THE PRIVATE SECTOR IN HEALTH CARE DELIVERY – POTENTIALS AND CHALLENGES

CONFERENCE REPORT

September 26-28, 2006
Jinan, Shandong, China
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STATEMENT BY PARTICIPANTS

SHANDONG CONFERENCE ON THE PRIVATE SECTOR IN HEALTH CARE DELIVERY

Researchers from a collaborative international programme on the role of the Private Sector (PSP) in health and policy makers and international scholars met in Jinan, Shandong Province, China, September 26-28 September 2006 for a conference on “The Private Sector in Health Care Delivery – Potentials and Challenges”.

The conference heard findings from six countries involved in the PSP programme: China, India, Laos, Vietnam, Uganda and Zambia. Researchers and policy makers from China also shared experiences regarding private sector involvement in health in China. Presentations were also given by scholars from the World Health Organization, The Alliance for Health Policy and Systems Research, the Bangladesh Rural Advancement Committee (BRAC), the World Bank, UCLA, Harvard School of Public Health, and Karolinska Institutet, Sweden.

Major study findings were shared during the conference:-

- Findings from two districts in Zambia indicate that informal providers constitute more than 75% of health care providers.
- District level studies in Uganda show that people’s positive assessment of the skills of informal providers contributed to their decision to use these providers. Yet, very little is still known about quality of care among informal health care providers. More information is needed on how less than fully qualified providers can be better utilised by governments to deliver services, especially in underserved areas.
- Research conducted in Guangdong, China, indicated that health services offered by private qualified providers are growing rapidly and that patient satisfaction is generally higher among clients of private health care providers than among those of government health providers.
- In Shandong, China, study results showed that over 60% of ambulatory services are provided through private providers in rural China. No significant differences among rural government and private primary care providers were detected in their “appropriate” prescribing behaviour.
- Studies conducted in India showed that pharmacists, village health nurses, qualified doctors and less than fully qualified providers are all potential partners to the government in HIV/AIDS control.

Based on this, and a wealth of other data presented at the conference, participants concluded that private health care providers are a significant part of national health systems in most low- and middle-income countries (LMC) today. Private sector providers already account for a large share of access to basic health care services and they
contribute significantly to public health outcomes. Public-Private Partnerships (PPP) have emerged as one of the main areas of innovation in health development; such partnerships can be created around health care provision, research, technology and communication and other relevant fields of work. There are many mechanisms through which the public sector can work with non-governmental providers, including the provision of subsidies, training and technical strengthening, contracting out and in, and regulation. More information is needed on how these mechanisms can be optimized for improved health outcomes.

Meeting participants noted that inadequate attention, at both global and country levels, is paid to critical issues around the growth and role of the private health sector in health care delivery. Too often, governments do not have clear policy frameworks to guide their engagement with the private sector. The lack of basic, routine data on the size, form and behaviour of the private sector is an impediment to sound strategic policy development. Furthermore there is limited global knowledge on the effectiveness of different mechanisms to engage private sector providers.

In light of this, participants at the meeting jointly called for:-

- **Governments in low- and middle-income countries** to give greater recognition to the role that the private health sector plays and to develop clear policies that can guide national and local governments work with the private sector, as strategic partners in health care delivery, with the aim of strengthening public health and access for all to health services.

- **Governments in low- and middle-income countries, their development partners, and international collaborators** to invest in developing reliable, routine information on the private health sector, through, for example, the development, conduct and analysis of regular facility surveys, complemented by other routine data sources where feasible.

- **Research funders** to increase their investment in synthesizing existing studies and conducting new research, especially on well designed and rigorously evaluated intervention studies. This should increase knowledge on the effectiveness of tools and mechanisms that governments can use to engage the private sector, to help reach the poor and promote good quality care; all for improved health outcomes.

Meeting participants acknowledged that the time is ripe for a broader, more open network to be created for scholars and policy makers interested in issues related to the role of the private sector in health care delivery and public health. Such a network should be centred around the need to generate more evidence and knowledge on the way private actors operate and how they can be engaged in improving health care and health outcomes. Meeting participants undertook to investigate how the existing PSP collaboration could be transformed into such a platform for the exchange of policy-oriented evidence and debate.
On behalf of the Conference Participants

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<th>Birger Carl Forsberg</th>
<th>Yuanli Liu</th>
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EXECUTIVE SUMMARY

A conference on “The Private Sector in Health Care Delivery – Potentials and Challenges” was held in Jinan, Shandong, China, September 26-28, 2006. It was organised jointly by the Centre for Health Management and Policy, Shandong University, Jinan, the Division of International Health (IHCAR), Karolinska Institutet and the International Health Systems Program (IHSP), Harvard School of Public Health. It was the third international conference within the research programme called Private Sector Programme in Health (PSP). The focus of the conference was “How can partnerships with the private sector improve health services and public health outcomes?” Studies have been going on in six different countries since 2002; China, India, Vietnam, Lao PDR, Uganda and Zambia, to provide evidence for policy making in this area. In addition to reports from these country studies, several papers on private sector issues were presented by invited international experts from the World Bank, World Health Organization, UCLA, and BRAC, Bangladesh. Lastly, the conference provided ample space for presentations and discussions on the development of private health care and private financing in the People’s Republic of China.

The conference provided further evidence of the significant role that the private sector is playing in low- and middle-income countries. It also gave examples of how the private sector has been involved in productive collaboration with the public sector through various types of public-private partnerships.

A major conclusion from the conference was that partnership as a concept need to be further defined. From what we can see from the studies partnership can be divided into at least three categories; co-existence, competition, and collaboration. It is hard to find real evidence on “true partnership” where both partners work together and share the same vision. It is rather two partners working together with more or less different visions. The private providers have challenges of their own such as profitability, the legal framework, staffing etc. The public sector is struggling with funding, efficiency issues and the political pressure to reach the entire population with basic health services.

Another important conclusion from the conference was that partnership is not always desired by either side. Governments are not always willing to share their responsibilities with the private sector, often fearing that they would be held accountable for things they can not control. The private sector on the other hand has a tendency to look upon public providers as their competitors, both in terms of clients but also in terms of resources, not least human resources. The vision to improve public health outcome by collaboration between public and private providers is thus pushed down the agenda.

This underlines the importance of providing policy makers with evidence on what works and what could be achieved by partnership between the two sectors. Evidence from Uganda, Zambia and Bangladesh show that a closer collaboration between the two sectors has made public health priorities known to the private providers and to a certain extent
The private sector in health care delivery – potentials and challenges

contributed to more efficient national health planning. On the other hand, evidence from China and India show that if you do not develop a partnership between the two sectors, public health outcomes will suffer, not least in terms of equity in access.

What can be seen in many of the countries that have been part of this study is in fact a privatization by default. The public sector has for different reasons not been able to fulfil its ambitious plans to provide health services to the population, thus unintentionally creating a “market” for health services. This opportunity has quickly been seized by entrepreneurs in the health sector, many of which are coming from the public sector, responding to a demand from the population. As a result of the Private Sector Programme quite a lot of evidence is now being produced. It is, however, important to make sure that the evidence is being translated into policy at country level.

Conference participants agreed that conclusions from the conference should be summarized in a “Shandong Statement” to be circulated widely. It was also agreed that efforts should be made to develop the PSP into a wider network for researchers and policy makers with interest in private sector issues.

Dr Tang Shenglan WHO Beijing, Mr Pär Eriksson Sida, Prof Zhan Tao Shandong University, Dr Liu Yuqin Shandong Health Department, Birger Forsberg Karolinska Institutet Stockholm, Yuanli Liu Harvard School of Public Health Boston, Prof Quingyue Meng Center for Health Management and Policy Shandong University Photo: Jesper Sundewall
BACKGROUND

In 2002 a collaborative research programme on “The Role of Non-Governmental Health Care” (called Private Sector Programme in Health - PSP) was initiated by the Division of International Health (IHCAR) at Karolinska Institutet, Stockholm and the International Health Systems Program (IHSP) at the Harvard School of Public Health, Boston. The objective of the programme is to strengthen health systems’ performance and outcome in terms of improved health. Specifically, the programme seeks ways through which the non-government health sector can be involved in providing health care to the population, with a special focus on those in most need. The programme is carried out in collaboration with eight organisations in six countries, one of them being the Centre for Health Management and Policy at Shandong University in Jinan.

The programme has organised workshops for the PSP collaborators in Stockholm in 2002 and 2004 and sessions at the iHEA World Conferences in San Francisco in 2003 and Barcelona in 2005 where findings from the PSP research has been presented.

The Private Sector Programme seeks to share experience and knowledge among the organisations involved and others interested in private health sector issues in low- and middle-income countries.

There is a continued need for sharing ideas and discuss experiences within this programme and with others who are working on issues related to private health care. For this purpose, a workshop on the potential and challenges for the private sector in improving health was held in Jinan, China in September 26-28, 2006.

WORKSHOP OBJECTIVES

The objectives of the workshop were to

- Contribute to the understanding of the private health care sector in low- and middle-income countries;
- Identify and discuss the potential for the private health care sector in contributing to overall health improvements, including the attainment of the Millennium Development Goals (MDGs);
- Identify and discuss the challenges that the private health care sector represents to national and international organisations seeking to ensure good quality care and cost-effective delivery of primary care interventions for improved health;
- Define key issues for
  - continued research and
  - actions

all to improve the contribution of the private health care sector to overall health improvements.
PARTICIPANTS

The conference was attended by 28 international participants, 54 Chinese researchers, policy makers and health care managers and 60 Master and PhD-students and staff from Shandong University. A list of participants is found in Annex 1.

