack of recognition of the proportion of caregivers who took their children to private sources; and decision makers’ belief that quality improvements would generate large shifts from private to public sources of care (Bryce, Victora et al. 2005). Overlooking the evidence of people’s reliance on private care and deploying a strategy lacking any actions or policy tools to improve the quality of private providers’ care, prevented the program from reaching most of the children it aimed to help.

Misunderstanding care-seeking behavior and the mixed nature of service provision is not uncommon. Over many years and throughout different areas of the world, MM4H faculty have offered seminars and courses for health policy practitioners. Through this medium, faculty have asked participants to answer the following question: what proportion of health services and products are obtained from private sources in low and middle income countries (LMICs)? Participants usually guess something along the lines of 11%, depending on the audience (see Figure 2).

In reality, when surveys ask people where they seek care, half say they turn to the private sector (see Figure 3). Though the services and medicines they receive are rarely subsidized, two-fifths of even the poorest people seek private care. And, as we noted above, utilization is increasing in many countries (See Figure 4). The magnitude of private vs public provision is not, in itself, important. However, public officials’ familiarity with the network of providers from whom their citizens actually receive care is important.

Figure 1: Delivery Network versus Implementation Network

Figure 2: Course participants’ significantly underestimate private sector utilization

Figure 3: Utilization of private sector in care for fever across regions. Source: Grepin, 2015. Summary of 205 Demographic and Health Surveys (1990-2013)

Figure 4: Private sector use appears to be growing
Harnessing all actors to control TB in Japan

World War 2 devastated Japan’s economy and impoverished many of its citizens. Real per capita GDP had fallen to $2,355, commensurate with that of Cameroon, Cambodia and Zambia in 2010 (See Figure 5).

Japan’s health system was in tatters, and the population was suffering from a raging TB epidemic. Mortality and case rates for TB are incalculable for some years during World War II, because of very low reporting. However, at the end of World War II in 1945, TB caused 15% of all deaths (Seita 2004). Further, the mortality rate attributable to TB was 212.9 per 100,000 people in 1940; this rate was similar to that seen in developing countries but much higher than in developed countries (Ohmori, Ishikawa et al. 2002, Seita 2004). In 1947, about 146,241 deaths from TB were recorded. In 1950, after initiating mass screening, government officials discovered that 2.3% of the labor force in Tokyo was actively infected with TB (Seita 2004). Many health care providers failed to properly diagnose and treat TB patients, and people with TB symptoms didn’t receive care quickly enough. As a result, transmission of the disease was high. In the 1950s, the annual risk for TB infection (ARTI) was about 4% in Japan (Mori 2000). In 1950, the Japanese government committed to rapidly scaling up coverage of TB care and other control activities. In the time following the implementation of national control protocols, the incidence of TB dropped from 698.4 per 100,000 in 1951 to 17.7 per 100,000 in 2011. However, because of limited national resources and the diminished state of health agencies’ capacity, implementation was not easy.

The ministry directed local health agencies to initiate TB screening; the ministry and local agencies worked with the national Anti-TB and the Women’s TB associations to scale up screening and health education in the community. The ministry also shifted resources to expand public hospital capacity to treat TB patients. They recognized that the vast majority of Japanese people were receiving care from private primary care doctors. Officials used the social health insurance scheme to encourage patients’ care seeking by making all TB related services fully subsidized (e.g. no copayments); and their social insurance contracts could incentivize doctors to comply with established treatment guidelines and reporting requirements. However, the schemes covered fewer than 40% of Japanese people. Clearly, officials needed to deal with TB care-seeking and services for the rest of the population – for people who were self-paying and receiving care from private doctors. They also worked with the Japanese Medical Association; they agreed to collaborate to form Local TB advisory committees. Representatives of the Medical Association and ministry worked together to develop and disseminate guidelines on proper treatment. The Medical Association’s involvement legitimized the guidelines; further, the Association took considerable responsibility for guideline dissemination and compliance by their members. Increasing numbers of doctors applied the recommended protocols. A number of patients weren’t completing their treatment, providing more opportunities for the disease to spread. Clearly, structured follow up processes for TB patients undergoing treatment were needed – to ensure they completed the regime. Yet doctors’ offices were not set up for patient follow-up. Physicians didn’t have time to track down patients at home or in the community, and few had nurses or other staff who could take on these responsibilities. Hiring new staff would be too expensive for most of these small practices. Health officials consulted with doctors, and came up with an arrangement whereby local public health agencies assigned community nurses to patient follow-up activities. The Local TB Advisory Committees, which consisted of local, private doctors and health officials, were housed within these agencies. They helped community nurses to interface with doctors – to sort out any logistical or communication problems that arose. These efforts succeeded in rapidly bringing TB under control.
Mobilizing private providers

