Private Healthcare in Developing Countries

NEWS & EVENTS

2/03/11
Private Sector Working Group Meeting
Washington DC

The PSWG will meet at the Public Health Institute to plan for coordination over the coming year

2/15/11
Abstracts due - iHEA Private Sector Symposium
Toronto

The 2011 Congress of the International Health Economics Association in Toronto Symposium on the Private Sector in Health. Submit abstracts here.

2/17/11
Healthcare in Asia Conference on Public and private healthcare delivery
Hong Kong

The Economist Intelligence Unit is holding a two day conference on the role of the private sector in healthcare provision in Asia. The conference is focused on East and Southeast Asia, looking at policy and investment. link.

3/29/11
e-conference: Expanding Access to Finance for Health

Strengthening Health Outcomes through the Private Sector organizes an online conference. More information here.

Utilization of HIV-related Services From the Private Health Sector

Wang et al., Social Science and Medicine 2011

In an analysis of Demographic and Health Surveys of twelve African and Latin American countries, Wang et al. find a robust level of participation of the private sector in HIV-related service delivery and an unclear association between service participation and socioeconomic standing. Analysis of HIV testing reveals that the majority of HIV testing occurs in public facilities, with low rates of testing (between 2.6% and 23.6%) occurring in the private sector. HIV testing in non-governmental organization facilities was generally less common than in the private for-profit sector. Among the population seeking care for sexually transmitted infections, the authors find a larger reliance on the private sector for care. In the two countries surveyed in the Latin American region, Guyana and Haiti, a larger percentage of the populations received STI care from the private sector than the public sector. Several countries show a significant association between wealth and both HIV testing and STI care, however there was no association between wealth and use of for-profit or non-profit services. The authors argue that the private sector plays an integral, if variable, role in HIV related services in developing countries, and "as the global approach to the AIDS epidemic continues to evolve from an emergency response to a sustained effort, and as levels of donor funding become less certain due to the current global economic crisis, it is critical to explore options for efficiently engaging all sectors of the health system to maximize the AIDS response." Wang et al. also note concern that "large amounts of donor money flowing into countries may have a 'crowding-out' effect on the private sector in providing HIV services." *Link*

A Maternal Health Voucher Scheme: What Have We Learned From the Demand-Side Financing Scheme in Bangladesh?

Ahmed and Khan, Health Policy and Planning, 2011

In a case-study evaluation of the Bangladeshi government Maternal Health Voucher Scheme, Ahmed and Khan find limits in efficiency, performance, and market competition among healthcare providers but an expansion of services and increased provider satisfaction. The scheme operates in 33 Bangladeshi governmental sub-districts with the aim of reducing financial barriers to maternal health service access. Voucher recipients can obtain three ante-natal care visits, safe delivery at a facility or at home with a skilled birth attendant, a post-natal care visit, complication management, transportation costs, and a nutritious food stipend and gift box. The government reimburses selected public, private, and non-governmental providers for providing these services; while private providers are reimbursed in full at set rates, public providers are reimbursed partially with available "seed funds" deposited for "improvement of service provision, repair and maintenance of the health facility, and for any other activities related to maternal and child health/ survival." Stakeholder interviews in the Jamalpur sub-district revealed problems with the program's implementation, including reimbursement delays and inconsistent voucher distribution to beneficiaries due to inadequate administrative and financial resources. Interviewees nonetheless noted a marked increase in demand for services, "especially by the poorer sections of the community." The authors contend that the selection criteria in the district, which

limited voucher delivery to mothers with less three pregnancies to discourage additional births, may be unfair to women with larger families, who are more likely to be poor. The authors additionally note that the lack of a private facility in the study district prevented competition amongst providers, which was intended to spur increased quality. Ahmed and Khan conclude that although the vouchers did increase purchasing power among poorer women and expand utilization, districts must ensure the health system is ready to meet increased demand. *Link*

The Use of Vouchers for Reproductive Health Services in Developing Countries: Systematic Review

Bellows et al., Tropical Medicine and International Health 2011

Bellows et al. review thirteen reproductive health voucher programs in Asia, Africa, and Latin America, finding promising quantitative evidence that the programs increase women's use of reproductive health services and improve quality of care and population health outcomes. Most voucher programs offered women multiple reproductive health services through contracts with both public and private providers. Bellows et al. find that overall, the programs successfully targeted needy populations, lowered costs, and increased participant's reproductive health knowledge, without contributing to unnecessary treatment. The programs, however, did nothing to increase user satisfaction or health provider knowledge. Although only three studies reported population health outcomes, one program in Taiwan significantly reduced the birth rate, and two others in Nicaragua and Uganda significantly lowered the prevalence of sexually transmitted infections. Although the studies were primarily "cross-sectional or before-and-after without controls and thus not considered particularly strong study designs," the authors contend that the "potential for reproductive health voucher [programs] appears positive." *Link*

Private and Public Health Care in Rural Areas of Uganda

Konde-Lule et al., BMC International Health 2010

Konde-Lule et al. survey health care services in rural Uganda, analyzing quality, cost, and utilization of care rates between private and public rural providers. The authors mapped 445 health care providers in the rural Iganga, Mpigi and Masaka regions. More than three quarters of all mapped providers were informal private providers, primarily traditional healers and drug shops. Of the 102 formal healthcare providers mapped, 18.6% were public, 6.9% were private not-for-profit, and 74.5% were private for-profit. Using a household survey of health care utilization, the authors found that of people who sought care for illnesses "37% visited a public health care provider, 11.8% a [private not-for-profit provider], 40% a [private-for-profit provider] and 10.6% a traditional practitioner." Individuals of lower socioeconomic status were significantly more likely to engage in care at a public facility. Proximity and skill levels were the most important factors in engaging in private care. Non-emergency medical care seeking generally was constrained by finances, transportation, and poor quality care availability. Konde-Lule et al. also found that despite accounting for more than two-thirds of health care providers, traditional practitioners received only 5.8% of all visits. In conclusion, they contend that the size of the private sector demands a "more active engagement … in public health promotions," however, the variegated nature of the private sector also requires "an appropriate policy and regulatory environment" to advance quality of care. *Link*

Health Insurance Systems in Five Sub-Saharan African Countries: Medicine Benefits and Data for Decision Making

Carapinha et al., Health Policy 2010

Carapinha et al. survey the benefit scope of thirty-three health insurance programs in Ghana, Kenya, Nigeria, Tanzania, and Uganda, finding that most programs were private-for-profit schemes with voluntary enrollees from urban areas. Almost all programs covered primary care outpatient visits and inpatient medical treatment. The programs limited costs through use of formularies, cost-sharing, mandatory generics, and required dispensing from public pharmacies. Insurance companies also permitted prescriptions only for medicines from National Essential Medicines registries, with favorable cost-effectiveness, and with availability at "negotiated prices." Demographically, the authors found enrollees more likely to be employed in the formal sector and saw little coverage of "pensioners, informal sector workers, the unemployed, or the poor." They report that "two thirds of health insurance programs mentioned fraud as a serious problem," noting how limited data available to health insurance companies created difficulty in efficiently managing benefits and reducing fraud. The authors note a need for further data collection to address the "impacts of corporate status, revenue sources, structural relationships with health care facilities and dispensaries, and membership profiles" of existing health insurance programs. Carapinha et al. conclude that existing health insurance systems need "strong government commitment and international donor support" to expand coverage to poor and vulnerable groups in the region. *Link*

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