ORGANIZERS

The conference was organised by The Center for Health Management and Policy, Shandong University and The Division of International Health at Karolinska Institutet, in collaboration with the International Health Systems Program at the Harvard School of Public Health. The conference was supported financially by Sida (The Swedish International Development Cooperation Agency) and Shandong University.

PROCEEDINGS

The conference was organised into sections of work. The first was an opening session with a key note address by Professor Peter Berman. The second was on Working with the Private Sector - Experiences and Issues. The third was on Developing Public-Private Partnership in China: Policies, Practices, Major Issues, the fourth on Innovations in Establishing Public-Private Partnerships with international perspectives, and the fifth on Findings from the Private Sector Programme on comparing public and private health sector performance. The final session was on how to move the programme forward with details on next steps in the collaboration. A summary of the deliberations in each of the sections is given below.

OPENING SESSION

Professor Zhan Tao, President of Shandong University, gave a welcoming speech on behalf of the Shandong University. The Shandong University was founded in 1901. The university is deeply rooted in Chinese culture under a strong influence from Confucius’ thinking. The university has 50,000 students. The university would like to expand its international network and collaboration with organisations overseas. The Centre for Health Management and Policy is a good example of active involvement in policy making at local and central level and collaboration with the rest of the world. Professor Tao welcomed all participants and wished them and the organizers great success with the conference.

The next speaker was Dr Liu Yuqin from the Shandong Department of Health. On behalf of the department and the province of Shandong she wished all welcome to the very important conference on private sector development and collaboration between the public and the private sectors. A brief on Shandong province was given. Shandong is located on the east coast of China. It has 90 million people and a surface of 115,000 km². It is a
beautiful province with Mountain Thai and Confucius’ home town Qufu as best known sights. The province is undergoing rapid economic development. The health status in the province is overall good. The infant mortality rate is 11.7/1000 and the maternal mortality rate 21.3/100 000. A new rural medical scheme covering 39 million people has been established. In 2005, 17 cities started building and establishing medical facilities. Work on the public health system has also been intensified. The provincial department is actively looking for international cooperation to learn from best practices in the world.

The department and the province are facing some challenges that they are fully aware of. The medical system does not meet the demand for services from the public. Accessibility and affordability are two important issues that need to be addressed. The socialist model does not respond fast enough to the market demand. That is why it is believed that the private sector is an important and complementary part. This conference is therefore important, bringing in best practices from other countries.

**Pär Eriksson**, representing The Swedish International Development Cooperation Agency (Sida), then gave a brief talk in which he expressed his appreciation of the conference and conference arrangements. He was very impressed by the conference program and the size of the conference. He saw both as signs of how important this issue, Public-Private Partnerships (PPP) in health, is. Eriksson said that we need to move forward on PPP for health improvements. In most countries where Sida provides assistance to health development the private sector is a major provider of health care. Traditionally, Sida and other development partners have mainly focused on public health care for delivery of services in an equitable way. Working with private providers has, however, now come to be seen as an additional way of increasing access to services. More and more aid is channelled through general budget support as agreed on in the Paris Declaration. Sida is supportive of this trend. In the light of this, finding ways of making use of the private sector has become an even more important issue, a reason why this conference is important and Sida is happy to be part of it.

**Dr Tang Shenglan** from the WHO Country Office in Beijing then gave an overview of some key characteristics and issues around private health care. The private sector plays a very significant role in provision of health services in low-income countries. Data from India and China indicate that 34-96% of children who seek treatment for diarrhoea go to the private sector. Private providers are perceived as more responsive to the needs of the consumers. Also, they are more accessible to many people. However, quality in the private sector is very heterogeneous. There is overuse of antibiotics and IV fluids. Many private providers lack adequate training. Unnecessary testing is carried out, even though many providers know the tests are not required. For these and many other reasons, it is a challenge to provide services in the private sector in a cost-effective way. In China, drug wholesale and distribution is a major problem. Drug provision has been privatized and it has contributed to irrational use of drugs in both the private and public sector. The cost of that irrational use has been estimated at 180 billion Yuan. Dr Shenglang hoped that the
Private Sector Programme in Health and the conference will help the Chinese government to address some of these problems.

Dr Birger Carl Forsberg from IHCAR at the Department of Public Health Sciences, Karolinska Institutet and coordinator of the PSP programme, expressed thanks and appreciation on behalf of the programme to the Centre for Health Management and Policy at Shandong University for the support and organization of conference. In particular, he extended his thanks to Professors Qingyue Meng and Jiangbin Qu.

Dr Forsberg gave a brief overview of the Private Sector Programme in Health. The overall objective of the programme is to improve health and health care delivery. It involves eight institutions from six countries: Uganda, Zambia, Vietnam, Lao PDR, China and India. Coordination of the programme is provided jointly by IHCAR at Karolinska Institutet and Harvard School of Public Health. The programme started in 2002 and the collaborators have since met at programme conferences in Stockholm in 2002 and 2004 and at the iHEA conferences in San Francisco (2003) and Barcelona (2005). The conference in China is an achievement and it represents a new step in the development of the programme. It is also a great opportunity to meet and interact with colleagues and other stakeholders in China.

Through the programme, participating institutions have been able to conduct country studies through support from Sida and the Jaikai Foundation. A significant amount of interesting information has been collected through the studies and a large part of the conference will be spent on presenting findings from very different settings and contexts.

One of the advantages with the programme is that participants can learn from each other. Countries who are already working extensively with the private sector and countries that have a large private sector can communicate their experiences with the countries that are facing a rapid expansion of the private sector.

Associate Professor Yuanli Liu from the International Health Systems Program, Harvard School of Public Health, then took the chair and expressed thanks to the organizers, especially Professor Meng and Professor Qu on behalf of Harvard. Dr Yuanli said that “Shandong is a great place, you are here once and you feel like you are part of it forever.” Dr Yuanli told the audience that twenty Harvard students had been received by Shandong University earlier this year to look at the three different tiers of the Chinese health care system. They had been looked after in an excellent way.

Dr Yuanli acknowledged the financial support of Sida and the Jaikai foundation. Without the support from the Jaikai foundation, extensive PSP surveys would not have been carried out in Guangdong and Shandong province. Dr Yuanli felt that the conference took place at the right time and the right place. Now, the Millennium Development Goals (MDGs) are on the agenda. The main goals are yet to be achieved and it is recognized that governments cannot do it alone. “There are both market and government failures and we
need to think about how we can work in a constructive way to develop the role that the private sector can play in this process”, Dr Yuanli argued.

China is currently at a very critical stage. Early next year, the government of China will present a number of brand new health policies that will shake up the health system significantly. The role of the private sector in this policy process is almost completely ignored. Hopefully, the discussions during the conference can help inform the policy makers and assist in the policy development process.

Dr Yuanli closed the introductory session by wishing all a fruitful conference with productive discussions as well as an enjoyable stay in Shandong.
MOVING FORWARD – NEXT STEPS

After the proceedings in which a number of papers were presented (given in the abstracts below) a closing session was held. Dr Yuanli Liu from Harvard School of Public Health gave a conference summary:

Participants of the conference had shared major study findings on the outcome of PSP, some of which involves primary data collection. Also, PSP collaborators had been given the opportunity to listen to guest speakers from the World Bank, WHO, The Alliance for Health Policy and Systems Research, BRAC, UCLA and China.

Private sector exists widely, all over the world. It exists in all forms and shapes – from faith healers in Africa to private tertiary hospitals in India. In whatever form or shape, they seem to have filled important gaps in the health care marketplace.

Most low- and middle-income countries have paid too little attention to the private sector. Fewer still have policy makers taking on private actors as strategic partners. One reason is that there is insufficient evidence on the public and private quality of care. There are many opinions on that quality but little evidence.

Where should the PSP go from here? Dr. Yuanli felt that there seemed to be two major tasks to consider in the next steps. 1. More comprehensive mapping exercises – both on the public and private sector as the two sectors always operate in relation to each other and not in vacuum. 2. Intervention and intervention evaluation studies.

In their policy towards the private sector governments could be lead by three “Cs”: Co-existence, Cooperation and Coordination.

Dr Yuanli then raised an organizational question regarding the future role of PSP. The PSP could continue to work as a loose network of like-minded researchers interested in this area. Or, “we might want to think and dream bigger. We might want to develop PSP into a new international NGO (Global alliance for PPP in health care). PSP has certainly helped generate certain momentum, and we can do more through such an international organization.”

Birger Forsberg then gave suggestions on the next steps to be taken in the Private Sector Programme in Health.

The first step was to put together and distribute a conference report. Next was for all PSP participants to prepare abstracts to the next World Congress of the International Health Economics Association (iHEA) to take place in Copenhagen, July 8-11 2007 based on work carried out within PSP. Dr. Forsberg said that there would not be specific funding for PSP participants in the iHEA Congress but persons who have submitted abstracts for
presentation can apply for iHEA scholarships for presenters from low- and middle-income countries. Sida is a significant source of funds for those iHEA scholarships.

A third activity would be to prepare an article overview of issues related to the private sector in health and health care that could be published in an international journal of good standing.

For each of the institutions that have completed studies, an important task would be to finalize reports for those that have not yet done so, and for all to start preparing articles for scientific journals on the findings. The PSP secretariat at the Karolinska Institute as well as the IHSP group is prepared to assist in that process.

Concerning the idea of Dr. Yuanli to let PSP grow into a wider network of scholars and policy makers with interest in private sector issues, Dr Forsberg said that efforts would be made to create a forum for discussing this idea in a wider audience at the iHEA Congress in Copenhagen.