Policy analysis should not, therefore, overlook the private sector, and, it should recognize the existence and influence of market forces. More than that though, implementing policy to engage the private sector, requires distinct approaches to analysis and implementation. To illustrate what we mean, we now turn to Japan’s struggle to improve primary care services in the 1950s to control a raging tuberculosis (TB) epidemic.

Which factors matter for managing mixed delivery?

Clearly, managing mixed delivery of social, welfare and other public services is different than managing public organizations and employees to deliver services. However, analysts examining experiences in these sectors, in which policymakers and agencies successfully manage mixed delivery as a matter of routine, mention three factors repeatedly: the logic or analytics, the policy tools, and the policy processes. We use the case of Japan again to elaborate these factors.

The logic of policy analysis in mixed delivery settings

The logic underlying Japanese officials’ analysis of the situation was appropriate to the market context. Inclusive analysis, that is, analysis which collects and examines information about all actors relevant for a particular problem, enabled them to devise policies that reflected the reality of their mixed delivery system. Their diagnosis of the situation consciously built upon a clear-eyed, and reasonably accurate, understanding of the status of service provision and care-seeking in their country. They built on information about: which primary care practices were in operation and where they were located; where people were receiving care; and about the capabilities of providers. Officials could allocate subsidies via social insurance to ensure contracted doctors provided free care to covered patients. But officials also realized that in the short term, they had no alternative but to take actions to improve the care that the remaining proportion of citizens received from private doctors. Their policies to influence the doctors’ behavior reflected a recognition that most operated as small businesses – and, like many small businesses, these practices faced a very challenging economic environment after the war. To help doctors fulfill their responsibilities, their strategy provided direct support via social insurance reimbursement, as well as indirect support, by tasking the community nurse cadre with patient follow-up.

Use of external policy tools

Like health agencies everywhere, Japanese officials used a variety of internal policy tools in their efforts to bring their epidemic under control (See Box: What is the difference between internal and external policy tools?). They directed ministry staff and local public health agency managers to implement mass screening. They adjusted personnel rosters and allocated financial resources to local public health agencies to initiate recruitment of additional community nurses. They instructed directors of public hospitals to expand TB services, and they shifted public hospital budgets and staffing configurations to enable them to do so. However, they also deployed a range of external policy tools – which allowed them to influence private providers and non-governmental organizations – toward their aim of bringing TB under control. They altered regulations governing social insurance organizations to make changes to the service package, provider contracts and reimbursement. They disseminated information to the population, often collaborating with non-governmental organizations, to improve care seeking and treatment compliance. They worked with the Medical Association to formulate and disseminate guidelines regarding treatment and reporting.
Consultative and adaptive policy processes

The processes officials deployed manifest several features that, the political science and public policy literature suggest, are often integral to managing mixed delivery. That is, Japanese officials’ efforts exhibit features that reflect the role and operating context of private actors. Their policy formulation and implementation process was inclusive, consultative, and, adaptive. Above, we pointed out that officials’ situation analysis included information on all practitioners’ providing services to people – that is, the analysis was inclusive. Their assignment of key responsibilities to the Medical Association and non-governmental organizations manifests an inclusive approach to implementation as well. Officials’ efforts to acquire an understanding of the root problems that sustained the TB epidemic were consultative (e.g. the Medical Association and other stakeholders were involved), and their efforts to identify solutions and policy actions to bring those solutions about were likewise consultative. Officials recognized that their actions might, or might not, bring about desired changes in peoples’ care-seeking behavior, and adherence to protocols; they might or might not bring about desired changes in treatment and follow-up. Hence, they monitored these, and adjusted their policy “package” over time. This is a notably adaptive approach to policy.

