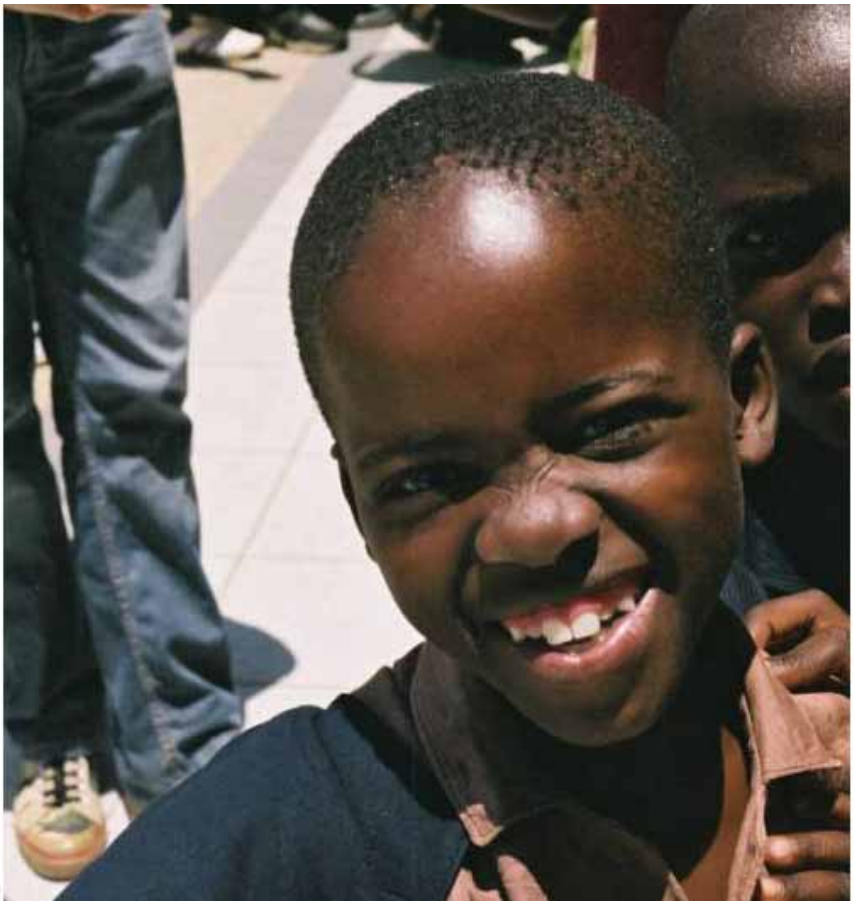
PRIVATE SECTOR

P S P

PROGRAMME



ANNUAL REPORT
2005

ACKNOWLEDGEMENT

This report could not have been compiled without the valuable contributions and input from all partner institutions in the Private Sector Programme.

For more information about the Private Sector Programme, please contact any of the coordinators below or visit our webpage: www.psp.ki.se

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INTRODUCTION

The Private Sector Programme – PSP - is a collaborative research programme involving ten research institutions in Sweden (IHCAR, Karolinska Institutet), USA (IHSP, Harvard) China, Vietnam, Laos, India, Uganda and Zambia (see list of institutions in ANNEX 1). The programme seeks to strengthen health systems' performance and their outcome in terms of improved health by exploring the non-state (private) health sector and how it can be involved in providing adequate health care to the population, in particular those in most need. The programme started in 2002. Large-scale studies of the private sector are either on-going or have been completed within the programme in the six low- and middle-income countries. Results have been presented at conferences in San Francisco (2003), Stockholm (2004) and Barcelona (2005).The PSP functions as a network for the collaborating institutions, each one seeking their own funding for local studies. Sida is providing funding for a core budget of the programme.

ACTIVITIES DURING 2005 IN BRIEF

Overall, the programme has progressed according to plans in 2005, though as always at varying pace in different places. In China, the data collection has been completed and a report on the study is under preparation. In Vietnam, data collection tools have been finalized. The field work will be implemented in first half of 2006. In Laos, the early phase of policy and document review has been initiated. Funding for the actual fieldwork in not yet secured. In Ujjain, various research projects related to private-public issues are being implemented with plans to bring out data for a wider audience in 2006. In Trivandrum, several research projects on private-public issues are in the early implementation. In Uganda, all data collection has been completed and the study report is under preparation. In Zambia, finally, policy interviews were made in the second half of the year. The field work was about to start in October when the country was hit by a severe fuel crisis bringing most vehicles to a halt for several weeks. The data collection will now take place in February-March 2006. A brief summary of each country's activities during 2005 is provided in this report.