In an ensuing discussion, support was expressed by several for the idea of a wider network. It was also suggested and agreed that a statement on the importance of further research on the role of the private sector and the need for a formalized network should be made by the conference participants. (The statement is included in this report.)

Forsberg concluded by thanking all for a useful and productive conference. In particular he thanked the organisers, the Centre for Health Management and Policy of the Shandong University, the Shandong University and the Shandong Province for having hosted the conference in such an excellent manner. He expressed special thanks to Pär Eriksson from Sida for his personal engagement in the PSP throughout. He also thanked Sida for their financial support to the conference. Lastly, he thanked on behalf of all participants, Professor Meng and Professor Qu for all their efforts in making the conference a success.

Dr Forsberg extends words of thanks to Prof Meng. Photo: Jesper Sundewall
PRESENTATION ABSTRACTS

Public-private partnership in the health sector: past, current status and future development

Peter Berman
Harvard School of Public Health/the World Bank

Background
The discussion about the private sector has changed in recent years. The initial title for the research program organizing this conference was PSP, an abbreviation for Private Sector Providers. The program was aimed at looking at the role of individual providers in health service delivery. This is still a very important question, but it must now be placed in a larger context. Through current significant health systems changes taking place in the world, the scope for collaboration with the private sector has changed.

This presentation will provide an overview of trends in the development of interest and support for public-private partnerships in the health sector in developing countries. It will also explore some of the important factors affecting these trends and new directions that are emerging in public-private partnerships around the world.

Health systems trends
Many low- and middle-income countries are committed to a National Health Service model, often financed by taxes and services provided through government organizations. In such a model, there is not much room for a private sector. In reality, however, many countries have not evolved according to plans. It has also been seen that, with few exceptions, the National Health Service models have performed poorly. There has been insufficient financing for comprehensive benefits and weak management of public systems. As an effect, private financing and provision has become increasingly significant for all, not only for the urban population and middle- and upper-income groups.

In many countries, there used to be a large gap between reality and perception of the role and size of the private sector For example, when a study was presented in India in 1992 showing that 80% of health care expenditure was out-of-pocket and going mainly to private providers, government officials did not believe those figures. Since then, a number of studies have confirmed this picture and similar statistics are now reported in official government documents.

The potential of public-private partnerships
Public-private partnerships have emerged as one of the main areas of innovation in health. There is an increasing role of the private sector in research, technology development, and communication. True “partnership” however is more the exception than the rule. Public-private partnerships can involve much more than just private participation in health care
provision. There is a wide menu of options available to governments choosing to work with the private sector.

The private sector has usually been seen as a useful partner in financing and service provision. Now, it has also been recognized that the private sector can be included in input production (e.g. human resources), distribution of goods and commodities (e.g. insecticide treated bed nets), and managing demand side interventions (such as community health funds and voucher systems). All of these activities have significant potential for improving health services and outcomes over a wide range of health problems.

The government can work with different mechanisms for public-private partnerships;

• subsidies – providing real inputs or funding to non-government entities
• training and technical strengthening – increasing knowledge, skills and capacities
• contracting out and in – purchasing services from non-government entities
• regulation – using legal and administrative rules to affect non-government entities

Currently, some evidence exist on what works and what does not work, but there are still gaps in what we know, related to both sound evaluations of outcomes as well as comparative assessments of processes and costs. There are both risks and benefits to working with the private sector. Poorly developed partnerships with the private sector can make things worse so caution has to be taken when establishing partnerships.

Public-private partnerships are not a natural or easy fit for most developing country health systems, since almost universally these are based on an ideology of universal entitlement to government financed and provided care, although the bases for this entitlement differ. Partnerships imply joint participation in planning, decision-making and program management. It also requires sharing power, and often governments are reluctant to do that as it can challenge their authority and accountability.

New areas for public-private partnerships
The interest in, and need for, public-private partnerships reflect longer term changes in the health sector and its supporting environment which are not likely to be easily implemented. These include the weaknesses of public sector institutions, changes in organization of producers of inputs (both human and technological) to health systems, and growth in important knowledge and skills in the non-government sector. The changes have given rise to a much broader scope for public-private partnerships than the government-NGO partnerships that were the early innovations.

A number of new potential areas for public-private partnerships can be identified:

• Financing – New dedicated taxes (e.g. air travel tax) or commercial arrangements (e.g. the Global Fund’s “RED” initiative).
The private sector in health care delivery – potentials and challenges

- Research and development – Advanced purchase commitments (to stimulate drug development).
- New international counterparts – Foundations such as the Bill and Melinda Gates Foundation play a new and important role between the traditional donor organizations and the government. Those counterparts are becoming international intermediaries that are large enough to participate in national programs, but still remain autonomous private partners.
- Importing management skills to public sector organizations which are de facto managers of large networks of health care facilities.
- Health communications – where private organizations in marketing and advertising are today the technical leaders even in developing countries.

Conclusions
The changing scene for public-private partnerships poses some challenges for the future:

- Can public-private partnerships move beyond a marginal add-on to government health systems in many countries? There is a fundamental conflict with the commonly existing National Health Service model. Will governments take seriously a model in which they alone do not try to provide all services that people demand?
- How will public-private partnerships interface with trends towards decentralizing government systems? Knowledge must be generated to determine if these two strategies are alternatives or complements.
- Do governments have the capacity to manage large-scale public-private partnerships? Can governments develop and acquire the necessary skills to handle this task?
- Is “partnership” really possible? We need to understand how trust and cooperation can be built.
Private pharmacies in low- and middle-income countries: Problems and possibilities

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Introduction
There are enormous inequities in the world, for example in health spending, distribution of health workers and in access to essential drugs. Medicines essential for global public health problems is a human right. Yet, a large proportion of the world’s population lacks access to these. A potential solution advocated has been distribution through private pharmacies and drug shops.

Objective
To present experiences from private drug retailer services in relation to major public health diseases, problems and possibilities.

Methods
An informal literature review was conducted complementing the work of the research group (www.phs.ki.se/ihcar/hsp) in one of our priority health system research areas: private pharmacy service in general and diarrhoea, malaria, STD and TB management in particular. Possible links to control programs are explored as well as interventions to improve quality of care.

Results
Many governments have supported the exponential growth in private drug retailers the last 15 years with little efforts in regulating, continuing professional development and monitoring of quality of service. In Nepal only 20% of staff advised ORS to clients, the recommended treatment for diarrhoea. However educational interventions improved diarrhoea case management with increased ORS sales on average 30% in Kenya and 21% in Indonesia, compared to control (p<0.05). Non-recommended anti-diarrhoeals sales declined by 15-20% (p<0.05). TB treatment is commonly reported to be of suboptimal quality. In Ho Chi Minh City, Vietnam, thousands of TB patients buy anti-TB drugs each month in the 1,800 registered pharmacies, many without a prescription. An intervention in Bolivia showed decreased proportions of pharmacies selling TB drugs and increased referral to doctors. A study in Uganda showed low quality of STD treatment; only 9% were treated according to national guidelines. In Hanoi a multifaceted experiment improved quality of STD treatment tenfold from initially very low levels. Regulations have been shown to seldom function in the private sector. However an experiment in Laos with enforcement of regulations improved quality of private pharmacy service and significantly reduced substandard drug sales from 46% to 22% (p<0.001). Malaria is still a major killer in sub-Saharan Africa and studies from Tanzania have shown that drug store clients do not obtain malaria specific treatment where it is warranted. In Kenya an
educational program however achieved major improvements in drug selling practices for malaria.

**Discussion**
Today much public health is in private hands but disease control programs often fail to make appropriate links to private drug retailers. Evidence show low quality of service but also that improvement can be made by targeted interventions and human resource development. To achieve better impact of health programs a more systematic analysis of how to engage the private sector to deliver essential drugs and provide good quality services is required.
Evidence informed policy for the health system public and private sectors

Dr. Ulysses Panisset  
Research Policy and Cooperation, WHO, Geneva

Evidence-informed policy network – EVIPNet (www.who.int/rpc) is a program to promote the use of health research in policy-making and implementation of health policies. It brings together policy makers, groups of the society and researchers to facilitate decision making and policy implementation through the use of the best quality and safest scientific evidence available globally and locally. When resources are scarce, we cannot have the luxury of not using research evidence to implement what works better. The pilot project of EVIPNet concept was first discussed at the WHO ministerial summit on health research in Mexico in November 2004.

The network initiative is an experiment in itself. WHO intends to evaluate its process, outcomes and impact in order to decrease the gap between what we know and what we do. The network promotes a learning environment at country level in low- and middle-income countries in Africa and Asia.

EVIPNet will work by making existing research evidence (global and local) user friendly through evidence-informed policy briefs (which are context specific). Also, follow up of implementation will be conducted through evaluation and dissemination of best practices. Furthermore, knowledge gaps will be identified and research agendas developed and new systematic reviews will be promoted.

This presentation addresses the progress achieved in recent years in developing mechanisms to facilitate the use of research results and scientific evidence to address fundamental health systems policy-making and implementation issues. Considering a "systems approach," it argues that these mechanisms must address the high complexity of the private and public coexistence of health systems in developing countries in a context of rapid change, multiple and frequently contradictory interests and expectations, and limited resources. Although existing mechanisms in developing countries (such as EVIPNet) are initiated from the perspective of the public sector decision-making process, this presentation makes a case that these mechanisms must expand to consider implications of scientific evidence use in the private sector of health systems as well.

