PRIVATE SECTOR
P S P
PROGRAMME

The Role of Non-governmental Health Care: A Study of its Scope and Potential with a Focus on Policies to Promote its Contribution to Improved Health.

Framework and generic protocol for phase 1

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For the Private Sector Programme PSP
A Joint Research Programme

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Stockholm

International Health Systems Program
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Stockholm 2001

Introduction

The overall objective of the research programme is to strengthen health systems' performance and their outcome in terms of improved health. A second overall objective is to seek ways through which the non-government sector can be involved in providing health care to the public, in particular those in most need, while ensuring affordability of those seeking this care.

The programme will seek to analyse the organisation of health services and health care delivery for a set of important population health needs and outcomes. Targeted health problems will be leading causes of illness and deaths, e.g., TB, STI, ARI, diarrhoea, malaria and other diseases with a significant impact on, in particular, children's and women's health. The programme will assess the role of private providers and public-private linkages in relation to these health needs.

The programme has two main phases:

Phase 1: Development of methodology and implementation of descriptive and analytical studies in the 6 participating countries. Phase 1 consists of two components:

- 1A. Development of theoretical framework, core methodology for the programme and country specific protocols.
- 1B. Application of country specific protocols, including data collection and analysis of data within and across countries.

Phase 2: Design, implementation and evaluation of policy interventions to improve health systems' outcomes. Findings in phase 1 will form the basis for phase 2. Type of interventions and choice of focus on specific health problems will thus be determined after phase 1.

This document is an output from phase 1A. The intention of the document is to outline a framework on which to build country specific proposals that will be implemented in phase 1B.

General framework for phase 1

The main aim of the assessment in phase 1 is to provide data that allows design of interventions that improve the contribution of private providers to overall ~~public~~ health goals. In order to do this, the current role of private providers as well as factors that determine private healthcare performance will be analysed.

The programme has specified the following objectives for phase 1:

- To assess the development over time of non-governmental health care.
- To analyse existing regulatory framework and other relevant health policy characteristics (financing, incentives, demand side interventions, etc.).
- To describe and enumerate all types of relevant providers (government or public, and non-government or private, not for profit and for profit) and their important characteristics (their size, role, etc.).
- To analyse treatment seeking behaviour in relevant sub-groups (socio-economic, gender, ethnic, religious etc.).
- To assess technical and perceived quality of services of different provider types.
- To measure, through direct and proxy variables, likely outcomes in terms of health and financial protection.
- To investigate the interaction between patients and providers and the interaction amongst different provider types.

These objectives can be grouped into three main analytical dimensions:

1. ***What the private sector is:*** Analysis of basic characteristics of private health care such as size, distribution, competition, regulation and linkages to the public sector.
2. ***How well the private sector performs:*** Analysis of current health impact, through proxies such as quality, efficiency and equity in access.
3. ***Why the private sector performs as it does:*** Analysis of determinants of ~~public~~ health impact of private health care.

All these dimensions should be analysed in relation to national health policies and health targets, especially with a focus on the poor. A similar analysis should also be made within the public health care sector as a reference point and an integrated part of the analysis. Thus, the analysis should be carried out with clear linkage to the whole health system, while focusing on private health care.

(Both the Harvard and the WB tools identify important aspects of the analysis of basic characteristics and performance of the private sector.)

The third analytical dimension links up to the two first dimensions. It should lead to the formulation of appropriate interventions which aim to improve private sector contributions to public health. Such intervention may target the private providers, or it may target any of the contextual factors that determine private sector performance, such as private sector policy or the demand by consumers/population. The framework by Options/LSHTM is a relevant tool both for formulating specific research questions and designing interventions.

Part 1. Analysis of basic characteristics of private health care

This part first of all aims to determine the size, composition and distribution of private health care providers. Second, it aims to describe the nature of both competition and integration between private as well as public providers.

This part involves 4 components:
1. Building a typology for private providers.
2. Enumerating and mapping private and public providers.
3. Analysing geographical distribution of providers in relation to geographical variations and socio-economic characteristics.
4. Analysingthe nature of provider competition, linkages between providers and different levels of care, collaboration and referral structures.

1.1. Building a typology for private provision

Main objective: To develop a categorisation that enables further analyses that accounts for the heterogeneity of private health care.

Berman and Hanson suggest building a typology based on the following broad dimensions:
1. Organisational form, e.g. by level of complexity ranging from single practitioners to tertiary hospitals.
2. Commercial orientation; for-profit or not-for-profit.
3. Therapeutic system; e.g. modern and various types of traditional systems.

