

**Oxfam's response to The Center for Global Development's blog on Blind Optimism by April Harding**  
[http://blogs.cgdev.org/globalhealth/2009/02/oxfam\\_this\\_is\\_not\\_how\\_.php](http://blogs.cgdev.org/globalhealth/2009/02/oxfam_this_is_not_how_.php)

We were sadly disappointed with your response to our [paper](#), which we feel is not representative of either the paper or the discussion at the Washington seminar. We would completely agree with you that there is a need to move beyond staunchly ideological positions to one of pragmatism. Indeed it is through this paper that we are seeking to shift the debate away from accusatory and emotive exchanges to rather focus on the evidence of what policies and programmes will most effectively achieve the rapid and sustained expansion and improvement of health care delivery so urgently needed in so many countries.

For this reason we would like to question some of the evidence you present and also correct some of the misrepresentations of our report and position.

**'Beyond anecdotes'**

Our starting point is not a simplistic or ideological case of 'public good', 'private bad', and we feel to suggest this is to miss the point of the paper. Our paper draws on a variety of evidence including from health surveys, peer-reviewed journals, World Bank and World Health Organisation reports and particularly the [Commission on the Social Determinants of Health](#). It was reviewed and commented on by academics from across the political spectrum. Rather than focus on anecdotes our decision was to focus on the empirical evidence on what has worked to achieve universal and equitable access in successful developing countries despite low incomes. We found that even though high health performing countries do often have a thriving private health care sector, the evidence shows that it is their level of commitment to pro-poor public investment and public provision that sets them apart from the rest. By the same token, no successful high health performing country has chosen to rely primarily on private instead of public provision. In their official response to our paper the World Bank agrees with this point. They go on to say that they feel the main factor in these successes was good governance, but we believe that although good governance is critical, the mix of policies used is also a major learning point, and here rapidly scaling up public provision was central. Our key message is therefore quite simple - that donor agencies and governments should be doing significantly more to learn and apply the lessons from successful countries and what they did to scale up public provision. This does not preclude learning from the lessons on the evolution and governance of the private health care sector in these same countries. Far from 'reverting' to an old tried and tested approach as you suggest, for many aid donors this will mean redressing their own poor record of long-term systematic disinvestment in government health care delivery in poor countries.

Secondly, our advice against investing in risky and unproven approaches that aim to expand the role of the for-profit private sector in health is not the same as advocating a public-sector only approach, or that the private sector should somehow be 'stopped', contrary to your presentation of our arguments. In the paper Oxfam is explicit that the *'private sector can play a role in health'*, that it *'will continue to exist in many different forms and involves both costs that must be eliminated and potential benefits that need to be further understood and capitalised upon'*. Government capacity to regulate the existing private sector and ensure its positive contribution to equity goals is prioritised as one of our core recommendations. On the other hand, unchallenged enthusiasm for private sector solutions is neither justified nor helpful. Based on the evidence available there is an urgent need for more honesty about the significant risks to efficiency and equity associated with private sector growth, and more openness about the paucity of comprehensive evaluations of private sector approaches and the lack of evidence that these approaches can be scaled up. The poor quality of the data on contracting private providers as an alternative to expanding public provision is a particular concern especially the lack of attention to transaction costs, the level of financial risk placed on governments and the wider impact of contracting on the health system as a whole.

**'The informal Sector – We May Not Love it, But Many People Can't or Won't Leave It'**

Far from ignoring the informal private sector and 'sweeping the challenge of getting people to change their care-seeking behaviour under the rug' as you suggest, the primary focus of our paper is on the poor women, children and men across the developing world who face the unacceptable choice between seeking care from unqualified providers or going without care altogether. In this regard we query your argument that the poor 'want to go' to informal private providers and will 'persist in doing so'. It is hard to conceive that when faced with a real and genuine choice between informal unqualified providers and decent and accessible care provided free of charge by trained professionals in the public sector poor people would continue to use the former. In fact the empirical evidence from higher health performing countries shows that when care is available and accessible in the public sector the majority of poor people do choose to use it, and it is the better-off who are more likely to go to the private sector. We also know in cases such as [Uganda](#), where increased investment in government health services was combined with the removal of user fees, utilisation rates for poor people increase dramatically. And even in those countries with less than adequate public provision, the poor still choose the public sector for curative care, not least pregnant mothers as our paper demonstrates. Public provision in these same countries has also proven the most effective regulator of the informal sector by crowding out the most dangerous elements and giving those providers that survive something to compete against.

None of this means we can ignore the informal sector and contrary to your suggestion our paper in fact calls for 'urgent action' to 'minimise its dangerous practice and improve its standards'. We cite some success of negotiated interventions such as training and public education, although perhaps more cautiously than you, given the highly resource-intensive nature of these programmes, lack of evidence on impact to date as well as the Herculean nature of the task. However, even if standards can be improved within selected interventions the kinds of services that can be offered safely via this sector will always be limited and market forces to over- or under-prescribe will be a continuing threat. Monitoring and regulating private sector providers even in advanced nations like the US is also very complex and resource intensive. That doesn't mean interventions shouldn't be tried but they must not be perceived as a substitute to scaling up and strengthening decent quality health care services provided free of charge by the public sector.

### **The 'unpopular-with-Oxfam Affordable Medicines Facility for Malaria (AMFm)'**

Our concerns about repeating the same mistakes of the past through the AMFm are shared by many others including the US and Canadian governments, and we question how quick you are to dismiss them. Chloroquine, once an effective drug, has been widely available through the private sector for decades and under- and over-prescribing led to widespread drug resistance. The AMFm is using the same delivery route for Artemisinin – the last effective drug available for malaria - with minimal safeguards. We think this is a mistake. The AMFm also ignores research by organisations such as [Médecins Sans Frontières](#) showing how subsidisation of Artemisinin is not enough to significantly increase access to treatment for the poor. Their direct experience in countries across Africa has shown that it is only when completely free care (medicines, consultations and other related costs) was introduced that access rates dramatically increased.

You are correct to point out that AMFm will be applied to the public as well as private sector but you should be aware that this was only agreed after our paper went to print and only as a result of intensive lobbying from Oxfam and many other civil society organisations involved in the negotiations. It is also misleading to suggest attempts to improve access to Artemisinin through the public sector have failed. Such attempts have been hampered until recent years by a severe lack of funding. Since 1998 there has been a 25 fold increase in the resources available for malaria and with it a significant number of public sector [success stories](#) including a 50% reduction in in-patient malaria cases and deaths throughout Rwanda and Ethiopia, a 33% decline in deaths in children under five in Zambia and a 34% decline in deaths in Ghana.

In this difficult period of economic uncertainty it is more important than ever to invest what limited resources are available in policies and programmes that are going to make the most effective difference in ensuring poor people have access to the health care they need. There is no question that the private sector is an important actor, but in countries where the poor have access to qualified health care at scale the evidence is clear that it is the public sector that has reached them. The question we need to be asking is how we get the public sector in other countries to do the same. As Dr Rannan-Eliya from the [Institute for Health Policy](#) in Sri Lanka said at our seminar at the World Bank, 'we don't do it by turning our attention away from the public sector'.

Over the coming months we will be organising a series of follow up seminars and lobby meetings in Geneva, Delhi, Brussels, Addis Ababa, London and Oslo where we are keen to continue this debate and call for a more evidence based approach. We look forward to continuing this conversation with you.