In 2005, the PSP programme was instrumental in organising and partly funding a Harvard training course in Delhi, India on "Private Health Care: Developing Successful Policies and Programs". Five PSP institutions were represented in the course. The course programme is attached as ANNEX 2 to this report. The material from the course has been made available on a CD to all institutions. It can be provided on request through the programme management.

The programme organized a session on "Involving the Private Health Sector in National Health Programs in Low- and Middle-income countries – from Mapping to Interventions" at the 5th World Conference of the International Health Economics Association (iHEA) in Barcelona. The programme for the organized session is attached as ANNEX 3. The

presentations at the seminar have been circulated within the PSP group and are available from the programme management.

In 2005, an article on "Health Care in China: The role of non-government providers" was published in Health Policy Aug 19, 2005 by the Harvard-Shandong PSP teams (Liu, Berman, Yip, Liang, Meng, Qu, Li).

During 2005 work on a website for the programme progressed. The website will be put on the internet in 2006.

COUNTRY REPORTS

CHINA - GUANGZHOU

Summary of the PSP activities in Department of Health Management of Sun Yet-sen University

1. Market share analysis of non-governmental medical services in Guangdong Province.

The results of systemic surveys and medical statistical datum indicate: in 2003, non-governmental medical services held only 2.96% of the in-patient service market share; this was mainly provided by non-governmental hospitals. 10.6% of the outpatient services were provided by non-governmental institutions, including private hospitals, clinics, community health service centres, rural medical rooms, etc.

2. January, 2005- February, 2005, Survey of the medical service market in Guangzhou City.

Tianhe District, Guangzhou City was chosen as the sample. And three streets- Linhe, Tianyuan, and Yuancun were selected according to their economical status- ranked as high, middle and low.

Surveyed targets: all the medical institutions in the chosen street, including governmental hospitals, governmental clinics, community health service centres, non-governmental hospitals, private clinics, unlicensed clinics, etc.

Survey result: there were 21 medical institutions in Linhe Street, of which 3 were unlicensed; 12 in Tianyuan of which 6 were unlicensed; and 68 in Yuancun of which 35 were unlicensed. Totally 101 institutions were found out in the 3 streets: 5 governmental hospitals; 17 governmental outpatient departments, clinics, community health service centres; 2 non-governmental hospitals and 77 non-governmental outpatient departments/ private clinics.

3. July, 2005- August, 2005, Survey of patients' satisfaction in non-governmental hospitals.

The survey was performed in Donghua hospital- a non-governmental hospital in Dongguan City, Guangdong Province and Dongguan People's hospital- a governmental hospital in the same city.

Surveyed targets: patients in the two hospitals. 2138 questionnaires were sent out and called back, of which 605 were responded to by outpatients in Donghua hospital, 453 by inpatients in Donghua, and by 594 outpatients and 486 inpatients in Dongguan People's hospital respectively.

Main result: Outpatients' total satisfaction in Donghua hospital was higher than in Dongguan People' hospital with a p-value less than 0.01; meanwhile, inpatients' total satisfaction in Donghua hospital was also higher than in Dongguan People' hospital with a p-value less than 0.05.

CHINA - SHANDONG

The fieldwork of the project was conducted in Shandong in May, 2005. During the fieldwork, Professor Yuanli Liu came and visited the fieldwork and assisted in conducting the study. Dr Forsberg from Karolinska Institutet visited Shandong University in early 2005 to advice on the study.

The major activities in this period were:

May – June, data and related information collection in rural areas. From July to Aug, the major work was data entry and analysis.

Sep – Nov. During period, time was spent on drafting the Chinese version of the research report.

Currently, the Chinese report is being translated into an English version. The English version of the final report will be submitted before June, 2006.

A summary of the research activities and the methodology employed in the study of "The role and scope of Non-government and private health sectors in China: - the case of village private health practitioner in rural Shandong" is given in ANNEX 4 of this report.

INDIA – UJJAIN

The following 5 studies have been conducted in R D Gardi Medical College, Ujjain with regard to the PSP project. All studies are in the analysis phase.

I. Objective: To describe the geographic distribution and other provider characteristics (qualifications, the system of medicine practiced, size and scope of practice, organizational set up) of private health care providers in Madhya Pradesh and digitize the information (develop a computerized GIS).