Berman and Hanson's framework leaves it open to identify relevant specific components and dimensions for specific settings. It is suggested that all study sites use a core set of common variables for the classification in order to allow comparisons between countries. The variable definitions need to be determined further when data collection has started. Based on this the following variables are suggested:

A. Organisational form

Authorised or unauthorised
Size of company / organisation (number of health facilities by type, turnover etc)
Number of staff in clinic, by profession
Proportion of staff also employed in public sector
Fixed or mobile location
Opening hours
General orientation: preventive, general practice, specialist
Linked to / member of professional association
Inpatient service provided or not
Number of beds
Drug dispensing: Selling drugs, yes/no
Interaction with public health care and referral routines: Established formal referral routines?, Gate-keeping function?

B. Commercial orientation

For-profit: a/ owned by clinician or b/ corporation, or

Not-for-profit: a/ ”NGO” (local/national/international), b/ trust, b/ co-operative , c/industry, or d/other

C. Financing and taxation

Proportion of public financing (source), private financing (private insurance and out-of-pocket financing), and funding by international donors (source).

Type of contractual arrangements: Public health care sector, insurance company, other private providers

Payment mechanisms (clinic and individual staff): Prepayment / capitation / Fee-for-service

Taxation: Type and level of taxation of services

Legal organisation of private provider (equity-based company - public/not-public or privately owned without shareholders, etc.) (SHOULD THIS BELONG UNDER THE COMMERCIAL ORIENTATION?)

D. Therapeutic system

Modern or traditional/alternative

Type of traditional/alternative

Rough categorisation on group level can be made in a desk study, making use of available documentation, statistics and literature. However, more elaborate individual categorisation could be made based on information from individual providers through a survey/census and/or interviews with key-informants (see below).

If data on these variables are obtained for individual providers, a profile for each provider can be created. Grouping of profiles can then be done in various ways.

1.2. Enumeration and mapping

Main objective: To establish the number of different types of private as well as public providers and to determine their geographical distribution.

Official statistics can be used to get rough estimates of size and distribution of different categories. However, such data sources would not enable elaborated categorisation of organisational forms nor include unauthorised providers. Furthermore, data may in most settings be of questionable quality and sometimes out of date.

A census and mapping of providers in a defined and confined study area should be considered in each study setting. A census would involve a visit to each provider in order to obtain basic information concerning categorisation variables listed above. Identification of providers to include could be through a combination of provider registers, interview with key-informants (health staff, other private providers, community officials etc) and door-to-door census techniques.

In Ujjain, a protocol has been developed for this purpose. In the first step, surveyors visit all sign-posted providers. In a second step, information is collected from key-informants about additional providers. The location of all providers is defined using a Geographical Positioning System (GPS) which allows for the creation of a electronic map.

Information on variables listed in the previous section can be collected through a questionnaire or interview with the providers. These tools can be developed during the field studies. Through communication between the participating institutions the tools will be improved as the works progresses.

Enumeration and mapping can further be used to
(1) facilitate analysis of health care utilization patterns,
(2) sample Private Providers (PPs) for further investigation and
(3) target interventions to specific PPs.

1.3. Analysis of geographical distribution

Geographical distribution of different provider types will give an overview of health care availability for different parts of the population. For example differences in health care availability and density can be compared between urban and rural areas, between economically advantages and disadvantages areas, between areas with and without a high proportion minority population etc. Based on basic socio-demographic characteristics of different areas and data on provider distribution in these areas relationship between socio-demographic characteristics and availability to different types of providers can be analysed, with area as unit of analysis. A more detailed analysis (with the individual/household as unit of analysis) of relationship between socio-ecomnomic status and health care access and utilisation should also be done (see below).

1.4. Analysis of the nature of provider competition, linkages, collaboration and referral structures.

In order to analyse how the market for health care actually works qualitative studies are required, when such information is not already available. Some questions to be answered in this phase are

- What is the extent and characteristics of collaboration and competition between providers?
- What is the status of referral systems? How well do they work?
- What is the status and role of professional organisations?
- (More to be added as the work develops)

Part 2: Analysis of impact of private health care

This component concerns impact on overall population health, equity in health and affordability. However, it is difficult to empirically determine the impact of private sector provision on outcome variables such as health, equity and financial status even within the scope of a large project. Outcome evaluation requires a longitudinal design with considerable follow-up time and possibilities to control for various confounding factors. It is more realistic to analyse performance in terms of (1) characteristic, quality and efficiency of care (as a proxy for impact on population health), (2) equity in health care access (as a proxy for equity in health) and (3) health expenditure at the time of health care use (as a proxy for financial burden).

