Private Healthcare in Developing Countries

NEWS & EVENTS

7/21/10

Population Services International Reports on Incentives to Increase HIV Counseling and Testing in Myanmar Social Franchises

In a presentation at the 2010 International AIDS Conference in Vienna, Population Services International reports on an incentive program to increase HIV testing among TB patients at Sun Quality Health social franchises. Monetary incentives were provided to both patients and private providers for participation in HIV counseling and testing. The pilot sites showed a sustained five fold increase in HIV testing and counseling compared to the baseline. *Link*

6/6/11

The International Finance Corporation Releases Report on Private Sector Health in Africa

The World Bank Group released a comprehensive report on the role of the private sector in meeting future health care needs in Sub-Saharan Africa. The report also outlines policies that governments and international donors can make to help foster the growth of private healthcare in the region.

Above: An image from a PSI/Burundi advertisement for ORASEL

Evaluation of a Social Marketing Intervention Promoting Oral Rehydration Salts in Burundi

Kassegne et al., BMC Public Health 2011

Kassegne et al. evaluate the effect of a social marketing program in Burundi and find a strong association between exposure to the social marketing campaign and use of an oral rehydration salts package to avert childhood diarrhea. From 2004 to 2007, Population Services International Burundi embarked on a national social marketing intervention for the ORASEL oral rehydration salt brand. The campaign involved broadcast radio advertisements, community outreach, and branded promotional materials. In addition, nearly two thousand "health workers, vendors, and pharmacy employees" were trained in the promotion and use of ORASEL. The authors estimate the intervention reached over a half a million people. Analyzing household surveys, Kassegne et al. find that between 2006 and 2007 use of ORASEL significantly increased from 20% to 30%. During this time period, surveyed individuals reported increased availability and affordability of the product as well as significant increases in diarrhea knowledge, social support, self-efficacy, and willingness-to-pay for ORASEL. Product use was significantly associated with availability, perceived affordability, brand appeal, social acceptability, and self-efficacy in ORASEL delivery. The authors note that program was more effective when paired with interpersonal communication training and outreach. The authors conclude that "ORS use can be improved through social marketing campaigns that make the public aware of the availability of the product, encourage dialogue about its use, and increase skills and confidence relating to correct product preparation and administration." *Link*

Global Fund Financing of Public-Private Mix Approaches for Delivery of Tuberculosis Care

Lal et al., Tropical Medicine and International Health 2011

Lal et al. review The Global Fund to Fight AIDS, Tuberculosis, and Malaria funding of public-private mix (PPM) tuberculosis care delivery and find that the organization supports PPM programs in 58 countries, but has limited engagement with non-governmental and private providers. The public-private mix (PPM) approach for tuberculosis care aims to expand access, coverage, quality, and treatment outcomes through engaging the private, non-profit, and prison health sectors in national, government-coordinated, tuberculosis treatment and detection programs. The authors survey official Global Fund grants as well as an annual WHO report on global TB strategy to assess the extent of institutional support for PPM programs. Over 60% of the 93 Global Fund supported countries contain funding for PPM programs, with a higher prevalence in Southeast Asia (82%), compared to Latin America (67%), South and East Asia (62%), and sub-Saharan Africa (52%). The authors find PPM programs most frequently engage prison health services (in 48% of countries), but also commonly collaborate with NGOs (34%) and private sector (26%). Prison PPM collaboration was more common in Eastern Europe, Latin America, and West and Central Africa, whereas the private sector was most engaged in South Asia and East Africa. Lal et al. also find that in 2008 the Global Fund allocated $38.3 million dollars, or 4.4% of their total TB funding, to PPM programs. The authors argue the current level of engagement of the private and NGO sectors is less than adequate given studies supporting that PPMs with NGO and for-profit providers can significantly increase detection and

treatment success rates. The authors additionally note that PPM plans largely focus on provider training, failing to discuss "what enables and incentives (financial or non-financial) will be used for private sector engagement" and "continuous supervision, monitoring, and evaluation" issues. In conclusion, the authors contend that although the current budget allocation for PPM activities is "probably sufficient for limited engagement," added funds would be needed to scale up the PPM initiative to engage the private sector commensurate with the percentage of care contributed by private and non-governmental actors. *Link*