II. Objective: To describe the historical development of the health sector, particularly the private sector in the Indian province of Madhya Pradesh over the last 50 years and to find reasons for this development of the health sector through in depth interviews with key informants

III. Objective: Study health-seeking behavior of the community in the study area for tracer conditions (ARI and diarrhea - common condition of public health importance) and understand reasons for this behavior

IV. Objective: to describe treatment patterns for ARI and diarrhoea among practicing health care providers in Narwar sector, Madhya Pradesh the study area

V. Objective: To describe attitudes and expectations of private providers in the study area towards partnering with government for the management of these conditions

A more detailed description of the studies and the methodologies employed can be found in ANNEX 5 of this report.

INDIA – TRIVANDRUM

The following activities have been undertaken by the Sree Chitra Tirunal Institute for Medical Sciences and Technology

Completed research

1. Prasad BM. 2005. *Quality of private dental care: An analysis of policy and practice in three districts of Karnataka, India*. MPH thesis
2. Sachi Regmi. 2005. *An economic analysis of a community based health insurance scheme in Nepal.* MPH thesis

Ongoing research

3. Varatharajan D, Muralikanna M. Banking for better health: *Medisave* for rural women in Karnataka, India. Project funded by the Ford Foundation, New Delhi.
4. Edwin A Sam. *Partnering with non-government sector to attain national health goals vis-à-vis HIV/AIDS*. Ph.D. thesis.
5. Ashwani K Singh. *Performance of private health insurance in Delhi: An analysis of content, coverage, and outcome.* MPH thesis.

Proposed research

Four proposals were developed and submitted to the World Bank, New Delhi on the following topics:

6. Partnering with non-government sector to attain national health goals: Exploring new areas of partnership for the management and control of HIV/AIDS and TB in Tamil Nadu
7. Share of private sector inefficiency and induced demand in the financial burden of receiving treatment for non-fatal road traffic injuries
8. National Health Accounts for cardiovascular diseases in Kerala: An estimation of size, distribution and flow of resources in government, private, and household sectors
9. Private in government: User fee experience in Madhya Pradesh under Rogi Kalyan Samiti

Conference participations

10. Two students (1 Ph.D., 1 MPH) participated in the PSP course on 'Private health care: Developing successful policies and programs' in New Delhi.
11. One Ph.D. student attended the 4th Global NHA symposium in Barcelona, Spain during 7-8th July 2005.

Conference presentations

12. Varatharajan D. 2005. *Industrial adoption of PHCs in Tamil Nadu: Is it a sustainable model of partnership?* New Delhi: National Institute of Health and Family Welfare, National Planning Workshop on Public-Private Partnership in Health,
13. Varatharajan D, Wilson Arul Anandan D. 2005. *Re-activating the Primary Health Centres through industrial partnership in Tamilnadu, India.* Barcelona: 5th World Congress of the International Health Economics Association (iHEA)
14. Godwin SK, Varatharajan D. 2005. *Role of government and competition in drug price differential for 12 common drugs in Kerala.* Barcelona: 5th World Congress of the International Health Economics Association (iHEA)

15. Sonia A, Varatharajan D. 2005. *Organisation and functional dynamics of non-government in-patient facilities in a sub-district of Kerala.* Barcelona: 5th World Congress of the International Health Economics Association (iHEA)

LAO PDR

Activities undertaken by the Laos PSP-study team:

1. Organized and received approval for a study team consisting of senior officials in the Ministry of Health.

2. Organized meetings with study team 6 times.

3. Organized meetings between the study team and technical experts from IHCAR on two occasions – in March and September 2005

4. Two people attended a training course in Delhi on "Private HealthCare: Developing Successful Policies and Programs" April 4-9, 2005

5. One person attended a seminar on "Involving the Private Health Sector in National Health Programs in Low and Middle income countries from Mapping to Intervention" at the 5th World Conference of the International Health Economics Association (iHEA) in Barcelona in July 2005.

Plan for 2006 Activities

1. Revise the study proposal

1.1 Sub-study 1: First draft will be completed before March 15 and Final report before April 30. Kotsaythoune and Viengsavan have the main responsibility.

1.2 Sub-study 2: First draft before March 15 and Final report before April 30. Phisit and Viengsavan have the main responsibility for this activity.

