Private Healthcare in Developing Countries

NEWS & EVENTS

11/17/09
Business Coalitions on AIDS Regional Meeting
Bangkok, Thailand
This meeting brought regional participants together to discuss business coalitions working to prevent and treat HIV in the workplace and its surrounding communities. The meeting will produce a manual to serve as a technical resource for the 47 business coalitions on AIDS worldwide. *Link*

11/13/09
Introduction to Health Systems, Online Course
David Bishai of Johns Hopkins University and the Health Systems Board have published an online course to introduce users to health systems and current strategies to strengthen them. *Link*

11/8/09
Voucher Program Shows Success in Uganda
A recent online article details an innovative voucher program run by Marie Stopes and funded by KfW and the Global Partnership on Output Based Aid which provides costless STI screening and treatment as well as child delivery and antenatal care. *Link*

Above: RPS recipients in Nicaragua

The Effect of Conditional Cash Transfers on Vaccination Coverage in Rural Nicaragua

Barham et al., Journal of Health Economics 2009

Barham et al. assess the Red de Proteccion Social (RPS) plan in central Nicaragua to determine the program's effectiveness in providing vaccination services to rural households. The RPS plan provides mothers bimonthly cash transfers, contingent on their attendance at medical appointments and health education workshops and their child's rate of weight gain. Although vaccinations were not explicitly required, Barham et al. discover that the RPS program significantly increased the on-time vaccination rate for children by between 15 to 20 percent. The RPS plan additionally produced a marginally significant 15 percent increase in vaccination coverage of older children who had missed previous vaccinations. The authors additionally note that the RPS plan showed particular success with populations experiencing geographic and educational barriers, leading to an equalization of vaccination rates between underserved groups and the larger population. The authors conclude that the success of the RPS program "underscores the ability of conditional cash transfers to reach sub-populations for whom supply-side oriented strategies have been less successful." *Link*

Changes in Utilization of Health Services Among Poor and Rural Residents in Uganda

Pariyo et al., International Journal for Equity in Health 2009

An assessment of Uganda's recent health sector reforms reveals mixed results in promoting access to care for the poor in both public and private sector. In the recent past, Uganda has abolished user-fees, provided subsidies for non-profit health facilities, and decentralized resource allocation and delivery to health districts in an attempt to increase access and quality in both the public and non-profit sectors. Pariyo et al. analyzed the Uganda National Household Survey to track changes in health system use between the 2002/03 and 2005/06 surveys, discovering that use of public and private not-for profit services increased among rural and poor populations but that private for-profit providers continued to provide the majority of health services. Surprisingly, the authors found that during the study period the odds of not seeking care also increased, reflecting the continued influence of financial and geographic barriers in health access. The authors conclude the private for-profit providers need to be encouraged to provide safe, effective, and affordable care through "better measurement of performance and accountability mechanisms, contracting, or engagement of consumer groups, provider associations and franchises." The authors also argue that targeted subsidies or community-based health insurance schemes could be used to increase care for poor and rural populations. *Link*

Out-of-Pocket Costs for Facility-Based Maternity Care in Three African Countries

Perkins et al., Health Policy and Planning 2009

Perkins et al. survey out-of-pocket costs for child delivery in Kenya, Burkina Faso, and Tanzania and discover that over a quarter of all institutional deliveries occur in private sector facilities. Across both public and private

sectors, hospital-based delivery costs mothers nearly twice the amount as in lower level health centers and maternity facilities. In Tanzania and Kenya, mean out-of-pocket fees for a normal delivery at a private facility are higher than those at a public facility, whereas in Burkina Faso, mean fees are lower at private religious health centers because drugs and supplies are subsidized. In all countries, the majority of deliveries occur outside the formal health center, largely because of affordability issues: non-institutional deliveries cost between ten and twenty-five percent of the price of an institutional delivery. Perkins et al. reveal that regardless of official government positions for cost-sharing or free-of-charge services in these three countries, all individuals were required to pay out-of-pocket fees to use public facilities. The authors document no difference in costs between the poorest and wealthiest quintiles suggesting that "both user fee and nominally free services [appear] to be equally regressive, and that waiver or exemptions to support the very poor are absent or ineffective." *Link*

The Effect of Community-Based Health Insurance Utilization in Burkina Faso

Gnawali et al., Health Policy 2009

In a study of the effect of community-based health insurance (CBHI) in Burkina Faso, Gnawali et al. find increased use of health facilities amongst insured individuals, but uneven rates of enrollment and use of services based on socio-economic status. The cohort enrolled in the CBHI scheme increased care-seeking behavior by forty percent for outpatient visits, with no significant increase in inpatient care, which the authors believe suggests CBHI enrollment increased initial provider contact and likelihood of patient follow-through. The authors found that affluent individuals were far more likely to enroll and use services (with the richest quartile most likely to access services), whereas financial barriers generally prevented poorer individuals from enrolling. When the government subsidized CBHI premiums, the lowest socioeconomic quartile had a ten-fold increase in enrollment. Gnawali et al. found that membership in a CBHI scheme correlated with a decrease in home treatment and treatment by traditional healers, suggesting these modes of care are more the result of financial limitation than personal choice. *Link*

Contracting Private Sector Providers for Public Sector Health Services in Jalisco, Mexico

Nigenda et al., Human Resources for Health 2009

Nigenda et al. analyze the experience of Jalisco Ministry of Health's in contracting private providers to extend medical coverage to traditionally low-access rural and semi-urban populations and increase the efficiency of service provision. Contracting in Jalisco was seen as an opportunity to expand access on a cheaper basis than hiring permanent personnel. The contracting payment scheme included a mix of 50% fixed salary and a variable 50% based on monthly productivity (number of consultations). The system employed a strict regulatory mechanism where each health unit (consisting of a doctor, nurse, and health technician) produces productivity reports that are monitored and occasionally audited by government offices. Interviews with program managers showed satisfaction with the expansion of health access because of the program, as well as with the productivity and efficiency of contracted parties. Contracted personnel were less satisfied with the program than managers because of unsatisfactory work conditions and the lack of job security. The authors conclude that the contracting mechanism allows the Ministry of Health to better determine the geographic location of services provided than they could through the use of salaried public workers. The program successfully linked productivity to salary payments to increase the number of services offered. The authors applaud the system's adaptability in allowing contracted providers to negotiate for health and retirement benefits, which influenced worker satisfaction and was an important factor for the long-term sustainability of the program. *Link*

Commentary: Public Stewardship of Mixed Health Systems

Lagomarsino et al., The Lancet 2009

In a recent commentary in The Lancet, Lagomarsino et al. call for the public sector to take a renewed role in effectively stewarding both the public and private elements of developing world health systems. Through creating and monitoring "the rules and incentives that define the environment and guide behaviors of health system players," the authors believe governments can ensure improved systemwide quality and effectively mobilize the resources of the private sector. The authors contend that "social franchises, professional associations, ... vouchers, community-based health insurance, and social marketing" are models that have emerged in the absence of proper stewardship, and can serve as "stepping stones to comprehensive government-led reform." *Link*

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