2.1. Performance of private health care

The main general questions under this heading are:

- What health interventions are provided by private providers? How often are they provided?
- What is the relative provision of e.g. preventive / curative interventions?
- To what extent are public health relevant interventions provided?
- To what extent are interventions with negative public health consequences provided?
- What are the characteristics and quality of interventions in relation to costs?

Part 2A has two components:

1. Description of type of care provided.
2. Assessment of quality and efficiency of care for selected tracer diseases.

The first component is partly overlapping with categorisation of providers (part 1). It may be possible to obtain some information through surveys as discussed above. However, it is advisable to instead collect detailed information from a sub-sample of providers mapped in part 1. In a sample survey, information may be collected simultaneously about the general profile of care delivered as well as the quality of care for selected tracer diseases. Alternatively, data on quality of care for selected conditions may be generated through targeted studies for separate conditions.

Efficiency of services is defined as cost per output. To get an idea of this efficiency cost data will be required. Such data may come from special studies of provider costs or from reports from providers.

21.1. Type of care provided

This information can be collected through a survey using the following data collection formats:

Clinical activities

	Available/ Provided		Frequency (put ”X” in one)			Number of patients last week
	Yes	No	Daily	Weekly	Monthly	
Basic equipment						
Stethoscope			N.a.	N.a.	N.a.	N.a.
Blood pressure manometer			N.a.	N.a.	N.a.	N.a.
Other…			N.a.	N.a.	N.a.	N.a.
Preventive services						
Immunisation						
Antenatal care						
Well Baby Clinic						
Family planning						
Other preventive activities						
Screening						
Mammography						
Other…						
Surgery etc						
Delivery						
CS						
Minor surgery						
Major surgery						
Other						
Investigations						
Chem. lab.						
Microbio. Lab						
Pathology lab.						
ECG						
X-ray						
Ultrasound						
CT-scan						
MRI						
Endoscopy						

Other…						

Disease specific activities (put ”X” in one or several columns for each row)

Disease	Deals with this disease	Diagnoses	Treats	Refers (when applicable)	
				To private	To public
Diarrhoea					
ARI					
COPD					
Malaria					
Other trop. Infections					
STI					
TB					
Lepra					
HIV/AIDS					
CVD					
Cancer					
Psychiatric illnesses					
Neurological disorders					
GI-diseases					
Other					

21.2. Quality and efficiency

Information on the quality of services can be collected from reports on outcomes like case/fatality rates, complications, average length of stay etc. When time and resources allow for it, a better documentation of quality can be generated from site visits where services are monitored. Standard protocols for such quality assessments have been developed for many types of services and conditions. For instance, health facility survey protocols for assessment of child health services are available from the Programme on Integrated Management of Childhood Illnesses (IMCI) at WHO.

Indicators of efficiency are for instance cost/bedday, cost/visit and cost per diagnostic intervention or treatment course. Data on efficiency should always be related to quality indicators to avoid a limited focus on economic outcome variables such as efficiency.

Examples of design and data-collection approaches

- Literature / document review
- Qualitative / semi-structured data collection, e.g.:
  - -in-depth individual interviews
  - -focus-group discussions
- Provider survey
- Provider / key informant interviews
- Patient / population survey
- Inventory / observations of private health facilities, equipment, medical records etc.
- Review of medical records
- Exit-interviews

Many of these components are covered by a health facility survey.

2.2. Access, utilisation and health expenditure

- Under this chapter answers to certain questions related to access, utilisation and health expenditures are sought. They may be:
- What is the utilisation pattern of different types of private providers (e.g. with regards to income level, education, urban/rural residency etc)?
- What is the expenditure pattern of private health care consumption for patients in relation to income, non-food expenditure etc?

Equity issues are addressed under this component.

