Private Healthcare in Developing Countries

NEWS & EVENTS

Call for papers
The 2011 Congress of the International Health Economics Association in Toronto includes a one-day symposium on the private sector. Call for abstracts and more information can be found here.

11/16/10
Health Systems Research Symposium - Montreux

A four day meeting on health systems; a number of private-sector sessions are scheduled. *Link*

11/30/10
Health Professionals for a New Century - Harvard

Public report by a commission studying the needs for training of health professionals in LMIC. link

03/11/11
2nd World Non-Profit & Social Marketing Conference - Dublin

From behavior change marketing and academic analysis to 1st-world marketing companies. link

11/09/11
First Global Conference on Social Franchising - Mombasa

The first ever global conference on Social Franchising has just been announced. link

Above: A JSY Beneficiary with Community Health Worker in India

An Impact Evaluation of India's Janani Suraksha Yojana Conditional Cash Transfer Program

Lim et al., Lancet 2010

Lim et al. assess an Indian government-run conditional cash transfer scheme to increase facility birth and find that the program significantly reduced antenatal and perinatal deaths but encountered equity issues among the poor and least educated members of the population. Since 2005, the Indian Government's Janani Suraksha Yojana (JSY) program has provided eligible women a monetary stipend if they give birth in either a government or accredited private health facility. In certain "high-focus states … with low in-facility birth coverage," the cash benefit was provided to women irrespective of socioeconomic status. In the last fiscal year, the program provided cash transfers to 36% of all birthing women in India. Lim et al. found that uptake of the program was variable across Indian states and among population groups. In most high-focus states, women with moderate levels of wealth and education were more likely to receive the package. The authors suggest that differential levels of state governance, program implementation, oversight, and health infrastructure may have affected program uptake. The authors also contend that program's difficultly in reaching the most disadvantaged populations was due to deficient targeting, limited geographic access, and continuation of a separate stipend for home births. The authors' analysis reveals that overall the program increased antenatal care in India by around 11%, in-facility births by around 43%, and skilled birth attendance by about 36%. Additionally, the JSY program significantly reduced perinatal and neonatal deaths, with an unknown effect on maternal mortality. The authors suggest that the incentive scheme be tied to antenatal visits to increase this type of care. Lim et al. also argue that the increased workload for health delivery personnel requires the Indian government to "maintain and improve the quality of [available] obstetric care" through "continued independent monitoring and evaluation." *Link*

Innovative Health Service Delivery Models in Low and Middle Income Countries - What Can We Learn From the Private Sector

Bhattacharyya et al., Health Research Policy and Systems 2010

In a review of private sector health service delivery models, Bhattacharyya et al. review 10 case studies to discuss innovations in "marketing, financing and operating strategies" and the potential for these models to increase effectiveness and access in resource poor areas. The authors selected ten private sector health organizations in Latin America and South and Southeast Asia, including Aravind Eye Care System in India, Greenstar Social Marketing in Pakistan, Top Reseau social franchise in Madagascar, among others. The authors found that organizations have successfully applied social marketing practices to address taboo subjects and educate populations to change personal behavior. The authors note that successful organizations, such as Jaipur Foot, also have tailored services to meet the needs of poor clients and have used social franchising principles to increase quality and access. The authors found that organizational financing was oriented to increase affordability for poor customers by lowering operating costs, accomplished by simplifying medical services and using "less than fully qualified providers," by providing a high volume of services with low unit costs, and by allowing wealthier patients to cross-subsidize poorer ones through a tiered payment system or promoting charity care among providers. In addition, all the organizations reviewed modified their operating strategies to expand access by using lay health workers or telemedicine, or improving efficiency through altering practice habits or products. Bhattacharyya et al. note that the organizations studied

employed a narrow clinical focus but used "multiple innovations allowing them to market their services on a large scale, reduce costs, and streamline operations to target poor patients effectively." The authors stress a need for better information on quality of care and suggest that "linking future investment to robust measures of social impact would help identify effective approaches" and ultimately expand the scope of successful services. *Link*