2. Sub-study 3 and 4: Consider integration with other related projects where team members are active and where objectives are similar to the PSP objectives. The main reason is to utilize human resources in the best way and to get possibilities for funding. As we can foresee now, such possibilities exist with the EU-funded POVILL project and with the Sida-funded KTS project (contract not yet signed).

3. Attend the International Conference on Public-Private Partnership in the Health Sector, in Shandong, China, September 26-28, 2006

VIET NAM

1. Participated in the International Conference on Health Economics (iHEA) in Barcelona. One PSP team member (Mr. Thien) attended the IHEA 2005 and held

a short presentation about a study on reported quality of care in the private health sector.

2. Worked with Sida's Hanoi office to discuss and get agreement on the funding to carry out the study on roles and potential of PSP with contribution to public health goals. Accordingly, Sida Hanoi agree to fund Health Policy Unit (HPU) to conduct a study on role and potential of PSP. PSP team within HPU developed study proposal and protocol. It includes 3 major sub-studies:

   i. Analysis of current status of private health providers. We will mainly analyze secondary data from the Ministry of Health (routine reports from provinces, annual health statistics, routine and survey reports on from MOH's departments and its institutions, National Health Survey 2001-02); General Statistical Office (Vietnam Living Standard Survey 97-98, 2002-03, Health and Demographic Surveys etc.); other ministries and sectors; international organizations and scientific publications related to private health sector in Vietnam.;

   ii. Exploration of basic characteristics of private health providers in selected settings. Two districts (one rural and and one urban setting) would be selected to further explore real situation of private health care providers;

   iii. Investigation of the role and potential of private health providers. It is mainly based on qualitative methods and a workshop.

   Sub-study (i) is already on-going. A consultant has been hired to review literature. Data collection at the field (sub-stud y ii) has been completed. Data entry will be finished by the end of February 2006. Sub-study (iii) will be carried out in March 2006. Overall, the final study report is expected to be available in Sep 2006.

3. One researcher, Ms Thuy, a PSP team member, attended the Master Programme in Public Health at Karolinska Institutet in Sweden. She is planning to write her Master's thesis based on part of the overall PSP-study.

UGANDA

January 2005

Field work for the Uganda study was started. All the study instruments had been developed during 2004. In January 2005 the study investigators made visits to the study sites to identify contact persons and to establish good working relations with local officials in all study areas.

February and March 2005

Data collection was done by study teams. This included a household survey, health facility survey and a census mapping of health care providers in defined administrative areas.

April and May 2005
Key informant interviews with policy makers were difficult to arrange, but they were completed during April and May 2005.
Data entry was largely done concurrently with data collection during the period March-May 2005. Data cleaning and analysis were done during the period June up to September 2005.

Report writing
From October 2005 onwards the main activity of the project was report writing. To date (early 2006) we are in the final stages of writing the study report. The exercise has taken longer than we had anticipated because of the many aspects of the study. The report includes both descriptive aspects and analytical aspects needing interpretation.

Conferences / International Meetings

1. During April 2005 two members of the Uganda PSP team attended a course about the private health sector in New Delhi, India.
2. During July 2005 two investigators from the Uganda PSP team attended the iHEA 5th World Conference in Barcelona, Spain. Preliminary findings from the Uganda study were presented during the conference.

ZAMBIA

During 2005, the Zambia PSP-team worked on securing funding for the PSP-fieldwork and getting the study approved by the Ministry of Health. The process of getting all necessary approvals proved to be more difficult than anticipated which led to serious delays in the work. By December 2005, the study had finally been approved by the Ministry of Health, funding had been secured, and the study had received ethical clearance by the Research Ethics Committee. While awaiting approval and funding, the study team started preparing for the fieldwork and also incepted the interviews of policy makers and other stakeholders which was part of the study. Other activities during 2005 included participation in the course of private health care providers in Delhi in April 2005 by three staff members from the department of economics.

Fieldwork will be conducted during the first quarter of 2006. Two districts have been identified as study sites namely Chingola (Urban district in Copperbelt Province) and Lundazi (Rural district in Eastern Province). In each of these districts, a number of surveys will be conducted:

1. Mapping of all health care providers (both formal and informal, facility based and non-facility based) in the districts
2. Facility survey of a selection of providers
3. Exit interviews with clients from all types of providers
4. Household survey of a sample of households in each district.

Data entry and analysis is scheduled to be conducted before the Summer and the team hopes to have a report out before September 2006. If time permits, the team will explore the possibilities of turning the report into one or two papers for publication in international journals.