Examples of design and data-collection approaches

- Literature review
- Cross sectional population survey with retrospective questions concerning health, perceived health care needs, health care utilisation, experiences of health care, health expenditure.
- Cross sectional population survey with questions concerning health care preferences, health and health care knowledge.
- Cross sectional survey with exit interviews of patients attending private providers
- Focus-group discussions with patients concerning health care options and preferences
- Case studies of consumer organisations as well as health information channels with multiple data collection approaches

Tools to be developed

- Generic indicators for quantifiable variables such as various aspects of health care utilisation and expenditure.
- Core component of population survey instrument
- Analysis matrices for patients' health care preferences
- Analysis matrices for consumer empowerment and influence

Part 3: Analysis of determinants of public health impact of private health care

The main objectives of this part are:
1. To identify factors that influence private sector performance
2. To identify the mechanisms through which such determinants influence private sector performance in a positive or negative way.
3. To identify interventions and policies through which the private sector and its performance can be influenced.

In earlier studies of the private health care sector eight broad groups of determinants for private sector impact have been identified:
1. Provider knowledge
2. Payment mechanisms in the private sector
3. Nature of competition between providers
4. The organisation and status of public health care provision.
5. Links, collaborations, contracts and peer influence between providers.
6. The nature of demand and expectations from patients / individuals.
7. Type and category of the health good
8. The government's stewardship and functions.
9. Financing modes of health services, public and private.

For some determinants, in the following called contextual factors, there is enough scientific data at least to sketch a rough picture of what constitutes a favourable environment for private health care provision. For example, certain stewardship functions, financing arrangements, payment mechanisms, and demand patterns may be defined at onset as favourable or not. Through an assessment of the contextual factors a "diagnosis" can be made of the health care environment. When it is difficult to obtain valid data on output variables such as quality, efficiency and equity in access, this may be the only way to make an assessment of the likely public health impact of private provision. Thus, moving "upstream" in the causal chain linking health system context to output of private provision creates an opportunity to make an indirect assessment of the output and to identify broader factors at macro level that may be addressed in interventions.

However, the knowledge of what determines processes of private provision and thus quality, efficiency and equity in access is incomplete. By relating performances to potential determinants contributions can be made to the understanding of such associations.

The Options/LSHTM tool would have a role in this process. It provides ideas on how to determine potential areas of interventions through the process of analysing providers, policy makers and target population.

Part 1 and 2 of the study should describe several aspects of the first six areas of contextual factors. The seventh, type and category, or nature, of the health good, should be taken into account in separate analysis of public health impact concerning specific diseases or interventions. Here, the framework developed by Chakraborty and Harding may be applied.

Below, a framework for the analysis of stewardship functions and public financing is outlined. This is a central of the private health care environment that is not directly captured in part 1 or 2 discussed above. It therefore warrants a separate study.

Status of the government's stewardship functions and financing.

The general aim of this component is to analyse evolution of private health care and government policies towards private health care and to assess what stewardship functions are actually in place to steer the private sector in the desired direction. In order to understand the rational of current policies, they should be analysed in relation to the history of health system development in general and development of private health care in particular.

Main research questions:

- How has the private sector size and composition changed over time?
- What does the state want from the private health care sector, how does it attempt and how does is it succeed in steering it?
- What types of steering mechanisms through public financing exist and what is the magnitude, distribution and efficiency of these mechanisms?
- What regulatory barriers to establishment and availability of private providers exist?
- What factors influences private sector policy other than aims to promote population health status, financial protection, consumer satisfaction, and the equity of distribution of these outcomes?
- What potential conflicts exist between private sector policies and overall health policy objectives?
- What are the main weaknesses in stewardship functions and how can they best be overcome?

This study component can be divided into three areas of analysis:

1. History of private health care development
2. Current government policy with regards to private sector
3. Current situation with regards to government's stewardship role and government financing of private health care

History of private health care development

The current status of private health care as well as policy-makers visions for its future is likely to be closely linked to the history of private health care as well as to the general political development in the country. The symbolic value of private health care and public health care may look very different depending on historically determined perceptions of the role of the state and the market. This in turn may strongly influence the willingness and ability to introduce policy changes to change the private-public mix.

Some broad questions that may be relevant to address are:

- What is the development of the private sector during the last decades?
- What factors have been of importance for the development, e.g.:
  - -Political history

-Current political situation
-Social and economic development
-Donor and loan givers policies / advises
-Health transition
-Influence of scientific knowledge on health systems

These broader questions need to be further specified. Possibly, a few country specific hypotheses could be formulated.

Current government policy concerning private health care

Most countries will have some form of legislative framework and documentation that set out rules for private health care provision and financing. Policy documents concerning specific areas of private health care is likely to be found. However, it is less likely that there are comprehensive policies that define what the state should expect from private health care, how it should contribute to public health, what roles different private providers should have in relation to the public sector and so on.