This narrative is not a comprehensive portrayal of Japan’s TB control efforts. It undoubtedly oversimplifies the actions officials took, and how they implemented them. Nevertheless, policy literature and educational material characterize the features we highlight as integral to policy initiatives to engage the private sector. We will elaborate on these throughout the course.
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2. WHAT IS A ‘MANAGING MARKET’ APPROACH?

Guidelines... but no silver bullets
A “managing market” approach is the label we give to policy analysis, formulation and implementation that reflects the factors laid out above: the logic, the use of external policy tools; and consultative, adaptive policy processes. Getting these three factors “right” cannot guarantee policymakers’ success in efforts to engage the private sector. It will, however, increase their likelihood of success.

Mental models matter
Underlying much health policy and many programs is a mental model about how services are delivered and how service-related goals are achieved. In this mental model, public officials are “formulating plans, mobilizing resources, developing processes, and directing employees”, while implementation takes place through a hierarchy of public agencies and service provider organizations (Rhodes 2007). The perception is that people seek care only from nearby public facilities, and proceed to more sophisticated public facilities according to the seriousness of their condition. When officials wish to take action to address a problem, grounded in this mental model, it makes sense to devise a strategy that focuses on the public sector and deploy strategies to influence what different cadres of public employees are doing.

However, relying on this mental model can give rise to problems. As we saw in Bangladesh, officials may simply forget to examine the real situation with regard to the delivery of products and services. They may overlook information that might shed light on actual provision and care-seeking patterns. Even where officials decide to engage the private sector, this mental model predisposes them to developing strategies in the style of traditional public sector implementation. They may forget to consult with the private actors they wish to understand and influence; and they may forget that private entities are operating in a market environment, one in which all must pay their bills and cover their costs, or cease to exist. Based on this mental model, and officials’ own experience of implementing initiatives involving only public agencies and employees, they may formulate implementation plans that are notably linear. That is, they may focus on the process of implementing program elements, and neglect to check that policy actions have the anticipated effects or whether they generate any undesirable side effects. Linear approaches are unproductive when multiple public and private entities are involved with implementation, and they are especially problematic when policy actions achieve their aims via changing the behavior of actors operating within a market. This a common pitfall for public officials’ first efforts to manage public-private initiatives across public services – including in the health sector (Bloom, Wilkinson et al. 2014). Such habitual practices undermine efforts to strengthen health services and accelerate progress towards health goals in a mixed service delivery context, as we shall see in subsequent modules.

More tools in the toolbox
Most public officials are familiar and experienced with internal policy tools – the tools officials use to guide the behavior of public agencies and employees. Most have long used such tools to guide service provision by providers operating within the public sector. That is, they have considerable experience pursuing service-related objectives when the implementation network consists entirely of public providers. Many officials know how these tools work; and many public administration and public health programs provide training on how to do these tasks. Few officials, however, are as familiar with external policy tools. Yet, where we see successful management of mixed delivery, officials and agencies are skillfully deploying these external policy tools to guide mixed, public and private actors to achieve social objectives.
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As later modules will illustrate, health agencies are accrediting and allocating grants to non-governmental organizations (NGOs) providing services to special groups. Regulatory agencies are deploying social regulations like licensing, complemented by considerable self-regulatory action by professional associations and other intermediaries; and agencies are monitoring prices and deploying economic regulations like price and mark-up regulation – often tapping industry groups and trade associations for information and implementation support. Health agencies and funding bodies are negotiating and managing contracts for emergency services; they are negotiating and managing contracts with pharmacies and primary care practices serving identified patients. In some instances, health agencies and funding bodies are regularly negotiating and managing contractual relationships with hospitals and labs. In a growing number of countries, health agencies are overseeing implementation of policy tools by independent bodies, such as contract management by third-party payers (Cotlear, Nagpal et al. 2015). These experiences constitute a rich foundation for policy practitioners who wish to learn how to use these policy tools. This course draws on materials derived from these experiences.

Solving policy problems does not always require private sector engagement

Do these points suggest that all answers can be found through handing responsibilities over to the private sector, or that answers are found in leaving important services to be delivered, or not, by the market? Do they suggest that health officials will always need to engage the private sector to address important problems and achieve priority objectives? Absolutely not. Health officials, doubtless, often find themselves in settings where public sector delivery can solve key problems. In these instances, the analytics, tools, and processes discussed in this course won’t be needed. When officials find they do need to grapple with mixed delivery to solve problems and to achieve public goals, this course content will be useful.
3. WHAT WILL YOU LEARN?

