”WORKING WITH THE PRIVATE SECTOR TO IMPROVE HEALTH – FROM THEORY TO EVIDENCE AND IMPLEMENTATION”

WORKSHOP

STOCKHOLM MAY 12-14, 2004

Photo by Jesper Sundewall

DIVISION OF INTERNATIONAL HEALTH (IHCAR)
DEPARTMENT OF PUBLIC HEALTH SCIENCES
KAROLINSKA INSTITUTET

The Workshop "Working with the private sector to improve health – from theory to evidence and implementation" was held in Stockholm May 12-14 2004. It was organised by the Division of International Health (IHCAR) at Karolinska Institutet and the International Health Systems Program (IHSP) at the Harvard School of Public Health (HSPH) with support from the Swedish International Development Cooperation Agency (Sida).

The Workshop was organised within the framework of the joint IHCAR/IHSP research project, the Private Sector Programme (PSP), which involves ten research institutions in eight countries.

Birger Carl Forsberg
Project Coordinator, IHCAR

Peter Berman
Project Coordinator IHSP

Jesper Sundewall
Assistant Project Coordinator

For correspondence regarding the project or to order additional copies of the workshop report please contact:

Birger Forsberg (birger.forsberg@phs.ki.se) or
Jesper Sundewall (jesper.sundewall@phs.ki.se)

Mailing Address:

Karolinska Institutet
Department of Public Health Sciences
Division of International Health (IHCAR)
SE-171 76 STOCKHOLM, Sweden

Phone: +46 8 517 7000 (switchboard)
Fax: +46 8 31 15 90

Executive Summary

During 12-14 May 2004, a workshop on the topic ”Working with the private sector to improve health – from theory to evidence and implementation” was held in Stockholm. 36 participants from Europe, The Americas, Africa and Asia attended the workshop.

The workshop was an opportunity for, foremost, the participants of the Private Sector Program to meet and discuss what has been done so far, what needs to be done and how to do it. It also provided an opportunity for other researchers from Karolinska Institutet and Sida staff to obtain more information about the character and objectives of the program.

In short, the Private Sector Program has two main phases. The first phase includes development of methodology (phase 1A) and implementation of descriptive and analytical studies in the 6 participating countries (phase 1B). Phase 2, the intervention phase, involves the design, implementation and evaluation of policy interventions to improve health systems' outcomes. Findings in phase 1 will form the basis for phase 2. The workshop focused mainly on the upcoming phase (1B) and the intervention phase.

As the title of the workshop implies, the focus was on how to move beyond theory to look more closely at what works and what does not work. Each of the participating countries and also some specially invited guest speakers therefore gave presentations on different private sector topics. Most presentations were focused on recent experiences from public-private collaboration or private health sector development more generally. The aim of the presentations was to get an idea of what is happening in the private sector in a number of low-income countries around the world in order to give a foundation for further discussion. The main points from the presentations are summarized below.

First, the presentations reconfirmed the strong role of the private sector in low-income countries. For example, the presentation “How can private providers contribute to TB control” showed that by utilizing the private providers, the coverage and treatment of TB patients was significantly expanded and improved. Also, the presentation “Why focus on the private sector” showed that private providers are the main provider of out-patient services in India.

Second, the presentations touched upon efforts that are being undertaken to examine how the government can regulate the private sector. One presentation given at the workshop discussed how to regulate dual job-holding among public sector health workers. Furthermore, a couple of presentations discussed the government's challenge to regulate prices and uphold quality among private providers.

Third, several presentations, and the general discussions, touched upon the issue of capacity development. It is widely acknowledged that capacity to work in public-private partnerships is low on both sides. 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 also often lacks the administrative competence to meet the accounting requirements of the public sector and to participate in competitive biddings.

Preliminary findings from the countries involved in the Private Sector Program suggest that people tend to use private sector health services because of their convenient location and working hours and because they are well received. However, there is still lack of evidence on the quality of services provided by the private sector. The intention of PSP is that the studies conducted during phase 1B will provide input in this area.

In groups, participants discussed and drafted outlines of protocols for studying interventions to improve private sector performance and participation in public health programs. In the concluding discussions, all partners were encouraged to carry the research process forward by identifying planned or on-going interventions in their surrounding, initiate discussions with interventions implementers and funders and start work on evaluation design.

From the presentations and the discussions at the workshop, the following conclusions can be drawn with regard to the intervention phase:

i. There is little evidence on what works and what does not work. Too few intervention studies aimed at private sector issues have been conducted.
ii. Theory does not provide a lot of guidance when designing interventions.
iii. There is a great need and demand for a stronger evidence base on how to work with the private sector to improve health.
iv. Intervention studies are difficult to perform because they require access to significant funding and take significant time. Researchers should avail the opportunity to study interventions that are undertaken within on-going programs run by governments or non-governmental organisations.