From the perspective of the public sector, the presentation raises questions on how can scientific evidence best inform health interventions in the private sector (either for profit or non-profit), for instance, in terms of ethical standards, legislation and regulations set by the public sector. In seeing the whole health system as fundamental to the improvement of the health situation of the entire population, the guiding principle of any mechanism to use scientific evidence to inform policy-making and its implementation, either in the
public or the private sector, must be the attainment of high quality, safe and effective policies that improve health equity.

Challenges for EVIPNet are to keep the momentum with few resources, pursuing the attainment of high quality, safe and effective policies that improve health equity. Also, the concept of EVIPNet is relatively simple. However, it develops in complex settings, within the health system.
Working with the private sector to expand service coverage: knowledge gaps and current research priorities

Dr. Sara Bennett
Alliance for Health Policy and Systems Research

Introduction
As part of its mandate to leverage additional resources for health systems research, the Alliance for Health Policy and Systems Research (HPSR) (http://www.alliance-hpsr.org) is in the process of defining priority research questions ("best buys") within three thematic areas, including the role of the non-state (or private) sector.

Objectives of the presentation
- Provide an overview of which topic areas within the broad theme of the role of the non-state sector have been researched and identify areas in which knowledge is better developed;
- Based on an analysis of emerging policy issues and the mapping of existing research, identify research priorities in the field.
- Seek feedback from the audience on what they believe to be priority research questions.

Methods
- Rapid literature search
- Consultations with existing research networks and partners engaged in priority setting
- Review of secondary data sources (e.g. minutes from ministerial meetings).

Findings and Discussion
While there are considerable regional differences in terms of values and attitudes towards the private sector, there is nonetheless considerable similarity in terms of research priorities identified. Vast amounts of research has already been undertaken and synthesized on means of working with private providers (e.g. on franchising and contracting), and there is a need to communicate this evidence base to policy makers.

When searching through the literature, the critical domains in the policy statements includes the view of the private sector as “partners”, “investors”, “employers” and “competitor for health workers”.

Neglected questions deserving of more attention in the future include;
- issues around health workers and the private sector
- understanding the ethical implications of commercialization of the health sector
- defining clear roles and functions for government with respect to the private sector (including minimum regulatory requirements).
Where are the current knowledge gaps?

- Synthesize research domain where evidence already exists, quality of care etc.
- Operational research on what real partnerships mean and when it works.
- Private sector and the health workforce; issues of dual practice, career paths etc.
- Understanding the market for health care.

Possible emerging domains are: the evolving role of NGOs, particularly briefcase NGOs, and the privatization of medical education.
Social health insurance in Vietnam – challenges in financing and service provision

Mr. Henrik Axelson
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Introduction
Vietnam introduced a set of reforms in the late 1980s to move from a socialist to a market economy. In the health sector, the reforms included introduction of user fees, authorization of private provision of health care services, and liberalization of pharmaceutical production. To address the potential negative consequences of user fees, Vietnam also introduced social health insurance. Social health insurance is seen by the government as the preferred option to achieve a stable, efficient, and equitable health financing system and the goal of universal coverage of health insurance has been established by several recent policy documents.

Objectives
• Provide an overview of the national health insurance system in Vietnam
• Explore the role of the private sector in health insurance

Findings and discussion

Health financing system
Generally, Vietnam has achieved good health outcomes: life expectancy is high and child mortality low. This is especially remarkable given the level of socioeconomic development (GDP/Capita US$ 600). However, the impressive health outcomes hide the fact that inequalities in health are widening. One of the key reasons for increased inequity is the way in which health care is financed in Vietnam.

There are several problems with the current health financing system. First, overall spending on health is relatively low (US$ 25 per capita, equal to 5% of GDP), particularly public spending, which only accounts for about 30% of total spending. Second, due to increased use of high-technology interventions and imported drugs and the way in which providers are reimbursed, health care costs have escalated rapidly in recent years. Third, there is limited financial protection against spending on health. This has the consequence that many households fall into poverty because of health expenditure. There are also significant access barriers for vulnerable groups, which leads to self-medication or delayed health care-seeking. Social health insurance is increasingly viewed as an appropriate policy instrument to address these problems.
Health insurance
Social health insurance was piloted already in 1989 and nationwide implementation was initiated in 1992. There is strong political commitment to universal coverage of key stakeholders such as the Communist Party, the National Assembly, and the Prime Minister’s office. However, while coverage has increased in recent years, only 40% of the population is currently covered. Ensuring the attractiveness of health insurance is therefore one of the challenges of the health insurance system in Vietnam, as is financial sustainability and gaining providers’ commitment.

Private health sector
The private health sector has grown rapidly in the last 10-15 years and now provides most of the curative care in the country. Many of the private providers are informal and unregulated. The private sector’s share of inpatient care is still very small (about 5% in 2002), but it is considered likely that it will increase.

The private sector in health insurance
Until recently, the Vietnam Social Security agency (VSS), which administers health insurance benefits, was not allowed to contract with private providers. However, this changed when a new health insurance decree was enacted in 2005. Private providers that contract with VSS must be licensed by the Ministry of Health and are reimbursed at the same rates as public providers. As of September 2006, a very small number of private providers had contracted with VSS. While it may be too early to interpret this low rate of contracting, it is likely that the low reimbursement rates are a major reason.

Challenges
Some challenges of contracting with private providers have been identified. First, quality of care is a major concern because the government’s capacity to regulate the private sector is weak. Second, the current reimbursement system, which is fee-for-service, gives incentives for over-provision of services.

Opportunities
However, the private sector also presents opportunities to the national health insurance system. First, it is clear that the private sector will continue to remain an important part of the health sector. It is likely that the private hospital sector will grow, which means that more private providers in the formal sector will be available for contracting. Second, the private sector can make an important contribution to the health system and to reaching national goals.

Conclusions
To take advantage of the opportunities of including the private sector in the national health insurance system, there is a need for the government to take on a different role within the health system, that of being a steward. Stewardship implies less focus on service provision and more focus on developing and monitoring policy, including the regulatory framework and instruments.
Comparing public and private hospitals in China: evidence from Guangdong

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Government and private roles in health service delivery remain controversial in many countries. Evidence on ownership differences in China’s health sector to date is limited and primarily derived from ambulatory services. Yet China’s recent hospital sector reforms including opening to private entry and ownership transformation (gaizhi) of existing government hospitals has led to a growing, albeit still small, private presence in inpatient delivery. Do government, private non-profit, and for-profit hospitals serve similar patients and compete, or do they specialize in niches? Does the quality of care differ systematically by ownership form? This study uses 2002 and 2004 data from over 360 government-owned and private hospitals in Guangdong Province to shed light on these important policy questions.

Our data shows that private hospitals, and particularly for-profits, are more likely than their government counterparts to be specialty hospitals. Even within general-acute hospitals, private hospitals seem to serve an overlapping but distinct market. They are smaller and newer market entrants. For-profits in particular have a higher percentage of outpatient visits for surgery, as well as a higher share of beds allocated to surgical departments. Private hospitals also are significantly less likely to receive a contract from a social insurance bureau to serve as an appointed hospital. However, almost one in five government hospitals in our sample is also excluded from social insurance, and a significant minority of private hospitals particularly nonprofits are included in the social insurance provider network. We also document differences in staffing and financial performance by ownership form, controlling for size, location, and other confounding factors.
Our multivariate results find that despite significant variation in quality across hospitals, ownership form is not systematically associated with higher or lower quality, after the effects of size and case-mix are taken into account.

Overall these findings seem to suggest that government and private delivery can play complementary roles in China’s evolving healthcare delivery system.
Reaching the poorest of the poor with health services: the case of BRAC’s CFPR/TUP programme in Bangladesh

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BRAC is an indigenous Bangladeshi NGO (http://www.bracresearch.org  www.brac.net) which seeks to alleviate the burden of the poor in Bangladesh. The organisation has 4.84 million participants in credit programme. 99.5% of them are women. BRAC runs 31,877 primary schools and engages 3,285 community health workers and 48,583 community health volunteers. 31 million people are covered by BRAC’s general health programmes and around 83 million by the organisation’s TB control activities. The organisation has 37,000 full-time staff.

Poverty undoubtedly has an impact on health. BRAC recognizes that health is a complex social phenomenon that requires integrated interventions, including improved household income. There are several barriers for poor people to access and utilize healthcare. Some of these are demand side related such as; lack of awareness, lack of access to information, lack of opportunity and inability to pay.

More than three decades of grassroots experience led BRAC to the realization that regular micro credit-based intervention is not enough to effectively reach the most vulnerable section among the poor, i.e. the ultra-poor. Ultra-poor households are for example; female headed households with divorced or widowed women, households that have negligible household assets, usually does not own land and have children of school age that have to do labour. All or a combination of these may be found in ultra-poor households.

BRAC has initiated an intervention targeting the ultra-poor. The intervention, which runs for 18 months, goes under the name of “Challenging the frontiers of poverty reduction/targeting ultra-poor, targeting social constraints (CFPR/TUP)” The CFPR/TUP programme includes a targeted grants-based intervention (integrating income-generating asset grants, subsistence allowance, skill training, pro-poor advocacy, and health inputs). Once the grant phase is over, it is expected that the ultra-poor will attain the foundation for sustainable livelihoods and participate and benefit from mainstream micro-credit programmes. The asset’s long-term impact is enhanced by the health component of the programme which by reducing income-erosion effect of morbidity acts as a safety net and allows productive engagement in livelihood activities.

The CFPR/TUP programme has components to address all of the above mentioned constraints that face the ultra-poor.