This aim of the MM4H course is to introduce students to the analytics of health markets and related policies that countries and agencies use to influence markets in the public interest. The course will provide students with an introduction to five health markets (or ‘subsectors’), how they work, and the problems their operation commonly gives rise to. The course will review the multi-faceted goals which societies have with regard to these markets, and the most common policies and processes societies use to influence these markets towards achieving those goals. The course provides concepts and tools that policy practitioners need - to think and act strategically in devising strategies to engage the private sector.

The course will introduce common problems that officials encounter in managing health markets, as well as some rubrics they can use to compare approaches to managing those markets and influencing private actors in the public interest. The term ‘public interest’ encompasses a focus on resolving the most common health sector problems (e.g. low access to services - in general or for particular groups, inefficiency, and low responsiveness) and pursuit of improvements in the full range of intermediate (e.g. care quality, medicine safety) or ultimate performance domains (e.g. disease incidence, population health levels). The course covers health and health system policy, but does not delve into management or business strategy, or other issues related to the operation and performance of organizations within the health sector.

The course and readings focus on the tasks of assessing the situation, selecting a policy approach, and planning the implementation process. Policy analysts sometimes refer to these tasks collectively as “upstream” tasks. The final module delves into common challenges policy practitioners face when implementing strategies to manage markets; however, the course does not cover the ‘nitty gritty’ details involved with implementing any specific policy tool (e.g. the “downstream” tasks).

Who will find this course most useful? The curriculum is aimed at experienced health policy practitioners. It is aimed at practitioners who are familiar with health policy and health systems analysis; it is aimed at practitioners seeking to learn how to analyze and understand the role of the private sector, as a means to develop strategies to engage the private sector in the public interest.
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4. LAYOUT OF COURSE MODULES

The course content [videos, readings and activities] allow you to examine a wide variety of settings where private activities are successfully harnessed toward achieving health and social objectives. We look across instances where public agencies and policies are deployed to manage private wholesalers, retailers, primary care service providers, and hospitals and specialist services toward public objectives. The module content highlights how agencies and processes associated with mixed delivery are distinct from more traditional processes - whereby officials are managing implementation through public agencies and employees. The course groups these distinctions into the three categories, logic, policy tools, and policy processes, as outlined above.

The course organizes the content into three blocks: Foundations; Markets; and Processes. We describe each of these below.

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Foundations

The course provides rubrics for examining the operation of social services markets and interpreting the resulting observations in a way that can inform policy decisions. These rubrics are presented in the Foundations block. We start, this week, with the Market Forces template, which aims to provide analysts with a lens for examining a market’s operation. The template draws attention to both market forces and structuring forces operating in a market. Analysts can use the template to illuminate these forces, much like a doctor uses an x-ray machine to gain additional insight about the causes of a patient’s swollen arm. The template draws attention to the range of policy tools and processes that may underlie the beneficial structuring forces they observe in a market. In the following week, you will study the Tools of Government in Health framework, the second part of the Foundation block. This examines the policy tools policymakers use to pursue public and social objectives in mixed delivery settings. It covers the mechanics of policy tools, like contracting and social regulation, that are used to steer health markets. Evidence and experience demonstrate that policy tools work differently depending on the broader policy framework and the institutional setting. Hence, this week’s work also covers governance regimes which, for our purposes, refers to the policy framework elements most relevant for the private sector role. Analysts can use this information to check a country’s or sector’s policy framework and implementation apparatus to identify features that frequently influence the implementation and effectiveness of policies toward the private sector.
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Markets

This next block, Markets, goes through the most important markets in the health sector. More to the point, it goes through the range of approaches countries use to manage different health markets. It covers two types of markets: product and services markets. The Markets block applies the tools and templates to examine how different countries’ health agencies deploy policy tools to manage distinct health markets. The modules you will study in weeks 3 to 7 make it clear that management approaches vary considerably between subsectors; for example, policymakers use different approaches to the management of product distribution markets than they use for hospital services markets.