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ANNEX 1 – List of institutions involved in the Private Sector Programme

Country	**Institution**	**Principal investigator(s)**
China	Department of Health Management School of Public Health Sun Yat-sen University of Medical Sciences Ghuangzhou	Prof. Liang Haocai
	Centre for Health Management and Policy Shandong University Jinan, Shandong	Dr. Qingyue Meng Dr. Jiangbin Qu
India	Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) Trivandrum, Kerala, India	Dr. Varatharajan Durairaj
	R D Gardi Medical College, Xhir sagar, Ujjain	Dr. Vijay Kumar Mahadik
Laos	Ministry of Health Vientiane Dept of Curative Medicine Food and Drug Department	Dr Lamphone Sihakhang Dr. Sommone Phounesavath Dr Sivong Sengaloundeth
VietNam	Health Policy Unit Department of Planning Ministry of Health Hanoi	Dr. Nguyen Hoang Long
Uganda	Makerere University Institute of Public Health	Prof. Joseph Konde-Lule Dr. Sam Okuonzi
Zambia	Department of Economics University of Zambia Lusaka	Mr. Webby Wake Mr. Chrispin Mphuka Mr. Dale Mudenda Dr. Margaret Maimbolwa

ANNEX 2 – Course programme for Harvard training course Private Health Care: Developing Successful Policies and Programs, April 3 – 9, 2005, New Delhi, India

IHSP Special Course Offering
This special course offering by IHSP benefits from significant external sponsorship, and so participants will be charged only a modest course fee.

Purpose
Private sector health care is increasingly recognized as a significant part of developing country health systems. In many countries, private providers are the major source of treatment for important health problems, even for poor and rural populations, as well as being widely present in urban areas and for the affluent.

This course has been developed to help policy makers and program managers develop practical strategies to increase the positive and reduce the negative contributions of private health care to achieving priority health goals. Using a stimulating combination of theory and real-world experience, it provides useful concepts and tools for defining, measuring, and assessing the role of private providers in the health system and for developing appropriate policy strategies surrounding the private sector. A particular focus is the linkage between private providers and interventions to control or reduce important public health problems such as tuberculosis, reproductive health, HIV/AIDS, and children's infections.

Who Should Attend?
Participants will be national and regional health policy makers and planners, leaders of private sector for-profit and not-for-profit professional associations; program officers of international organizations; and directors of disease-control programs. The course will address issues in middle income countries, countries in transition, and the lower income developing countries with a multi-regional perspective.

Course Topics
- What is the "private sector" in health? Finance and provision, for-profit and not-for-profit organizations and providers
- Methods for assessing the size, composition, and activities of private health care in comparison with government
- The politics of public-private collaborations
- Going wrong and going right: fitting the right strategies to specific problems
- Case studies of successful policies and programs and their evaluation
- Planning for implementation

Educational Approach
This course employs a blend of theory and practice and is geared to an audience focused upon implementation. Four types of sessions are planned: concepts and global overview,

case studies, skills workshops, and participant-driven country planning exercises. Lively discussion among experienced participants is expected throughout.

Participants are encouraged to bring their own country material and resources on health systems related to private health care.

About the Course Co-Directors

Prof. Peter Berman is currently Lead Economist—Health Nutrition Population for the World Bank in India and on leave of absence as Professor of Population and International Health Economics and Director of the International Health Systems Program at the Harvard School of Public Health, Boston, USA. He is well known for his research on the role and development of private health care in developing countries, with numerous publications on the subject from developing and transitional countries in Asia, Africa, the Middle East, and Europe.

Dr. Birger Carl Forsberg is Lecturer, Division of International Health (IHCAR) in the Department of Public Health Sciences at the Karolinska Institute, Stockholm, Sweden. Trained in medicine, social sciences, and economics, Dr. Forsberg has worked in international health policy and program implementation since 1985, often with a focus on the control of communicable diseases and child health.

Invited Faculty:

Dr. Knut Lonnroth, World Health Organization
Dr. Benjamin Loevinsohn, The World Bank
And several leading practitioners from the region.

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ANNEX 3 – Programme for the PSP organized session at the iHEA conference in Barcelona, July 2005.

