PRIVATE HEALTHCARE IN DEVELOPING COUNTRIES NEWSLETTER, NO. 6 SEPTEMBER 2009

Private Healthcare in Developing Countries

NEWS & EVENTS

9/17/09

Recent Initiative Uses Text Messages to Report Essential Drug Stock-outs

A new initiative by Health Action International and a coalition of NGOs is using text messages from members of the public and health workers to report stock-outs of essential medicines at local clinics and pharmacies. The initiative, currently underway in Kenya, Malawi, Zambia, Zimbabwe, and Uganda, provides real-time information on medicine supply levels to facilitate improved forecasting and supply-chain management in these countries. Link

8/11/09

Public-Private Partnership to be Launched in Kenyan Public Hospitals

Several public hospitals in Kenya are set to receive over $300 million dollars of investment from private equity funds in exchange for private management. The investment will be used to upgrade facilities, expand provider networks, improve the quality of healthcare services, as well as increase access for low-income individuals. Similar private-equity funded public-private partnerships are planned for Tanzania, Nigeria, Rwanda, Ghana, and Cote d'Ivoire. Link

Above: A Chiranjeevi participant, with child, in Gujarat, India

Maternal Healthcare Financing: Gujarat's Chiranjeevi Voucher Scheme

Bhat et al., Journal of Health, Population, and Nutrition 2009

In an assessment of a maternal health voucher program in Gujarat, India, Bhat et al. find the program appropriately targets the poor and results in significant savings. The Chiranjeevi scheme provides vouchers to expectant below-poverty-line mothers to reimburse them for the out-of-pocket costs associated with delivery, antenatal care, transportation, and accompaniment at a private provider. The assessment found that mothers enrolled in the scheme paid less than one-fifth as much as mothers not enrolled in the scheme, had a marked increase in antenatal services, and were significantly more likely to give birth in an institution. Assessment of the program also confirmed appropriate targeting of the poor. Deficits of the program included a low rate of post-natal care, and a failure to make delivery cost-free for mothers. Bhat et al. note that purchasing maternal health care packages in bulk from private obstetricians allowed for a significant economies of scale compared to market rates. *Link*

A Comparison of the Quality of Family Planning Services Provided in the Public and Private Sector in Kenya

Agha and Do, International Journal for Quality in Health Care 2009

Agha and Do's comparison of the quality of Kenyan family planning services in the private and public sectors reveals that private facilities maintain better infrastructure and service availability. Private providers were open for more days per week, more likely to have a trained provider present, in closer proximity to patients than public providers, and had shorter wait times. However, public facilities were noted to have better management, in particular stronger formal systems to review medical issues, stock organization and security, operating protocol, and record keeping. The authors noted that private facilities maintained higher provider motivation because of increased incentives and an appropriate workload. The authors found no significant quality differences between public and private facilities in technical performance or interpersonal processes, but clients reported more than twice the level of satisfaction with their experience in the private sector over the public sector. Controlling for structural and process differences, the odds of a client being satisfied at a private facility is three times higher than a public facility, suggesting client satisfaction may be affected by pre-service perceptions of higher quality in the private sector. The authors note further comparisons in quality of care between the formal and informal private sector are needed. *Link*

Severe Road Traffic Injuries in Kenya, Quality of Care and Access

Macharia et al., African Health Sciences 2009

In an analysis of road traffic injuries (RTIs) in Kenya, Macharia et al. found broad differences in access and quality of care between public and private facilities. The authors note that accidents primarily occur in commuter mini-buses (70%), that the rate of seatbelt usage is less than two percent, and non-health professionals deliver the overwhelming majority of post-accident transportation (92.5%). The primary site of care for

RECENT CONFERENCES

9/10/09
Franchising in Frontier Markets
Washington, DC.
IFC & John Templeton Foundation brought together investors, researchers, and implementing agencies for a workshop to discuss franchising based approaches to business development in low- and middle-income countries, including health social franchising initiatives.
[Blog summary of meeting]

9/16/09
Increasing Access to Health Services Through Social Franchising
Bellagio, Italy
A UCSF GHG led workshop on social franchising effectiveness and best practices. Updates on expansions into new technical areas were discussed, as well as planned and ongoing research on health social franchising.

9/21/09
Making Partnerships Work for Health: The Role of the Private Sector
Berlin, Germany
KfW & Bayer convened an expert group meeting to review programs on the private sector, particularly emphasizing PPPs and OBA initiatives.

9/25/09
Public Private Cooperation to Improve Healthcare in Low-Income Countries
The Hague, Holland
The Dutch Ministry of Foreign Affairs & Marie Stopes International organized a meeting to discuss the role of the private sector in health system finance and delivery.

Above: A hospital in Sao Paulo, Brazil

RTIs was public health facilities (72.3%) followed by private faith-based hospitals (15.6%), and ordinary private hospitals (12.2%). The authors attribute public hospital dominance to private hospital demands for monetary deposits prior to providing treatment. Macharia et al. note lower wait times in private hospitals compared to public and religious hospitals, and higher patient-rated quality of care in both religious and private hospitals when compared to public facilities. Public hospital personnel also report a low preparedness to handle trauma emergencies, with low levels of necessary supplies on hand. Recovery of RTI victims to full physical health was low in all sites of care, with the rate of permanent disability estimated at 72.4% in public hospitals and 86.7% in private hospitals. *Link*

Public-Private Partnerships and Public Hospital Performance in Sao Paulo, Brazil

La Forgia and Harding, Health Affairs 2009

La Forgia and Harding assess the performance of public hospitals run by NGOs in Sao Paulo, Brazil. The PPP for hospital operation by contracted NGOs was based on rigid performance specifications to address governance and accountability issues in public hospitals. The contracts allowed the NGO operating agency increased managerial autonomy and altered the government's role from service provision to monitoring the performance of contract specifications in volume, quality, and reporting. In a comparison between PPP hospitals and neighboring public hospitals, the PPP hospitals noted increased efficiency with fewer providers and no significant difference in quality. La Forgia and Harding contend that the PPP model created an "enabling incentive and accountability environment for human-resource and managerial practices that improved performance." Integral to this process was the increased autonomy allowed in recruiting, selecting, and dismissing personnel. *Link*

Public and Private Sector Treatment of Malaria in Lao PDR

Nonaka et al., Acta Tropica 2009

In a study of care-seeking behavior, Nonaka et al. find the formal and informal private sector crucial in the continuum of care for malaria treatment in Lao PDR. The authors' analysis reveals that more than a third of first-line malaria treatment occurs in the private sector, primarily in private pharmacies and with traditional healers. The researchers found that more than half of individuals initially receiving treatment in the public sector migrate to the private sector for secondary sources of care. More than a third of individuals who begin treatment in the private sector stay exclusively within the sector. However, this varies by provider type: as also shown in previous studies in Africa, a large majority of patients (86.1%) in Lao who began treatment with traditional healers switch to a public care provider. The authors argue that the demonstrated care-seeking patterns necessitate collaboration between the public and private sector for malaria treatment to strengthen follow-up and referral systems for acute issues. They also call for an expansion of artemisinin combination therapy treatment in the region. *Link*

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