Tuberculosis Management by Private Providers in Mumbai, India

Udwadia et al., PLoS ONE 2010

Udwadia et al assess tuberculosis management by private providers in Mumbai, India and find widespread inappropriate prescribing practices and minimal contact with a national tuberculosis program. The authors tested 106 doctors in the Dharavi slum in Mumbai on their ability to report appropriate prescription practices and treatment plans for patients with tuberculosis or multi-drug-resistance TB. Only 5.6% of the physicians surveyed reported an appropriate drug regimen. The authors report that the surveyed providers prescribed over sixty different drug regimens and only 4.7% reported prescribing an appropriate treatment regimen for multi-drug resistant TB. The surveyed private providers were more likely to over-treat normal tuberculosis and under-treat MDR tuberculosis and none had contact with the Revised National Tuberculosis Control Programme (RNTCP), which over the last decade has trained providers in DOTS treatment as well as provided "public-private mix schemes that define the input of the public sector and expectations from the private sector and offer financial assistance." The authors suggest accurate tuberculosis treatment can be fostered with parallel approaches including: an expansion of public-private initiatives, a certification program by the RNTCP, and support to intermediary professional association. *Link*

Analyses of Non-Profit Pharmacy Costs, Revenues and Profit in Rural Kyrgyzstan

Waning et al., BMC Health Services Research 2010

In a study of not-for-profit pharmacies in rural Kyrgyzstan, Waning et al. find mark-ups of prescription drugs necessary to maintain financial solvency and network sustainability. Waning et al. studied twelve pharmacies and one warehouse in the rural Jumgal district of Kyrgyzstan established through a public-private partnership to increase access to high-quality medicines in the region. In a three-year longitudinal analysis, the authors found that mark-ups on medicines grew annually during the study period, with "the vast majority [of the top selling medicines] marked-up well above 50% and 100%" by the end of the study. Pharmacy revenues were "highly erratic in the first two years of operations, likely due to inconsistent delivery of stock replenishment and seasonal variation in medicine use," and most pharmacies operated at "break-even levels over the entire study period." The authors argue that the high mark-ups on medicines were necessary to sustain the pharmacy network given the initial variability in costs and profits, despite "government subsidies and cost-sharing arrangements." They argue that mark-up variability was used to allow for sales of higher demand medicines to cross-subsidize other medicines. The authors suggest that mark-ups could be redistributed, so that low mark-ups could be used to encourage the use of key essential medicines whereas high markups could be used to discourage the use of non-essential medicines. Additionally, the authors note that the results from not-for-profit pharmacies could be used for for-profit pharmacies in the region. *Link*

The Impact of a Quality-improvement Package on Reproductive Health Services Delivered by Private Providers in Uganda

Agha S. Studies in Family Planning 2010

Agha evaluates the effect of a quality improvement package for rural reproductive health service providers in Uganda. This package includes a form for reviewing changes in service statistics, a self-assessment tool for quality indicators, and an action plan to help improve on aspects identified in the self-assessment tool. Quality self-assessments included six dimensions of service provision including: "physical environment, technical competence, continuity of care, management, marketing, and business practices." The package also included a tool to allow district supervisors to monitor progress on quality areas. The study included nearly 300 midwives employed in independent private practice in Uganda and part of a national midwives association. In a comparison between case and control groups, Agha notes that following the intervention, the experimental groups showed significant improvements in structural aspects of quality, including infrastructure, availability of service, business practices; as well as process aspects including counseling and technical aspects of service provision in family planning and antenatal care. The intervention was less effective in improving continuity of care, marketing, and organization and management of patient records and stock. Agha notes that areas showing the most improvement overlapped significantly with areas the providers self-identified prior to the intervention. The author finds that the presence of a supportive supervisor was necessary for monitoring progress, identifying "root causes of performance problems," and "enabling midwives to improve quality of care." Agha contends that the quality improvement tool could be a great asset for improving quality among small-scale private providers in reproductive health care who are part of a network or franchise. He also notes that the tool "should be combined with … trainings in areas that are identified [by providers] as being." *Link*

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