Organiser:

Birger Carl Forsberg, Karolinska Institutet
Division of International Health (IHCAR), Department of Public Health Sciences

Chair:

Peter Berman
World Bank / Harvard School of Public Health
World Bank New Delhi India and International Health Systems Program, Harvard

Session Description:

Involving the Private Health Sector in National Health Programs in Low- and Middle-income countries – from Mapping to Interventions

The Division of International Health (IHCAR) at Karolinska Institutet (KI) and the International Health Systems Program (IHSP) at Harvard School of Public Health (HSPH) are together with eight partner institutions in China, India, Laos, Uganda, Vietnam and Zambia engaged in a research program on the role of non-governmental health care. The program seeks to describe and analyse the private health care sector, and explores ways through which it can be engaged in health care provision within the context of national and international health programs. This session will build on knowledge and experience gained by researchers in the program.

The session proposed is important for a number of reasons. The private sector continues to grow in low- and middle-income countries. Data show that the private health care sector is by far the most significant in most of these countries. Significant investments are being made in programs that seek to make use of this already existing private sector in publicly funded health programs. Much more evidence is needed on how these investments can best be made use of.

Important research on the private sector is being conducted in several prominent health programs. It is essential that results and conclusions from this research is being widely disseminated and critically reviewed. The research work on private sector issues encounters a number of methodological problems that also need to be ventilated and discussed among health economists and health systems researchers, with the purpose to improve these methods. Furthermore, special issues like assessments of quality, user fees and informal payments in the public and private sector needs to be further examined, analysed and discussed.

It is widely acknowledged that the capacity to work in public-private partnerships is low among the actors. The public sector often has insufficient administrative capacity or expertise to work with contractual issues in large partnerships. The private sector on the other hand may lack the administrative competence to meet the accounting requirements of the public sector as well as the capacity to participate in rigorous competitive bidding. Researchers must become better at understanding and examining how management and capacity building can contribute to improved interaction between the public and the private sector.

All these issues show the importance of further exploring the private sector in low- and middle-income countries and identify and test models for positive engagement of private health care providers in health development. This panel session will be centred around new data from research work undertaken in China, Vietnam, Bangladesh, India, Uganda and Zambia. The implications for national and international health programs from these data and other recent findings will be discussed.

Given the experience from the IHEA in San Francisco, the topic for this session is likely to attract a significant audience of conference participants with interest in health policy, health systems development and private-public partnerships in health development in low- and middle-income countries.

Panellists/presenters

Dr. Yuanli Liu
Harvard School of Public Health
Topic: Characteristics of the private health care sector in Uganda and China – Implications for policy making in low- and middle-income countries.

Mr. Pär Eriksson
Swedish International Development Cooperation Agency (Sida), Lusaka, Zambia
Topic: Public-Private Collaboration involving non-profit private organisations (NGOs) – Implications for policy work from lessons learnt in Sub-Saharan Africa

Mr. Jesper Sundewall
Division of International Health (IHCAR), Karolinska Institutet, Stockholm
Topic: Attitudes to working with the public sector among private health care providers – How should they be considered when planning public-private partnerships?

Mr. Dung Doc Thien
Ministry of Health, Vietnam
Topic: Involvement of Private Health Sector in Primary Health Care. The Fact and Potential in Vietnam

Professor Joseph Konde-Lule, Institute of Public Health, Makerere University, Uganda
Professor Jiangbin Qu, Shandong University
Topic: Private Providers in Developing Countries: Survey Study in China and Uganda

ANNEX 4 – STUDY METHODS EMPLOYED IN SHANDONG PSP STUDY

Topic: The role and scope of Non-government and private health sectors in China: - the case of village private health practitioner in rural, Shandon.

1. The sampling:

- According to the geographical locations and high-, middle- and low-income counties, one county with high, one with middle, and one with low economical level were selected.
- From each county, townships were divided into high, middle and low income and one township in each income group was randomly selected.
- In each township six to eight villages were selected at random. In each village all clinics and health practitioners were included in the survey.
- In each clinic, 5 out-patients who had visited the clinic within 10 days were interviewed.

Table 1. the samples selected from three county.

	Towns	Private pharmacies	Village Clinics	Health workers	Out-patients
Zhucheng county	3	3	31	54	155
Licheng county	3	4	26	59	140
Chiping county	3	4	25	33	125
Total	**9**	**11**	**83**	**146**	**420**

2. Research instruments:

(1) Questionnaire for village public and private clinics;
(2) Questionnaire for village health practitioner;
(3) Questionnaire for out-patient who has visited the clinic during the last 10 days.
(4) Interview syllabus for village health governor and supervisor.