Household Demand for Insecticide-Treated Bednets in Tanzania

Gingrich et al., Health Policy and Planning 2011

Gingrich et al. conduct an economic analysis of consumer willingness to pay for voucher subsidized anti-malarial bed-nets and find that consumer demand is not highly affected by price or income, signaling that effective future distribution should focus less exclusively on consumer subsidies. The authors surveyed individuals who received voucher subsidies for insecticide-treated bed-nets (ITNs) under the Tanzanian National Voucher Scheme between 2004 and 2006. The program provided set-value vouchers to pregnant women that compensated for part of the ITN retail price at a private shop, necessitating the consumer pay a variable "top up" associated with "local market conditions and ITN characteristics such as size, brand and [color]." In their analysis of factors influencing a voucher recipient's decision to buy an ITN, the authors found that increased socioeconomic status and education, having a female head of the household, and having one child were most significantly associated with buying an ITN. Interestingly, the authors found that the added "top up" price to be paid by women had a significant but small effect on ITN purchase decisions, and thus low elasticity. The authors additionally find that income had a similarly low elasticity, "suggest[ing] that economic growth alone will not lead to substantial increases in ITN coverage." The authors argue that distribution of free nets "decreases short-term ITN purchases for voucher recipients," and that the higher density of retailers selling nets would increase the likelihood of purchase. They conclude that to have the voucher scheme "continue to contribut[e] toward increased and sustained ITN coverage" the government should supplement free ITN dispersal with a continuous inflation-adjusted voucher subsidy to maintain a stable or decreasing price, improve income growth for poor households, improve education levels for women, and expand the number of retailers. *Link*

Private Health Care Sector and Prenatal Care Services in Latin America

Arrieta et al., World Development 2011

Arrieta et al. analyze Demographic and Health Surveys of six Latin American countries with high rates of prenatal visits, finding that the private sector provides a greater number of prenatal visits in these countries than the public sector but that increased prenatal visits bore no relationship to better outcomes. Bolivia, Colombia, the Dominic Republic, Guatemala, Nicaragua, and Peru all reported prenatal visit levels well above WHO standards; visit rates below WHO standards ranged from only 3-17.9% of pregnant women in these countries. Arrieta et al. find that receiving care from a private provider was significantly associated with between a 4.2 and 5.5% increase in the number of prenatal visits. They additionally find that both "obstetrical factors" (including age) and socioeconomic factors (including wealth, marriage, and employment) were positively associated with the number of prenatal visits. They argue however that additional private sector prenatal natal visits were "unnecessary" because they did not significantly "improve delivery outcomes, measured by means of birth weight." The authors suggest "using a payment system not based on production (such as capitation, prospective payment, and payment for quality)" could curb ineffective services provided by the private sector. They argue further that the "lack of regulation and transparency" of the private sector fosters the provision of ineffective services and suggest that increased accreditation and social franchising could improve private sector healthcare quality and efficiency. *Link*

By the authors of PS4H:

Where Do Poor Women in Developing Countries Give Birth?

Montagu, Yamey, Visconti, Harding, and Yoong, PLoS ONE 2011

The authors of the PS4H website are pleased to report the publication of our Demographic and Health Survey analysis of maternal birth location and motivations in 48 countries. We find that in nearly half of the countries surveyed, more than half of all births occurred at home, disproportionately among women in the lowest socioeconomic quintile. Among home births, the poorest women were nearly three times more likely to give birth without a trained professional present and when an attendant was present, it most commonly was a traditional birth attendant. Women in the highest socioeconomic quintile were much more likely to give birth at a public facility with trained professionals present. Births in private / religious hospitals were more common among women of higher socioeconomic status. Surveyed women in both the richest and poorest quintiles who gave birth at home overwhelmingly cited a lack of necessity as the reason why their births were unattended by a trained health professional. Access to services was cited by roughly a quarter of those surveyed, and cost was rarely cited as a reason for unattended delivery. We contend that efforts to reduce maternal mortality should focus on community-based interventions training traditional birth attendants to make home births safer and help shape sociocultural norms about the necessity of attended births, as well as expanding emergency obstetric care. *Link*