Findings from an impact evaluation study revealed substantial improvement in self-rated health and other objective indicators such as children’s nutritional status, use of contraceptives, health-seeking behaviour and capacity to cope with health expenditure.
Lessons learned included necessity of sensitizing different sections of the society to the plight of the ultra-poor and engaging elite support as a prerequisite for success of ultra-poor related programmes; utility of consumer information on locally available health services in improving accessibility for the ultra-poor; utility of tools like health cards for facilitated access to government health facilities; necessity of community mobilisation of fund for helping the ultra-poor in various ways, like installation of latrines and tube-wells and financial support for illnesses requiring expenses, including hospitalization.

Reducing poverty through specific targeting of the disadvantaged groups with a pro-poor health system in a country with large out-of-pocket payments for healthcare is possible and is urgently needed in Bangladesh. The above scenario should be kept in perspective while designing such a health system for Bangladesh.
The role and scope of non-government and private health sectors in China: -
the case of village private health practitioner in rural areas, Shandong.

Professor Jiangbin Qu
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Introduction
The development of the private health care sector in China is closely related with China’s
overall political, social, and economic systems. Since private medical practice was
allowed in 1982, the scope of the private sector in health care has been steadily
increasing. In China, the majority of private practitioners are located in rural areas due to
the disorganization of village collective economy and the collapse of the Cooperative
Medical System (CMS). At present, the private sector is a major provider of ambulatory
health services in the rural areas. In order to understand the roles and scope of private
practitioners in rural health care system, a survey was conducted of 83 village clinics and
146 health providers in rural in Shandong, China.

Objectives
• To understand the current development of private village clinics.
• To gather evidence on type and quality of services and compare performance
between public and private health care providers.
• To identify the potential and bottleneck issues for involving the private sector in
public health activities.
• To develop policy recommendations and intervention proposals for the
government on how to improve the private health sector in order to build an
appropriate rural health system.

Methodology
Data collection methods:
• Review of documents and literature;
• Field survey with questionnaires for information on clinics, health practitioners
and out-patients;
• Key informant interviews at provincial, county and township level.

Study sample
Three counties were selected according to geographical locations and level of economic
development (high, middle and low). In each county, three townships were selected
according to level of economic development (high, middle and low). In total, 9 townships
were selected. In each township, 6-8 village clinic were selected at random, and all health
providers from the selected clinics were investigated (83 clinics and 146 health providers
in total). In each clinic, 5 out-patients who utilized health care within 10 days prior to the
survey were interviewed. In total, 420 out-patients were interviewed.
Results

Of the studied clinics, 30 percent were owned or operated by township health centres or by the village collective (defined as public by the research team). The remaining 70% were owned by individuals or jointly by village doctors (defined as private by the research team).

Buildings and equipment in some private clinics were more basic compared to the public clinics. Also, compared with public clinics a “three low phenomena” was observed in terms of low general educational level of village doctors, low professional training level and low quality of services of private providers. Furthermore, only two types of revenues existed in the clinics. The main source of revenue was from drugs sale (90%), the other was from user fees (10%) in the two kinds of clinics. It was also noted that health care procedures are not according to standards, especially in private clinics. These include:

- Record-keeping (case history): 65% of the public clinics and 22% of the private clinics kept proper records of their patients.
- Use of out-patient prescription slips: 95% of the public clinics and 17% of the private clinics used prescription slips.

Comparison of standard of health services in public and private clinics

<table>
<thead>
<tr>
<th>Item</th>
<th>Public clinics</th>
<th>Private clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use prescription slips</td>
<td>95%</td>
<td>17%</td>
</tr>
<tr>
<td>Use out-patient medical record (case history)</td>
<td>65%</td>
<td>22%</td>
</tr>
<tr>
<td>Use out-patient registration</td>
<td>95%</td>
<td>60%</td>
</tr>
<tr>
<td>Use report card for infectious diseases</td>
<td>95%</td>
<td>69%</td>
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Finally, quality of health services is low in both public and private clinic, but especially in private clinics.

Two cases were presented to the providers; common cold in adult and a 5 year old child with diarrhoea. The village doctors were asked to give diagnosis and prescriptions. A panel of paediatricians and physicians were then organized to assess the quality of prescriptions according to the scoring system presented below.

The contents of prescription evaluated according to (full mark = 100):

- Clearly written (score: 7)
- Correct drug name (score: 10)
- Correct dosage, standard and utilization (score: 30)
- Total dosage is rational (score: 30)
- No dispensation taboo, no overlap (score: 15)
- Correct diagnosis (score: 8)
For common cold there was no significant difference between the scores given to public and private providers. For childhood diarrhoea public providers performed better than private providers in rational choice of drugs and drug dosage.

The survey also found that village clinics were not involved in public health care provision due to lack of financing from the government. Compared to public providers, there was lack of equality in the policies of private clinics in rural areas.

**Discussion and policy implications**

The private sector plays a major role in ambulatory health service (60%) in rural areas. Hence the important complementary role of the private sector should be recognized. Furthermore, the private village clinics break the monopolistic situation of public health care facilities which existed under the planned economy period and have introduced consciousness of competition in rural health care. Private health care has also promoted the development of a rural health care system and increased access to basic health care for rural residents. Finally, development of private health care can increase the health resources for rural health and counteract the shortage of government health financing in rural areas.

**Recommendations**

- The government should take measures for professional retraining of both public and private health practitioners, to improve professional quality.
- Supervision and regulations are needed for proper management of private village clinics.
- Supervisors should treat the public and private clinic equally and encourage fair competition (equality in policies).
- The government should increase the budget to village clinics, including the private sector and encourage private sector involvement in public health service provision.
- Further intervention studies are needed on how to build public-private partnerships in health.
Non-governmental medical services in Guangdong province, China

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Introduction
Traditionally, governmental hospitals have been the main provider of medical services in the cities of China. In recent years, however, non-governmental hospitals have come up since the policy of reform and opening-up came into being, but growth has been slow and difficult. Currently, information concerning the non-governmental hospitals is still lacking. We do not know the amount, sorts, quality and fee of the services provided by the non-governmental hospitals. Neither do we know what problems exist in their development or what policies should be developed by the government to administer the non-governmental hospitals.

Objective
To provide evidence to the government about the development of non-governmental medical service in Guangdong province, China.

Methodology
A combination of quantitative and qualitative methods, including questionnaires, observations and interviews was used.

Results
The status quo of non-governmental hospitals
There are 138 non-governmental hospitals in Guangdong Province. They represent 5.7% of all 2410 hospitals in the province. Furthermore, the non-governmental hospitals are weak and have a market share of merely 3% of all service provided. The distribution of non-governmental hospital is imbalanced and most of them are located in the more developed areas of the Pearl River Delta.

The ways and characteristics of non-governmental hospitals’ management
a. Emphasize specialty feature; b. Strict management and flexible allocation; c. Emphasize patient-centred conception, the attitude and quality of medical services; d. attach much attention to person with ability; e. Focus on marketing themselves and presenting a social image.

Major difficulties for non-governmental hospitals in their development process
a. Governmental policy is not adequate to support the development of non-governmental hospitals; b. the heavy tax; c. no standard of consumption and difficult operation of price; d. scarcity and frequent staff turnover; e. poor social approval; f. management
Comparative research on patient satisfaction between the private and public hospitals
Two hospitals in Dongguan city, Guangdong Province were selected (one public and one private) to compare patient satisfaction between the two sectors. The selected hospitals are the two largest hospitals in Dongguan city and are already competing for customers. Questionnaires were returned from 2,138 patients, including 1,199 in-patients and 939 out-patients. 1,192 of in-patients and 927 of out-patients responses were valid (600 in-patients in private hospitals, 592 in-patients in public hospitals, 446 out-patients in private hospitals and 481 out-patients in public hospitals).

Demographic characteristics
Among out-patients there were significant differences (P<0.05) in age, marital status, occupation, education level, household income, residence and sort of payment between the private and public hospital. In the in-patients group, significant differences (P<0.05) were found in gender, age, marital status, occupation, education level and residence between the private and public hospital. Among both out-patients and in-patients more than 60 years old, the group going to private hospitals was smaller than that going to public hospitals. Also, the patients in private hospitals had a higher level of education and household income.

Outpatient satisfaction
The average score for out-patient satisfaction in private hospital was 70.16, ranging from high to low with regard to “medical environment and facilities” (80.29), “doctor and nurse service” (75.45), “checking and assistant section office’s checking” (75.37), “treatment outcome” (70.06), “waiting time” (67.77), “informed choice” (64.75) and “medical expenses” (60.50). The average score for out-patient satisfaction in public hospital was 69.37. Scoring ranged from above average for “doctor and nurse service” (76.24), “checking and assistant section office’s checking” (72.58), “treatment outcome” (72.57), “medical environment and facilities” (72.21) to below average for “informed choice” (68.62) and “medical expenses” (61.61).

The results were compared using multiple regression analysis. The total mark for outpatient satisfaction in the private hospital was significantly higher than that of the public hospital (P<0.05). There was, however, no significant difference in “medical expense” and “doctor and nurse service” (P>0.05). Satisfaction in the private hospital is significantly higher than that of public hospitals with regard to “waiting time”, “checking and assistant section office’s checking”, “treatment outcome”, “medical environment and facilities” (P<0.05). Finally, satisfaction of “informed choice” is lower in the private than in the public hospital (P<0.05).

Inpatient satisfaction
Average score for in-patient satisfaction in the private hospital was 76.59, ranging from “process to be in hospital” (85.53), “medical environment and facilities” (85.43), “nurse service” (83.26), “doctor service” (80.96), “assistant section office’s service” (79.97), “treatment outcome” (75.53), “informed choice” (64.40), “medical expenses” (61.50) and
“meals supply” (60.07). Average in-patient satisfaction scores in the public hospital was 76.55. The scores ranged from high to low with “process to be in hospital” (85.39), “nurse service” (82.54), “doctor service” (81.80), “medical environment and facilities” (78.75), “assistant section office’s service” (78.22) and “treatment outcome” (77.67) scoring above average. On “informed choice” (68.25), “meals supply” (64.94) and “medical expenses” (61.94), however, scores were below average.