This block includes two modules which focus on the application of core concepts and principles. In week 4, we apply the course analytics to examine how policymakers conduct analysis and use policy tools across multiple interconnected markets to increase use of an important health product, insecticide-treated nets. And, in week 7, we examine India’s experience using contracting by third-party payers to manage healthcare provision by public and private providers.

Processes

Finally, the third block, Processes, covers what is involved, from a public official’s perspective, with deploying policies to steer mixed delivery in the public interest. Most of us have heard about the importance of stewardship, and being a steward for the whole sector, not just the public sector. But, what do officials involved in managing markets actually do? What is involved with “steering” a health sector boat, rather than rowing? That is what this block is about. The discussion focuses on management, that is, it focuses on what officials involved in managing mixed delivery actually do on a day-to-day basis. And, it covers what is involved with implementing changes to expand and/or improve policies to manage mixed delivery in the public interest.
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REFERENCES

1: Nemec and co-authors note that educational programs for public officials in Central Europe have been slow to add these topics to their curricula, rendering their graduates ill-prepared for their careers which involve considerable ‘stewardship’ of service provision by independent providers [Nemec et al 2012].

2: Webpage for curricula description: Executive Master of Public Administration curricula at the Australia and New Zealand School of Government.


4: Each of the eleven subjects studied in the Australia and New Zealand School of Government’s Executive Master’s program is estimated to require 120 hours of work.

5: Complexity in this context refers to the fact that the behavior of health markets cannot be easily predicted from inspection of their operation as well as to the great ‘distance’ between cause and effect relative to other domains of policy analysis and intervention.

6: For example, Australian states’ local government associations developed operational resources and training for public officials in the late 1980s as government agencies decreased direct provision and increased contracting and ‘market management’ for social and welfare services [Industry Commission, 1996]. In the 1980s, US municipalities collaborated to develop operational resources and training courses for their staff struggling to develop strategies for managing or “stewarding” a wide range of services provided by independent providers [Hatry, 1983]; Central agencies took the lead in developing operational resources and training for officials managing mixed delivery of social services in Kazakhstan and Russia in the 1990s [Maltseva 2012; Chagin, 2005]; Finland’s municipalities developed operational guidelines and offered training and ‘peer exchange’ opportunities to staff newly involved in managing primary care and elderly care in the early 2000s [Tynkkänen 2013].

7: Australia’s Industry Commission (1996) found training of local officials to be essential to success in managing mixed delivery of social services.

8: See, for example: the description of training offered by Australia’s Local Government Association or the State of Victoria’s association of municipalities (Industry Commission, 1996); the primer ‘Understanding Health Care Markets’ prepared in 2009 for health policy practitioners in England [Frontier Economics 2009]; the learning materials and programs offered by the Institute for Social Care, listed under ‘commissioning’ and ‘market facilitation’.

9: Undoubtedly, this is why all training and guidelines for policy practitioners newly involved in engaging private actors cover the topic of ‘intelligence gathering’, or ‘market intelligence’ gathering.

10: Public clinics’ quality improvements can attract more patients; indeed, some care givers in Bangladesh did shift to public clinics as a result of quality improvements (from 13% to 18%). Any plausible shift, however, would still have left most people seeking care from private sources.

11: Bryce et al characterize the logic underlying most child health programs as grounded in the assumption that public services are used by most or all of the population [Bryce et al 2005]; Meessen and Malanda note that many African policymakers have a similar mental model [Meessen and Malanda 2014]. Similarly, Wells et al note that TB decision-makers significantly underestimate the proportion of TB treatment taking place in the private sector [Wells et al 2011].


13: Based on DHS data and household income calculations between 1998 and 2013 [ibid Grepin 2014].

14: These important distinctions are elaborated in Module 10: Managing Health Tools of Government and Implementing Market Reforms.

15: This section is based on A Seita’s 2004 thesis “Think PHC, Do TB: Integration-Based Scale Up of Tuberculosis Control”.

16: In 1940, a survey of TB epidemiology in Japan indicated that while only 22,827 cases were reported, 153,154 deaths were recorded [Lewis et al, 2013].

17: According to Sutherland and Styblo, who established this epidemiological measure, ARTI can be placed in three categories: high prevalence (>1%), middle prevalence (0.05–0.1%) and low prevalence (<0.05%) [Shimao, 2005].