Franchising Rabies Vaccine Delivery in India

Masum H, Batavia H, Bhogal N. PLoS Neglected Tropical Diseases, 2011

Masum et al. describe the case of Indian Immunologicals Limited and the Abhay Clinics social franchise, which provides

the public with affordable vaccines through private delivery franchises. Indian Immunologicals Limited (IIL) is a publicly owned but privately operated corporation with a mission to provide affordable vaccinations to the public. To address rabies' high morbidity and mortality, IIL both developed a new rabies vaccine and created the Abhay Clinic fractional franchise to assist with vaccine delivery. IIL recruits private physicians to join the Abhay Clinic franchise with educational, logistical, and marketing incentives and subsidized purchase of a cold storage system to further entice physicians into joining the franchise. Franchisees are required to take a continuing medical education course on animal wound care and to exclusively sell the IIL vaccine for a fixed price. IIL supports social marketing campaigns to promote vaccination and modern medical care of animal bites. In 2009, Abhay Clinics directly distributed nearly three quarter of a million vaccines and provided an additional quarter of a million vaccines to non-franchise doctors "on-call." The franchise has since developed several additional vaccines to provide a singular point of care for vaccination. The model has been expanded to the Philippines and includes over 3,000 franchise locations. *Link*

Comparing the Quality of Public-vs.-Private Ambulatory Care in LMICs

Berendes S, Haywood P, Oliver S, Garner P. PLoS Medicine, 2011

Berendes et al. report on a systematic review of comparative quality in public and private settings in LMICs. They found similar quality levels in for-profit and non-profit providers. Overall quality scores, measured according to infrastructure, clinical competence, and practice were low in all settings. The private sector, both for-profit and non-profit, scored better than the public sector in relation to drug supply, responsiveness to patients, and effort. Competence and patient satisfaction was equivalent between public and private sectors, although a synthesis of qualitative findings indicates that the private sector is more client focused. The private sector performs better in some key areas of healthcare provision than the public sector, however the principal finding of this study is that both public and private sectors in LMICs suffer from low levels of quality. *Link*

Public vs. Private Availability of Medicines for Chronic and Acute Conditions

Cameron A, Roubos I, Ewen M, et al. Bulletin of the World Health Organization 2011

Cameron et al. assess pharmaceutical availability in the public and private sectors of 40 developing countries and find availability of all medicines to be low in these countries, with generic medicines for chronic conditions significantly less available to consumers than generic medicines for acute conditions. In the public sector of the 40 countries, 53.5% of a basket of common generic acute medicines and 36.0% of chronic medications are available. In the private sector, these rates were 66.2% and 54.7%, respectively. Both sectors in these developing countries fail to measure up to the WHO recommended benchmark of 80% generic drug availability. In both sectors, antiulcerants and antidiabetics are most available, while drugs for asthma, epilepsy, and depression are less stocked. The authors find that the private sector has less of an income disparity for chronic and acute medication availability. They argue that availability of chronic disease medications can be increased through supply-side factors such as "improved procurement efficiency and supply chain management as well as adequate, equitable and sustainable financing." They also recommend further research into ways to stimulate demand for drugs including health insurance schemes. *Link*

A Maternal Health Voucher Scheme for Institutional Delivery in Pakistan

Agha S. Reproductive Health 2011, 8:10

Agha evaluates the effectiveness of a participant purchased maternal health voucher program in Dera Ghazi Khan district of Pakistan and finds that the program significantly increased institutional deliveries, antenatal and postnatal care. The program sells voucher booklets to targeted poor women, which they can redeem with private Greenstar social franchise providers under the Goodlife brand for antenatal and postnatal visits and medical institution delivery. The program also reimburses women's transportation costs. Agha finds that voucher purchase is associated with a 21.6% increase in antenatal care visits, a 22.1% increase in delivery in a health facility, and a 35.4% increase in postnatal care visits. Women who bought the voucher booklet were nearly five times more likely to use antenatal care, over four times more likely to give birth in a facility, and nearly six times more likely to receive postnatal care. The author also finds that the program significantly narrowed the gap in institutional deliveries between affluent and poor women in the district. Agha estimates that if the program were rolled out nationwide in Pakistan, that the voucher program could successfully eliminate maternal mortality for $339 million. He believes that the programs marked success provides evidence to support a "rapid and substantial scale-up of interventions using [the voucher] approach." *Link*