Multiple regression analysis was used to compare the scores between the public and the private hospital. The analysis showed that there was no significant difference between in-patient satisfaction in the private and public hospital (P>0.05). Neither was there any significant difference in the satisfaction of “process to be hospitalized”, “doctor service”, “nurse service”, “medical expenses”. Satisfaction of clients was significantly higher in the private hospital than in the public hospital with regard to “assistant section office’s checking”, “medical environment and facilities” (P<0.05); Finally, satisfaction with “treatment outcome”, “meals supply” and “informed choice” was significantly higher in the public hospital.

**Policy implications**
1. The government should fully realize the functions of non-governmental medical service and avoid treating them unfairly.
2. The government should bring the development of non-governmental hospitals into national health development programs, and break the government hospitals’ monopolistic position.
Dual practice among public health providers in Vietnam

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In Vietnam, private health practitioners are divided into two groups; purely private practitioner and government staff engaging in practice off-hours. The Vietnam National Health Survey 2001-02 (VNHS) results indicate that 51.2% of government staff working in public facilities engage in private practice off-hours (dual practice – DP). Among government staff with private practice, 43% are working at the grassroot level and 44% practice without license. Doctor and doctor’s assistant account for 41.2% and 42.3%, respectively. Midwife, traditional medicine practitioner and nurse account for less than 10%.

Main reason for dual practice is to get additional income due to low salaries of public practitioners. Another reason is that the public practitioners are motivated to use or improve their skill but their job in public facilities is either mainly routine low-level services or administrative and managerial. But why do they then still stay in public facilities? The reason is that the two jobs complement each other, private practice being primary source of income but public practice providing stability, prestige, higher training opportunities and better working conditions.

Positive outcomes of dual practice are reducing budgetary burden to recruit and retain skilled staff in public health sector, increasing access (distance, service time) to qualified health providers (e.g., well-trained and experienced), reducing burden (patient load) on public health facilities. However, there are a lot of negative outcomes of dual practice including (1) competition for time; physicians replace hours they should work at the government facilities with hours in their private clinics. (2) Conflicts of interest for their own benefit; dual practitioners may send patients in the public facilities for care and treatment at their own private clinics. (3) Outflow of resources; misuse of the public sector’s means of transportation, office infrastructure, stationeries, consumables, medicines and personnel for private practice. (4) Abusive behaviour; dual practitioners use their authority to prescribe treatment for their patients to generate additional demands for their own services leading to financial burden on patients. (5) Cream skimming; dual practitioners taking easy-for-profit patients, and easy-for-profit services from patient, leaving difficult cases to the public sector. (6) Labour reproducing; in addition to official working hours in public sector, dual practitioners may work for 4-6 off-hours which is likely to reduce quality of working hours in the public sector. (7) Brain drain; public-to-private migration compounds the rural-to-urban migration because cities also offer more opportunities to diversify income generation.

Therefore, the issuance of clear regulations on private practice for in-service government medical staff is needed. In the “Ordinance on private medical and pharmaceutical practice” issued in 2003, the Government prescribes conditions and measures to restrict
and proceed to ban state employees from private medical and pharmaceutical practice as from December 31, 2010. This has led to much feedback, positive and negative, from health workers as well as from society.

All policy options on dual practice should take into careful considerations the comprehensive socio-economic and cultural impacts (on whole society, patients, public and private, DP, Govt authorities etc). Paying doctors enough to match total public and private income is unlikely to be feasible or sustainable in a poor resource context. Prohibition is generally unlikely to be effective, it only drives dual practice underground and makes it difficult to avoid and correct negative effects. When regulatory capacity is weak and the resources are poor, dual practice may be seen as part of a solution rather than a problem.

The recommendations are minimizing negative outcomes of dual practice and try to increase the public service motivation of providers by

(1) paying salaries and wages according to outputs’ quality and efficiency (Decree 10/2002, Decree 43/2006);
(2) self-regulation related to an individual’s reputation as a doctor in public practice, which influences income generating capacity in private practice;
(3) defining the professional value systems to differentiate good services from bad;
(4) establishing professional associations to create peer pressure, support members to maintain their personnel, inform the public of their rights;
(5) creating opportunities for users to voice their discontent effectively;
(6) improving working conditions: equipment, training, etc.;
(7) regulating private practice’ conditions, rights and obligations and monitoring and supervision.
The quality of health care services in private clinics in Laos

Mr. Phisith Phoutsavath
Ministry of Health, Laos

Background and objectives
According to the private clinic regulation of 1991, private clinics are categorized into two types; Type 1 (private clinics open 24 hrs/day) and Type 2 (private clinics open after hours). Furthermore, they are classified according to characteristics namely if they are (i) General clinics, (ii) Traditional medicine clinics or (iii) Specialist clinics. There are in total 401 general clinics, 61 traditional clinics and 119 specialist clinics in Laos. Finally, private clinics are divided into three different levels as per:

- Level 1: Clinic using medical equipment with high technology
- Level 2: Clinic using medical equipment with general or middle technology
- Level 3: Clinic using basic medical equipment

It is recognized that the public health services cannot cover all areas of the country, especially the remote and rural areas. The development of the private health sector in Laos has had both positive and negative impact on improving health care treatment of people. Government policies aim at reducing poverty and improve quality of life. The private sector has been recognized as part of a comprehensive approach to improve health care services. No detailed studies regarding the role and quality of private health care in Laos has, however, been conducted.

Thus, the objective of the proposed research is to provide evidence on non-governmental health care providers in Laos to allow for the design of interventions contributing to improved health of the population.

More specifically, the objectives of the research are:

- To explore facility factors and quality of service among private health care providers.
- To assess knowledge and practice pf private providers in private clinics.
- To assess drug prescription patterns using standard treatment guidelines (ARI and diarrhoea).

Methodology
The study is a descriptive, cross-sectional study focusing on all general private clinics at all levels in the target areas (Luang-Prabang, Champasack, Savannakhet and Vientiane). Methods for data collection will include structured interviews, document review, checklist for evaluation of clinical facilities and case scenarios for communicable diseases.
**Expected results and outcome**

The research is expected to generate evidence on private facilities, equipment and services provided, but also on the knowledge of the practitioners and their adherence to standard treatment guidelines. In a longer-term perspective, the study seeks to contribute to improving the quality of non-governmental health care services in Laos and ensure that private medical practitioners are using standard treatment guidelines in the practice.
Attitudes of health care providers towards developing public-private partnership addressing acute respiratory infection and diarrhoeal diseases in children in Ujjain, India.

Dr. D A Dev
R.D. Gardi Medical College, Ujjain, India

Aims and Objectives
1. To create a database of the public and private health care providers and facilities for diagnosis and management of ARI and diarrhoea in the study area.
2. To study knowledge, skills and practices related to the management of ARI and diarrhoea.
3. To study attitudes of the health care providers towards developing a model of public private partnership.

Methodology
Trained surveyors carried out a census of all health care providers in the study area using a structured questionnaire. They also inquired about their background information, qualification, experience, medical system of practice and types of morbidities diagnosed and treated. The questionnaire also included questions to assess provider’s knowledge, skills and practices regarding diagnosis and treatment of ARI and diarrhoea. Health care providers were then separately interviewed with the help of a semi-structured questionnaire which covered the provider’s willingness to collaborate with the government in the management of the tracer conditions and the reasons for the same. It also explored the expectations that would need to be considered for public-private collaboration to succeed.

Results
A total of 90 health care providers were identified in the area. The majority (80%) were private providers and the rest (20%) public providers. Private providers consisted of Jan Swasthya Rakshak (31%) who were practitioners trained in management of minor ailments, identification of danger signs and timely referral. Female health care providers were trained birth attendants in the villages who conduct home deliveries. More than half (57%) practiced allopathic system of medicine and the rest practiced combination of systems. Most (80%) run a clinic, though without admission facilities. Providers observe almost all kinds of morbidities but mostly fever cases, respiratory infections and diarrhoea cases. Providers were not qualified enough to prescribe antibiotics, injectables, intravenous fluids and steroids but still practiced prescription of the same. Allopathic medicines were prescribed in combination with ayurvedic medicines.

All the providers accepted that some form of linkage is required between private and public health care providers which can be in the form of training (80%), recognition of unqualified providers (34%) and/or incentives for their services by the government. Private providers had the opinion that linkage with public health care providers will
improve their practice (54%), benefit the patients (51%), and decrease the patient load on the government facilities. Conditions for partnership with the public sector were monetary incentives (77%), supply of drugs (74%) and training (67%).

All the public providers agreed to the partnership for decreasing the patient load (38%), patient benefit (69%) and decreasing expenditure on illness. Ways to involve the private providers suggested by public providers were training (46%), giving them recognition (7%) and incentives (23%) for collaboration, including referrals of patients.

Public providers also indicated the possible risk of partnership with private health care providers. Most public providers (92%) think that there are risks associated with public-private partnership if unqualified providers are included without proper training and regulations.

**Discussion**

As revealed by the present study all the health care providers recognized a need for public private partnership in public as well as private health care systems. The attitude of the providers towards developing this partnership was favourable but there were some mutual suspicion and demands for participation in the partnership. The study indicated that the private providers intend to safeguard their personal interests in order to collaborate with public providers and public providers expressed concern over the risks of partnerships.