Current policies can be analysed with at least three different purposes. First, current policies may be related to the history of private sector development and political history. Second, one may analyse the policies in order to make some kind of judgement of its' appropriateness. Such analyses would have to be grounded in a paradigm of "correct" public policy on private health care. Third, the analysis could be seen as a reference point for analyses of other components such as actual stewardship functions, the status of the private sector, utilisation pattern and so on. In the latter case, the core question would be: does the reality correspond to the policy intentions?

Government / MOH definitions of private health care
If it has not been clarified through the analysis of private sector development, the first thing needed in an analysis of current policies is to understand how private health care is defined in policy documents. It may well be that private sector is not defined, is vaguely defined or that there are several, perhaps contradictory, definitions.

Some of the questions that need to be addressed are:
- Is there none, one or several official definitions of private health care?
- If there is any official typology of private provision and financing, what does it then look like?

Specific policy aims
Ends and means are often difficult to distinguish in policies on private health care. Often the means to achieve for example a certain dimension of welfare for the population is promoted to a policy aim in itself. This reflects that aims can be defined on several levels. From a public health viewpoint the ultimate aim of a health care policy is usually that health care simultaneously should contribute to enhanced total population health as well as to equity in health and financial protection. This is achieved through establishing a health system that provides cost-effective health interventions in an equitable way and that is used by the

population in a rational and efficient way. The later are thus both a possible policy aim for a health system and a means for achieving ultimate health goals. One aim of an analysis of policies concerning private health care is to distinguish ends from means and to understand what the rational for the policy directions are.

Ultimate health care policy aims could also include components that are not clearly linked to health (though it may be if one adopts a very broad health definition), such as freedom of choice for consumers and the right of private ownership for health providers. Another aim may be to ensure that people cannot make a profit on other peoples' ill health, which may be seen as a moral related but not health related aim. Another aim of this analysis should be to identify what non-health related dimensions are considered in policies concerning private health care.

Questions include:

What are the ultimate health policy aims and how do they relate to the private health care sector?

What are the risks and benefits of private sector contribution that policy makers expect at present and in the future? What are the underlying assumptions for the policy of private health care?

What is the intended mode of financing private health care in the future? Is there a policy for the development of private insurance schemes or social insurance schemes that should cover private provision of health care?

Is a particular proportion and distribution of public vs. private financing a policy aim in itself?

Is the size of private provision (large or small) a policy aim in itself?

What is the policy with regards to appropriate division of responsibilities between private and public providers and between different types of private providers?

What are the specific expected contributions or activities with regards to health problems of public health importance? Are there any policy directives on what diseases / health issues may be suitable for the private sector to become more formally involved in?

Is there a policy on how to promote establishment of private provision?

Is competition between providers a policy aim in itself?

Is freedom of choice for consumers a policy aim in itself?

Is right of ownership a policy aim in itself?

Is prohibition of profit-making in the area of health a policy aim in itself?

What does policies state concerning stewardship functions, e.g.:

-Monitoring and managing manpower and facilities in the private sector

-Regulating and enforcing regulation

-Limiting bureaucratic hurdles for private sector participation

-Financial steering: contracting / purchasing / use of appropriate payment mechanisms

-Quality surveillance and control

Current real situation with regards to government's stewardship role and government financing of private health care

The final component is to determine how policies are implemented in practice. The scope of this component depends on the focus as well as findings in the first two components. Possible questions concerning stewardship functions and financing are listed below:

Stewardship functions:
- How is manpower and facilities in the private sector monitored and managed in reality?
- How are regulations enforced in reality? (see Berman and Hanson, page 20)
- How are bureaucratic hurdles for private sector participation limited in reality?
- What types of contracting / purchasing / use of payment mechanisms exist in reality?
- How is quality surveillance and control performed in reality?

Financing:
- Total and shares of various types of private and public financing of all health care
- Total and shares of various types of private and public financing of private health care
- Proportion of population covered by private health insurance
- Proportion of population covered by compulsory insurance
- Proportion of compulsory insurance funds used to finance/purchase private health care provision
- Proportion of public funds used to finance/purchase private health care

Methods

This study should be a combination of desk studies and data collection from key-informants. The desk study involves review of policy documents and statistics.

Data sources
- Literature / document review
- Review of statistics at MOH / statistics office
- Qualitative / semi-structured data collection, e.g. interviews with key informants

Tools to be developed
- Analysis matrices
- Basic structure of an interview guide
- Indicators for describing financing mechanisms
- Data recording forms for collecting data for the indicators