Lessons on Equity from a Maternal Health Voucher Scheme in Bangladesh

Ahmed S and Khan M, Social Science and Medicine, 72(2001), 1704 – 1710

Ahmed and Khan assess a government run free maternal health voucher program in Bangladesh, finding increased ante and postnatal care, skilled delivery, and a significantly increased likelihood of participants seeking treatment for obstetric complications yet only marginally improved overall women's maternal health. The authors evaluate the Maternal Health Voucher Scheme in Bangladesh's rural Sarishabari subdistrict one year following implementation. In this program, voucher recipients are entitled to three antenatal visits at selected private, public, or non-governmental providers, skilled delivery at a health

facility or by a skilled provider at home, a postnatal visit, and transportation costs. All subdistrict women in their first or second pregnancies are provided vouchers. Ahmed and Khan find that participants were 3.58 times more likely to be assisted by skilled health personnel during delivery, 2.5 times more likely to delivery in a facility, 2 times more likely to receive antenatal care, and 2.8 times more likely to receive postnatal care than women outside the program. Poor women receiving vouchers were between two and four times more likely to take advantage of services, helping to increase health equity in the program area. Despite the elimination of financial barriers to maternal health care however, the authors find that overall usage of maternal health services in the subdistrict remained low, primarily due to perceptions of poor service quality. The authors argue that in places like Sarishabari, a more "comprehensive approach [to maternal health] is needed that explicitly addresses financial constraints, gender disparity, social barriers to access and supply-side concerns." *Link*

HPP SUPPLEMENT ON THE PRIVATE SECTOR:

Moving forward towards greater knowledge of the private sector in LMICs

Forsberg B, Montagu D, and Sundewall J; eds.
Health Policy and Planning (2011)

Since the 1990s researchers have worked to call attention to the previously unrecognized size of the private sector within health systems in LMICs. Among researchers, and increasingly among policy makers and global public health leaders, this battle is now won. As a result, research has begun to focus less on overall private sector measurement, and more on the nuances of private sector performance.

The eight papers in this special supplement are impressive examples of this. *Link*

Levin and Kaddar report the results of a systematic review of the private sector role in Immunization. Overall, there are few studies of the subject but the authors find that the private sector is contributing to immunization service delivery and help to improve access to basic vaccines in some low-income countries. *Link*

Heard et al. assessed large-scale contracting of non-governmental organizations (NGOs) for delivery of basic health services in Uttar Pradesh. The results showed that NGOs selected were generally small but well-established, had implemented at least two large projects, and had more non-health experience than health experience. *Link*

Ozawa and Walker used focus groups and household surveys to compare trust in public vs. private healthcare providers in rural Cambodia. Public providers were considered to be "honest", "sincere", "explain the disease" and have good skills and abilities more often than private by the respondents. The latter, were higher graded for being "comfortable and easy", "friendly" and "easy to make contact with". The study illustrates the importance of trust as a unique concept that could affect people's choice of healthcare providers in a low-income country. *Link*

Messen et al. conduct secondary data analysis of household surveys from Cambodia. The study confirms that the health care sector in Cambodia is now highly pluralistic, and that the great majority of people seek health care outside the public health system. *Link*

Bloom et.al. discuss the challenges related to making health markets work for poor people, using the example of informal health care providers in Nigeria and Bangladesh. They conclude that in order to improve performance of informal providers, the roles of different actors and the incentives they face must be better understood. *Link*

Nguyen et.al. address the topic of provider profits through a principal-agent problem analysis of the Vietnam health sector using household data from the national health survey. The study shows that private providers were able to induce demand by prescribing more drugs than public providers, private providers were significantly more likely to prescribe injection drugs to gain trust among the patients, and that patients' education as a source of information and empowerment enabled them to mitigate the demand inducement by the providers. The findings also suggest that regulation and check from a third party, whether it is an authoritative body in charge or an insurance agency, can provide another guard against provider-induced demand in the health care market in Vietnam. *Link*

Nirali and colleagues studied family planning programs in Ethiopia and Pakistan, comparing different types of providers and different modes of operations, including social franchising. They found that franchised providers can improve the quality of care in family planning. The study concludes that quality improvements in the private sector can be delivered to the poor in some settings. *Link*

Sulzbach and colleagues examined trends in private investments in HIV/AIDS in five sub-Saharan countries using national health accounts data. They found that total resources had increased in all five countries and out-of-pocket spending decreased in four countries. The private-for-profit sector is therefore partly crowded out by the not-for-profit sector. The authors argue that this raise questions about the donor dependence and sustainability of HIV/AIDS control over time as there may not be active for-profit providers to work with when donor funds cease to arrive. *Link*

July 9, 2011 - Toronto

Pre-iHEA Full Day Symposium on the Private Sector

Researchers on health economics and health systems will attend a one day symposium on current studies and findings. Dean Tim Evans and Dean Julio Frenk will present keynotes.

For more information including the agenda and accepted abstracts : link

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