The private health sector in India consists of diverse groups of health care providers practicing different systems of medicine. A considerably large number of private providers are unqualified and it is a challenge to regulate and mainstream these providers. Their existence cannot be neglected when designing models of public-private partnership as most of the poor living in rural areas; urban slums and remote parts of India are served by private providers. The public health system often fails to serve the poor population or is less popular and those private providers who are qualified are concentrated to urban areas.

There are possibilities for developing models of public-private partnerships but they require first a situational analysis to understand factors facilitating and hindering such partnerships.
Potential non-government partners for public-private partnerships in HIV/AIDS control: A survey of a Tamil Nadu district in India

Mr. Edwin Sam
Achutha Menon Centre for Health Science Studies, Trivandrum, India

Introduction
In India, 5.7 million people are HIV positive. Tamil Nadu is one of the high HIV prevalence Indian states accounting for 7 of 49 high-prevalence districts in the country. The state faces fresh challenges as infections have moved from ‘high-risk’ to general population through ‘bridge’ populations. The state has to think about fresh strategies to effectively deal with the emerging scenario as the conventional strategy of focusing on ‘high-risk’ cases will no longer yield results. Since sources of infections are increasingly unknown, there is a need to test hitherto unknown means of detecting new cases. This paper aims at enlisting new potential actors for Public-Private Partnership to successfully control HIV/AIDS. The focus of the paper will be on identifying new sources of infection, and the providers of care.

Objective
The main objective of the paper is to identify the hitherto unknown ‘risk’ groups, map the actors who are in a position to identify new cases, and to provide a typology of providers ‘treating’ HIV/AIDS cases

Methodology
The study is being carried out in one of the 7 high-endemic districts of Tamil Nadu state in India. It includes 24 focus group discussions (FGD) with various community groups and stakeholders (health care staff, teachers, barbers, washer men/women, lay community, youth club, cine fan clubs, traders, and others). In total 220 people participated in the discussions. The objective of the FGDs is to identify hitherto unknown ‘risk’ groups in the general population, to spot various ‘actors’ who are likely to identify a case first, and to enlist ‘providers’ of all forms. Second stage would elicit data from ‘provider’ groups using a checklist and an interview schedule. In total, 42 providers were interviewed (16, qualified, 9 trained but less than fully qualified (LTFQ) and 16 untrained LTFQ).

The results from the focus-group discussions were divided into groups covering the following themes:
- Perceptions about (high-risk) sexual practice (for example use of condoms)
- Known targeted risk groups (for example sex workers, drug users, truck drivers)
- Unknown, non-targeted, risk groups (for example construction workers, industrial workers, daily wages, college students, village dancers, police)
- Health seeking behaviour (with regard to HIV/AIDS)
• Reasons for the choice of provider (Nearer, Cheaper, No other alternatives, Fear, Confidence, Relationship with the patients, Respect for people)

Results/Policy Implications
• High risk sexual practices appear to be widely prevalent in general as well as high-risk populations.
• Many seek health care based on TV, paper and other media advertisements who claim that they have treatment for curing HIV/AIDS.
• Significant numbers of less than fully qualified providers are treating STD/HIV cases.
• Pharmacists, village health nurses, qualified doctors who are not treating at present and less than fully qualified providers could be potential partners in HIV control and therapy.

This is an ongoing study and the first stage is in progress now. The results will be classified into three types – new risk groups, potential actors to identify the cases, and the providers who may be used to refer the cases. A sketch of these three groups will provide valuable data and information to the policy makers to draw up policy so as to catch the cases early.
Streamlining private out-of-pocket spending through Medisave: rural women’s willingness and ability to pay for Medisave in the Karnataka, India

Dr. Varatharajan Durairaj

Achutha Menon Centre for Health Science Studies, Trivandrum, India

Introduction

The share of government health spending in India is one of the lowest in the world (23.9% of total health expenditure). Given that health insurance (social/private) is also underdeveloped, there is an excess reliance (73.5% of total health expenditure) on private out-of-pocket expenditure as a financing option for health care. Household spending on health has increased at a rate of 13.9% per annum during the last decade. Studies have shown that the burden is proportionately high for the resource poor. It is also inequitable as women receive less allocation from it due to unfavourable intra-household power relations. Even government expenditure targeting women do not reach them due to various reasons. As a result, women’s health care needs are under-serviced. Streamlining private out-of-pocket expenditure is a major challenge and is the need of the hour for India. This paper proposes medical savings account as an option for streamlining it.

Objective

The objective of the paper is to present estimates of rural women’s willingness and ability to pay for Medisave (medical savings) accounts in Karnataka.

Methodology

The study covered a population of about 32,000 from 27 backward villages, underserved by banks, in three districts of Karnataka state in India. The survey covered all households in these villages and all women present were interviewed, among other things, about their willingness to participate and pay for medical savings account. Out of 8,668 women interviewed, 600 women without prior banking experience were chosen for opening Medisave account in their names. Accounts were already opened in January 2006 and preliminary results about their ability to save are now known. The analysis is being carried out across various socioeconomic groups (based on literacy, caste, income, poverty, etc.).

Results

About two-third of the surveyed women were socially backward and 58.8% were economically backward. An average of 55.0% women expressed their willingness to participate in Medisave. The rate was high among Scheduled Caste/Tribes (68.6%), most backward (63.3%), and landless (64.9%) women. It was around average for literate,
married, and widowed/divorced women. Finally, the willingness to participate was low among never married (34.1%), forward (43.3%), unemployed (44.7%), regular readers/viewers of news (52.0%), and women lacking access to TV (51.4%).

Women were on average willing to pay US$ 1.47 per month. Never married, widowed/divorced and forward women are willing to pay 13.3% less, while backward and literate women and those who enjoyed autonomy to spend money and to seek care were willing to pay 13.3% more. On the other hand, news viewers/readers were willing to pay 33.3% more than the average. Actual contribution to Medisave fell short of the willingness to pay by 53.7%.

**Discussion**

Results showed that the willingness to participate in Medisave was quite high among rural backward women. The highest willingness was expressed by women hailing from households earning an income below the poverty line (about a dollar per day) indicating that even the poorest women were deprived of free government health care. Average savings by the women went up from less than US$ 0.10 to 1.20 per month in six months indicating that women were increasingly convinced that savings was one secure form of pre-payment for health care.
Effect of policy on the growth of the private health sector in Uganda

Dr. Sam Okuonzi
Makerere University Institute of Public Health, Kampala, Uganda

Background
During the early 1990’s the government of Uganda recognized the potential of the private health sector in providing health care, especially curative services. Conscious efforts have been undertaken by the Uganda government to remove barriers of entry for private providers. This led to that in 1995, three laws were enacted to stimulate growth of the private health sector. The laws made private practice legal for a wide range of medical professionals including nurses, clinical officers, laboratory technicians, dental assistants and others given that they followed four prerequisites. The prerequisites included that the provider must be trained, registered (with a professional association), supervised and, if needed, disciplined. Ten years later, the effects of these regulations have not been fully assessed.

Objective
To establish a typology of private health providers in Ugandan rural areas and assess the effects of policy on the private health sector.

Methods
As part of a health facility survey, different types of private health care providers were identified and interviewed to generate information on the particulars of health providers and various aspects of health services they provide to the community. Mapping of health care providers in one sub-county in each of the study districts was also carried out to assess typical distribution of public and private health providers in a rural district in Uganda. Sixty key informant interviews were conducted among policy makers and stakeholders from district and national levels to establish the effects of policy on the private provider mix.

Results
The health facility survey manifested two broad types of private health providers: formal and informal. The formal type comprises Private not for Profit (PNFP) and Private for Profit (PFP) health providers that altogether make up 37.6% of the entire private health facilities surveyed, while the informal type constitutes 62.4%. The formal private for-profit providers consist of private clinics, maternity homes, nursing homes and drug shops. On the other hand, the informal type of private health providers consist of traditional healers, mobile health care providers and shop keepers.

Mapping of health facilities showed a similar ratio in the three rural study districts. The most common private providers were traditional healers with a concentration of 16 facilities per parish of 5,000 people, which sharply contrasts with the concentration of 4 PFP providers per parish, 0.5 PNFP per parish and 1 public facility per parish. Policy
makers and public leaders agreed that laws and policy initiatives have not sufficiently stimulated the growth of the formal private health sector. They recommended that the government should provide financial support and tax exemptions as incentives to stimulate the growth of the formal private health sector.

Conclusions
The private health providers, in various forms, command a substantial stake in health service delivery to communities in Uganda. However, government policy is yet to significantly stimulate the growth of the formal private health sector and the greater fraction of private providers are still informal.
Reasons for choosing a health care provider in rural Uganda

Mr. Joseph Konde-Lule
Makerere University Institute of Public Health, Kampala, Uganda

Background
In Uganda there are many kinds of health care providers. At one end of the spectrum is a large informal sector, comprising traditional healers, faith healers and unqualified personnel that meet people’s health needs. On the other extreme are the qualified allopathic providers that work in government or the private sector; constituting the formal sector. The decision to choose a particular health care provider often involves evaluating several different factors.

Objective
To document reasons why patients choose to visit a particular type of health care provider.

Methods
A household survey was conducted in three rural Ugandan districts (Iganga, Mpigi and Masaka) between January and April 2005 using an interviewer administered questionnaire. A total of 636 subjects that had experienced illness in the month preceding the survey and reported visiting a healthcare provider were studied. The results are based on quantitative analysis of the answers to the question "Why did you choose to go to this particular provider?" A comparison of reasons given across different provider categories is given.