19: TB treatment involves a lengthy drug regime; patients usually feel better long before they are cured – adherence is a common problem.

20: See social services.

21: See welfare services.

22: See adaptive implementation process.

23: This mental model is referred to variously as: the health district model, and, the planning, central planner or bureaucratic model.

24: Meessen et al discuss the underutilization of DHS survey data to gain insight about care-seeking and private provision [Meessen et al 2011]; Waning et al note that social insurance claims data is underutilized for gaining insight into the operation of private pharmacies [Waning et al 2009].

25: Waning et al note that in LMIC countries, regulators decision-making on price levels for dispensing medicines rarely examines pharmacies’ cost of operation [Waning et al 2009].

26: See linear implementation approach.

27: This linear approach is contrasted with an adaptive approach to implementation.

28: A report from the regional conference “Health districts in Africa: progress and perspectives 25 years after the Harare Declaration” emphasizes that moving away from the old mental model of an entirely publicly administered health services system is a critical first step to strengthening health services in the region. (Health Services Community of Practice, 2013).

29: See ‘licensing of physicians’.
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ACRONYMS

DHS  Demographic and Health Survey
IMCI  Integrated Management of Childhood Illness
LMIC  Low- and Middle-Income Countries
MM4H  Managing Markets for Health
NGO  Non-Governmental Organizations
WHO  World Health Organization

GLOSSARY

Adaptive implementation: implementation characterized by a phased process involving decision points; the staging is organized to improve the chances of success through ‘course correction’. No single path is recognized at the outset; rather, subsequent stages build on the outcomes of the previous stages.

Conceptual framework (or model): a simplification of reality that depicts a relationship between specified aspects of that reality which holds with some regularity.

Copayment: fixed sum (e.g. $10) paid by a publicly-covered or socially-insured individual for the consumption of specific health care services or items (e.g. per hospital day, per prescription item).

Coverage: the extent of interaction between the services or product distribution activities and the people for whom they are intended. Coverage is not to be limited to a particular aspect of service provision, but ranges from resource allocation to the achievement of the desired objective.

Delivery network: a network constituted of all actors whose delivery activities influence outcomes. See also delivery system.

Economic regulation: regulations grounded in addressing a market failure to permit market processes to operate more beneficially; these regulations involve bureaucratic processes combining legislature and courts, target the behavior of firms, and aim to influence prices, outputs, and/or entry and exit of firms in an industry.

External policy tool: when policymakers deploy identified methods to structure and influence the behavior of society at large, not just government bodies and behavior of public officials and employees.

Governance regime with respect to private sector: the features of the sector policy framework and processes of operationalization that relate most directly to the role and operation of private actors.

Grant: a policy tool whereby agencies allocate financial resources or in-kind benefit to organization to support an activity they are performing.

Health market: places, institutions and processes through which buyers obtain and sellers provide health care goods or services; the interaction of demand and supply for these goods and services. Also, the set of all sale and purchase transactions that affect the price of some health product or service.

Health system: an enduring configuration of institutions, organizations and public policies involved in delivery of personal and population health services and products, exhibiting shared values and aims and evolving in tandem over long periods of time.

Implementation network: the collective of producers, distributors, retailers and/or other providers through which policymakers strive to achieve their social objectives related to service and/or product delivery.
**Inclusive analysis**: policy analysis which collects and examines information about all actors relevant for particular issue or problem.

**Internal policy tool**: procedures and processes that governments and agencies use to handle their own internal operations (e.g. processes related to personnel recruitment, management and development; budget planning and execution; procurement of supplies, or services).

**Licensing of physicians**: an approval or authorization which physicians are required to obtain before operating in an identified jurisdiction. The licensing process may be done by a government agency or a professional association, and usually involves extensive background checks on training and educational background, as well as, in some cases, additional professional examination.

**Market**: the interaction between all the buyers seeking a product and the collection of sellers from whom they may get it, and, whereby the product exchange price influences the allocation of products and funds.

**Market forces**: a range of economic factors that affect providers’ supply behaviors as well as buyers’ demand behaviors for goods and services.

**Market Structure**: organizational or competitive characteristics of a market; often with reference to the number of organizations in a market that produce identical goods and services. Market structure has great influence on the behavior of individuals firms within the market.