3. Data resources and information collection:

- Review of literature; mainly to collect the related policy, publication and research to the private health sector in rural.
- Field survey of clinics: the information on clinics was collected through the questionnaire; the information on health practitioners were obtained through questionnaire; and the data and information about the out-patient who has visited the clinic within 10 days were collected by the questionnaire.
- Key informant interviews at provincial, county and township level.

The ownership of village clinics find in this study

A. The composing of village clinic's ownership as showed in table 2:

Table 2. The composing of village clinic's ownership by this study

	Branch of township health centre (%)	Contracted with private(%)	Jointly operated by village doctors (%)	Privately owned (%)	Total	Number of private pharmacies
Zhucheng county	13（41.9）	4（12.9）	1（3.3）	13（41.9）	31	3
Licheng county	1 （4.0）	7（28.0）	1（4.0）	16（64.0）	25	4
Chiping county	6（22.2）	7（25.9）	5（18.5）	9（33.3）	27	4
Total	**21（25.3）**	**18（21.7）**	**7（8.4）**	**38（45.8）**	**83**	**11**

B. Definition of the ownership of village clinics:

(1) Branch of township health centre (public clinic)

The clinic was set-up by the township health centre, the personnel, belongings and operation of the clinic were managed by the township health centre.

(2) Contracted with private (contracted with individual):

After economic reformed since 1980s, as the economy of village collectives collapsed, the village clinic (CMS) lost the collective support. Within the clinic, some assets belong to the village collective, but most belong to the individual.

(3) Village collective clinic (public clinic)

The clinic was set-up by village collective, the personnel, assets of the clinic were managed by village committee, and operation were managed by village and township health centre.

(4) Jointly run by village doctors (contracted with village doctors)

After economic reformed since 1980s, as the economy of village collectives collapsed, the village clinic (CMS) lost the collective support. Within the clinic, some assets belong to the village collective, but most belong to the village doctors. Meaning is the clinic was contracted to village doctors.

(5) Owned by private (individual clinic)

In order to meet the shortage of health resources in 1982, the government issued a document to encourage individual to practice health care in the city or rural area. From that time, individual health practice developed quickly in rural areas. In such clinics, all assets belonged to the owner.

In this study, the branch of township health centre and village collective clinic were named as the public clinics, and the contracted with private, jointly operated by village doctors and owned by individual were named as the private clinics.

ANNEX 5 – Study methodology employed in Ujjain PSP-study

1. **<u>Objective</u>: To describe the geographic distribution and other provider characteristics (qualifications, the system of medicine practiced, size and scope of practice, organizational set up) of private health care providers in Madhya Pradesh and digitize the information (develop a computerized GIS).**

*(*The province has a population of 60 million people. A typology was developed for categorizing providers based on an adaptation of Berman and Hansen.*)*

<u>Study population</u>: All health care providers in the private (non governemental for profit and not for profit) currently providing health care in the province (curative and preventive health care provided by qualified or less than qualified practitioners)
<u>Study design</u>: Cross sectional survey
<u>Data collection method:</u>
A statewide survey by trained surveyors was undertaken to obtain this data. All necessary permissions from the State Dept. of Health were obtained prior to the survey. Information regarding the survey was provided to all District Medical Officers and heads of district administration in each of the state's 45 districts through the Office of the Commissioner, Dept. of Health, Government of Madhya Pradesh.

We conducted a pilot intially in one district (Jhabua) and one urban center (Dewas). The basic unit of the survey was a village in rural areas and a ward in urban areas. Formats were prepared in consultation with officers from the Dept. of Health. The methodolgy and the survey instrument (formats) were tested during this phase.
Surveyors were trained in the methodology (described below) of surveying each 'basic' unit. Follwing the pilot phase, a debriefing meeting between the field surveyors, the project staff, surveying staff and officers from the Dept. of Health was held. The methodology was refined further and the formats were ammended based on the inputs received. Survey formats and a special survey guide for conducting the survey were developed in Hindi.

Supervision of the surveyors on the field was carried out concurrently, and a sample of filled proformas underwent two levels of manual checking (at district level and then at the State capital and by dedicated project staff). In addition, validation was carried out by a repeat survey by project staff in 5% of villages in each district.
The data obtained were then be mapped onto a computerized Geographic Information System. Map Info software was used as the base program. Separate icons depict different provider types in separate layers and with superimposition if necessary.

Analysis of the data is ongoing and is expected to be completed soon.