Results
In the formal sector, the major reasons for choosing to visit a public provider were: technical skills of personnel 44.5%, convenient location 40.5%, low cost 11.4% and “other reasons” 10.2%. Reasons for visiting a private for profit (PFP) provider included: convenient location 58.2%, good technical skills of personnel 26.0%, relatively low cost 11.0%, courtesy of personnel 10.6% and “other reasons” 8.2%.

The most important reasons for choosing Private not for Profit (PNFP) were: convenient location 55.6%, technical skills of personnel 40.7%, relatively low cost 9.9% and “other reasons” 12.3%

The informal sector consisted of traditional healers and general merchandise shopkeepers. Major reasons stated for visiting a traditional healer were: technical skills of personnel 37.0%, low cost 19.2%, convenient location 17.8%, recommended by friend 15.1% and “other reasons” 15.1%. The main reasons for visiting general merchandise shops were convenient location (83.3%), and low cost (16.7%). The above numbers are summarized in the table below.
The level of education influenced the decision of a sick person to visit a health care provider. Adults (individuals above the age of 18) with secondary education (67/104, 64%) were more likely to have visited a health care provider than those with primary or no education (198/382, 52.8%) [OR=1.68, 1.05-2.70].

**Conclusions**
Overall, a convenient location was the main reason why persons chose to visit a particular provider, especially for providers in the private sector. Perceived good technical skills of health personnel was the most important consideration for patients choosing public facilities and traditional healers. Cost of treatment was not a major consideration when choosing a provider.
Reasons for visiting non-governmental health care providers – results from exit interviews in two districts in Zambia

Mr Dale Mudenda
Department of Economics, University of Zambia, Lusaka, Zambia

Background
Several studies have shown that non-governmental health care constitutes a large and important source of health care - not least for the poor and those in hard to reach areas. Yet, the private health care sector in low-income countries remains largely unexplored. This study reports the findings of exit interviews conducted with consumers of non-governmental health care providers in Lundazi and Chingola districts Zambia

Methods
The study was conducted using structured questionnaires, administered by trained research assistants. The questionnaires used were the generic Health Care Assessment Tools developed by the Private Sector Programme in Health (PSP). Adjustments were, however, made to make the questionnaires applicable to the Zambian context. Consumers of private clinics (25), pharmacists and drug vendors (63) and traditional healers and traditional birth attendants (214) were interviewed. In total, 302 clients were interviewed.

Results
The study revealed that consumers in private clinics visited that particular clinic because of “proximity” (72%) followed by “availability of diagnostic facilities” (32%) and “cost” (20%). Clients of pharmacies/drug vendors rated “cost” (86%) and “proximity” together with “availability of drugs” as the most important factor (82.5%) for visiting that particular drug store/pharmacy followed by “attitude” (70%) and “attitude of provider” (65%) Finally, the main reason for clients of traditional healers to go to that particular provider was “experience of the provider” (72%) followed by “proximity” (35%) and “familiarity with provider” (25%). The results are shown in the table below.
Conclusions

The findings indicate that proximity is a very important factor for clients of private clinics and drug stores/pharmacies while for clients of traditional healers, the experience of the provider is more important. Cost is important for customers of private drug stores/pharmacies, but does not seem important for clients of private clinics and traditional healers. The low consideration given to cost in private clinics can probably be explained by the fact that many of the clients of private clinics were under the mining corporations’ health insurance schemes.

Kalingalinga Clinic, Lusaka, Zambia. Photo: Jesper Sundewall
How can private providers be developed and regulated: the experience from Zhejiang, China

Ma Weihang
Zhejiang Department of Health, China

Zhejiang province is a coastal province located in south-east China. It has a population of 45 million and a GDP of 3,400 USD/Capita. The per capita rural net income is the highest in China, 6,660 RNB/capita.

Zhejiang was one of the first provinces in China to embark on market economy and the private market has grown rapidly. In 2005, the non-government economy accounted for 72% of the total economy. In terms of resources, Zhejiang province ranks among the first in China.

In terms of major health indicators, Zhejiang has reached a level of some developed countries; the infant mortality rate is 13.4 and life expectancy is 75 years.

Zhejiang was one of the first provinces to establish private institutions and the first was opened in 1989. Development of private medical institutions has been very rapid in recent years. In 2002, there were 42 private hospitals in Zhejiang and in 2006, the figure was 242. The majority of these hospitals have <100 beds and are quite small facilities but large private hospitals have started to emerge in the last three years. The non-governmental sector accounts for 14.7% of all in-patient beds in the province.

Three hospitals were studied in more detail: Taizhou central hospital, Wezhou Kanging Hospital and Jinhua No.3 Hospital. The study identified the growth in their operations, future opportunities and current difficulties. Difficulties included for example tax policies.

The study shows that non-public funds have supported the development of private institutions through technology development, complementary support (including support in equipment and facility development) and extension of medical services.

Problems identified in the private sector

There are managerial problems among private providers. One is that these providers are not abiding by the laws and regulations. Another issue mentioned is that the manager of private institutions often is a retired doctor from the public health sector. This means that the management follows the public sector standards, which stimulates little innovation.

On the financial side, one problem is that there is too little investment in the private sector. Facilities are often small and hence have little capability to handle difficulties. Retention of staff over time in private facilities is another issue. Private hospitals also suffer from a heavy economic burden, for example through heavy taxation.
It is concluded that private hospitals should be included in the planning process. For quality control, the private hospitals should be included in national planning.

**Issues for further discussion**

- *Relationship between public and private:* How can the private sector be strong enough to compete with the public sector? The private sector is often viewed as a wolf among sheep, but they are rather a sheep among wolves. Collaboration is the way to move forward.
- *When can private sector make money?* There is currently a vicious cycle. In order for them to work properly in an open way, they have to be allowed to make some money. If not, they will operate anyway on the black market.
The partnership of public and private practitioners in the community health care system in China

Dr. Yao Lan  
Huazhong Science and Technology University, China

Background  
Due to rapid economic growth and social changes, the existing health care system can no longer satisfy needs of people. In this context, Decision on Reforming Urban Health Care System by the central government suggested that the existing three-tier health care system be reformed into a two-tier system, with medical centres and prevention centres at higher level and community health clinics at grassroots level. Community health system facilities perform 6-in-1 functions including maternal and child health, and ensure basic public health needs addressed at the community level.

Public institutions dominate among CHS (community health service) facilities, representing 85% of the total in 2005. Private institutions are not willing to offer all kinds of services. They are more prone to provide the type of services which bring good profit. Also, the private CHS facilities are generally much smaller than the public.

Role of private CHS facilities in the urban health care system  
The role of private CHS facilities is to safeguard people’s health and offer more choices for the general public through cost-effective, efficient, and convenient services. Furthermore, the role is to encourage exploration and innovation in business management and service concept of public CHS facilities by breaking monopoly and introducing competition. Also, the private facilities can diversify investment channels to complement government investment and fill in the gap in medical resources and service capacity to offer pragmatic services to the general public.

Challenges faced by private CHS facilities  
Private facilities argue that it is hard to fulfil all CHS functioning when operating at small scale. There is also under-performing in public health services with distorted profit incentives, namely, preventive services are subsidized by income from medical services and drugs. Furthermore, there are sustainability concerns over health services. A final challenge faced by private providers is the insufficient government compensation and input.
Chinese rural health care system: pilot research in Luoshan of Shaanxi province, China

Yang Tuan
Chinese Academy of Social Sciences, China

Background
In China, township hospitals are increasingly focusing on economic benefits and village clinics become private. It has become more difficult to see a doctor, and the peasants are overburdened with health expenditure. Spending on catastrophic illnesses are forcing people into poverty. The traditional cooperative medical system was supported by a collective economy, adopting the method of reimbursement. This model, however, cannot resolve the demand of community farmers any more and lacks a sustainable financing mechanism. The new cooperative-medical-system pilots carried out in 2003 pay more attention to serious diseases and reduce the in-patient burden of costs, but the pilots do not cover minor illnesses and exclude health prevention and protection.

The content of the Luochuan pilot
The community health service (CHS) pilot of Jiuxian County in Luochuan is a social policy research activity conducted and implemented by the Centre for Social Policy of Chinese Social Academy. It began in May 2002 and was further developed in 2003.

Objectives of the pilot
1. To explore the rural township community health system reform and develop possible and operable pathways of public health industry through the organizing of peasant medical cooperation.
2. To explore the payment forms and reform mechanisms that could improve peasants’ health status.
3. To explore the health service policy of a combination of prevention and protection, primary care and in-patient care through the organizing of community health service.

Evaluation of the pilot
In order to test the effect of the community health service experiment in Jiuxian Township, 750 villagers were selected randomly in the Jiuxian Township and in the control town. The villagers were interviewed with the help of structured questionnaires. A baseline survey was carried out in March 2004 and an evaluation was done in March 2005.

Based on their opinions, villagers in Jiuxian have benefited from the pilot in six ways:
1. The accessibility and convenience of the CHS were improved.
2. The preference for CHS rose.
3. The service content developed.
4. The service stability improved.
5. The responsiveness of the CHS increased.
6. The knowledge and cognition of preventive and health services have improved.

**Problems found in the pilot**

1. The community health services are operating at the margin and are not well catered for in policy. Therefore the ideas, system and the mechanisms of the government need to be reformed.

2. The health facilities had difficulties in satisfying the need of the members of the rural medical-cooperation system.
## ANNEX I – LIST OF PARTICIPANTS

### INTERNATIONAL PARTICIPANTS

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The private sector in health care delivery – potentials and challenges

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