**Non-governmental organization**: an organization which operates independent of government, meaning it is not part of a government entity, nor controlled by a government. Non-governmental organizations are a category of non-profit organization.

**Objective**: a statement of a desired future state, condition, or purpose, which an institution, a project, a service, or a program seeks to achieve.

**Policy**: a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means for achieving them within a specific situation where these decisions should, in principle, be within the power of these actors to achieve.

**Policy apparatus**: the agencies and processes that structure and influence the behavior of individuals and organizations involved in addressing public objectives. These agencies and processes encompass the state’s use of policy tools in a particular domain (e.g. population health; primary education; social housing).

**Policy tool**: an identifiable method through which states attempt to structure and influence the behavior of individuals and organizations to address a public problem. The term is used interchangeably with ‘policy instrument’.

**Policy tool package**: The composition of policy tools used by policymakers to guide organization behavior.

**Primary care services**: first-line medical and health care services (diagnosis and treatment of acute and chronic illnesses, health promotion, disease prevention, health maintenance, counselling, and patient education) in which generalist clinicians (doctors, nurses, pharmacists or professionals from other community health cadres) operate as a first point of contact for people with undifferentiated health problems.

**Private providers**: individual practitioners and organizations providing health care and products to users, which are not part of the public sector, including non-profit organizations (faith-based, secular), small businesses, and corporate entities. Also referred to as ‘non-state providers’.

**Private sector**: for-profit and non-profit organizations; the part of the economy run by private individuals or groups, and, which is not administered or controlled by the state (areas of the economy controlled by the state being referred to as the public sector). In the health sector, this includes pharmacies, solo practices, pharmaceutical manufacturers and distributors, as well as clinics and hospitals under non-profit and corporate ownership.
Professional association (also called professional body, professional society): an organization which acts to advance professional or personal interests of an identified set of people, such as lawyers, nurses or physicians. It is typically organized as a non-profit organization. In mixed health systems, such associations are usually entrusted with an oversight role of all members of the profession. In many systems, they also play an institutionalized consultation role in policy formation and implementation in policy domains related to their practice.

Provider: a healthcare organization or individual who “provides” care including services and/or products.

Public sector: the part of the economy concerned with performing governmental administrative activities and providing various government services. The composition of the public sector varies by country, but in most countries the public sector includes staff of public administrative and judicial agencies, elected officials, and agencies involved with provision of services such as the military, police, public transportation systems, highway planning and management, education regulation and provision, public health and healthcare regulation and provision.

Public service: a service rendered in the public interest; typically encompasses social services, welfare services and infrastructure-related services (e.g. water, sanitation, social housing).

Regime: purposefully created normative and cognitive framework, governing interactions among a specified set of individual, corporate and collective actors that have explicitly undertaken to respect certain interest positions of other parties to pursue certain substantive goals and values, and to follow certain procedures in their future interactions.

Regulatory policy tool: policy tools rely on the gov’ts power to compel or prohibit actors to behave in a certain way

Responsiveness: response to individual’s legitimate expectations regarding the non-health enhancing aspects of health care or a health system (e.g. protection of confidentiality, being treated respectfully).

Social health insurance: an arrangement for funding health care, whereby an autonomous organization pools and manages funds to finance health care services, where contributions are set on a means- (rather than risk-) basis.

Social regulation: regulation addressing the behavior of individuals, firms, or lower levels of government dealing with the effects of economic activity on the health, welfare, or social well-being of individuals. It involves deploying rules of individual or organizational behavior and sanctions for non-compliance and an administrative apparatus that enforces the rule and administers sanctions. Because it sets rules and sanctions non-compliance. It is sometimes referred to as ‘command-and-control’ regulation.

Social services: services (e.g. health care, education) the provision of which a society has deemed require policy action to ensure provision. Social services are typically provided society-wide.

Upstream policy activities: policy or sector management actions implemented in a domain which are taken earlier in a reform initiative; typically they target changes in the enabling environment or ecosystem. Often, the changes sought are necessary for subsequent “downstream” efforts to be effective. Hence, the phrase has both a time and a causal meaning.

Welfare services: services (e.g. food, accommodation, child care) which a society has deemed to require action to ensure access to a minimum standard or package. Welfare services are provided to individuals that society deems to be needy; the goal, generally, is to alleviate extreme need.
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REFERENCES