2. **<u>Objective</u>: To describe the historical development of the health sector, particularly the private sector in the Indian province of Madhya Pradesh over the**

last 50 years and to find reasons for this development of the health sector through in depth interviews with key informants

Study population:

Participants for key informant interviews included at provincial level: senior bureaucrats of the Indian Administrative Service who have served in the Dept. of Health for a minimum of one official posting not below the rank of commissioner or director, directors/joint directors in the Depts. Of Health and Medical Education, Faculty from the Public Health Discipline in the province's medical university not below the rank of professor, leaders of private practitioners associations.

Study sample: All participants who met the above criteria, and who gave their consent to participate and were resident within the province at the time of the study,were included in the sample.

Study design: Qualitative, cross sectional study

Data collection method:

Each participant was individually invited to participate in an in-depth interview, which covered the following areas:

· Major considerations that have framed policy with respect to access to health care in different ethnic and economic groups?

· Changes in private and public health sector size and composition over time? Possible reasons for this change?

· What potential conflicts exist between private sector policies and overall health policy objectives?

· Government role in health care in the future, service provision and/or overall monitor responsible for steering the sector?

· Existing regulations with regard to private health care and their limitations

· What types of steering mechanisms through public financing exist and what is the magnitude, distribution and efficiency of these mechanisms?

· What are the main weaknesses in stewardship functions and how can they best be overcome?

The interviews were audio taped and have been transcribed. They are being analyzed.

3. **Objective: Study health-seeking behavior of the community in the study area for tracer conditions (ARI and diarrhea - common condition of public health importance) and understand reasons for this behavior**

Study population: All mothers residing in Narwar sector of Ujjain District of Madhya Pradesh (31000 people living in 30 villages which comprise this sector) with children less than 5 years who have had at least one episode of ARI/ diarrhoea (which will be the tracer conditions under study, as this is a significant public health problem in the province and in India)

Study design: Cross sectional survey followed by focus group discussions

Data Collection method:

A house-to-house survey of all households in the study area was undertaken. The basic socio demographic characteristics of the households were studied. In households where there were children < 5 years residing, the mother of the child was interviewed about whether the child had an episode of diarrhoea or ARI in the last month.

To study health-seeking behavior, a sample of these mothers (whose children had an episode of either diarrhoea or ARI in the last one month) were invited to participate in a focus group discussion. Trained workers from the medical college, explained the purpose of the discussion, sought their consent and then conducted the FGD on their health seeking behavior for their child's illness episode. This covered the following areas for each of the two tracer conditions separately:

- Perceived cause of the illness
- Point at which a health provider was sought
- The health provider who was contacted
- Treatment prescribed
- Reason for contacting the particular provider
- Home remedies used by the mothers before, during and after consulting the provider.

Analysis is ongoing.

4. **Objective: to describe treatment patterns for ARI and diarrhoea among practicing health care providers in Narwar sector, Madhya Pradesh**
the study area

Study population: All health care providers in Narwar as mapped on the GIS.
Study sample: All health care providers in Narwar who treat ARI/diarrhoea and who voluntarily consent to participate in the interview
Study design: Cross sectional
Data collection method:
All private providers in the study area (the listing will be obtained from the GIS) who treat the conditions under study were contacted to participate in a semi-structured interview. The interview schedule contained a case scenarios for ARI and diarrhoea separately, which were presented to the interviewee for a discussion on the management practices s/he would follow. The management was discussed under three categories: Non-pharmacological treatment, pharmacological treatment and advice to the mother.
Confidentiality of all information was ensured.
Analysis:is to be completed

5. **Objective: To describe attitudes and expectations of private providers in the study area towards partnering with government for the management of these conditions**

Study population: All health care providers in Narwar as mapped on the GIS.
Study sample: All health care providers in Narwar who treat ARI/diarrhoea and who voluntarily consent to participate in the interview
Study design: Cross sectional
Data collection method: All private providers in the study area (the listing will be obtained from the GIS) who treat the conditions under study were contacted to participate in a semi-structured interview. The interview covered the providers' willingness to collaborate with the government in the management of the tracer conditions, the reasons for the same and explore the expectations that might need to be considered for such a scheme to succeed from the private provider point of view. This perspective will enable a discussion on possible models that can be effective and prerequisites that need to be

considered before an effective model that can be feasibly upscaled can be planned. Confidentiality of all information will be ensured.
Analysis: To be completed.

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