The above conclusions present great challenges, but also great opportunities for the intervention phase of the PSP.

The workshop showed the importance of the Private Sector Program because of the significant role that private health care providers play in low-income countries. Also, since there is so far very little evidence of what works and what does not, the relevance of the program cannot be overemphasized. The strength of the program is, among others, its' connections to several research institutes and ambitious research agenda. The program connects research to policy development and intervention for improved health in countries of great importance when working towards Millennium Development Goals. With its' strong focus on outcomes, the Private Sector Program has a unique profile compared to other activities related to the private sector in the world.

This report was prepared by Birger Forsberg and Jesper Sundewall. A draft version of the report was circulated to all presenters for feedback. The authors would like to thank all those who participated in the workshop and provided feedback and input to this report.

Stockholm, September 2004

Birger Carl Forsberg Jesper Sundewall

Background

In 2002 a collaborative research program on The Role of Non-Government Health Care called the "Private Sector Program" (PSP) was initiated by the International Health Division (IHCAR) at Karolinska Institutet, Stockholm and the International Health Systems Program (IHSP) at the Harvard School of Public Health, Boston. The objective of the program is to strengthen health systems' performance and outcome in terms of improved health. Specifically, the program 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 program has, so far, engaged eight research institutions in six countries in the collaborative program.

The program has two main phases. The first phase includes development of methodology (phase 1A) and implementation of descriptive and analytical studies in the 6 participating countries (phase 1B). Phase 2, the intervention phase, involves the design, implementation and evaluation of policy interventions to improve health systems' outcomes. Findings in phase 1 will form the basis for phase 2.

The program has generated a number of activities, like development of a generic research protocol and country specific research proposals, reviews of the private sector in five countries, development of a technique for mapping private providers, conduction of a pilot study in Zambia of the private sector, and a presentation of the program at the iHEA conference in San Francisco. Also, the collaboration has lead to the establishment of a joint IHCAR/IHSP training course on working with the private sector for improved health. The study team has also provided input in international work on private health sector issues in various programs and projects, other than the PSP.

The PSP research program seeks to share experience and knowledge among the organizations involved and others interested in private health sector issues in low- and middle-income countries. As the program now enters a crucial phase there is a need for sharing ideas and discuss lessons learnt. Hence, a workshop on the role of the private sector in improving health was held at Sida Headquarters in Stockholm from May 12-14, 2004.

There were 36 participants attending the workshop (for a list of participants, please see ANNEX 1) from all the collaborating institutions involved in the Private Sector Program, IHCAR, IHSP and Sida. Also, there were four guest speakers from WHO, London School of Hygiene and Tropical Medicine and the Greenstar initiative in Pakistan. This report will give a chronological summary of the lectures and seminars held during the workshop.

Wednesday, 12 May

Workshop opening

The workshop started with a short welcome from the organizers, represented by Birger Forsberg (IHCAR), Peter Berman (IHSP) and Pär Eriksson (Sida – Health Division)

After the welcoming remarks, Pär Eriksson gave a short presentation of his department's work and he also strongly emphasized Sida's interest in private health care providers and stated that Sida's commitment to the Private Sector Program is strong.

He also talked briefly about Sida's publication "Making markets work for the poor". This publication describes the purpose and key principles of Sida's support to Private Sector Development and how this work is connected to Sida's overall goal of Swedish development cooperation i.e. poverty reduction. Sida sees the private sector as a potentially dynamic actor in market development. For this to take place, however, sound legislation and policy needs to be implemented and this is where Sida can provide support. Support can be given in the form of technical advice and budgetary support as well as targeted support to knowledge generating activities, like the Private Sector Program.

Finding a common ground

Peter Berman, IHSP at HSPH

The established view was, for a long time, that the private sector only served the rich. Evidence and theory then came along to show that this was not true. The private sector is everywhere and serves all kinds of people. The Private Sector Program gives an opportunity to move from theory to implementation. To find out what works, and what does not. Working with the private sector is not a goal in itself, but it is instrumental in reaching broader social goals. It is a pragmatic and not an ideological approach.

The overall goals of the Private Sector Program are to:

- Improve health
- Reduce financial burden of ill health on households
- Equity of these (improve health and financial burden)
- Satisfaction of users and communities
- Fiscal impact, sustainability

For each of these goals, it can of course be discussed how the impact could and should be measured. For example, should improvement of health be guided by the Millennium Development Goals or by other goals?

When we look to (economic) theory for normative guidance we can see that most "public health goods" are not "pure public goods". For those that are, public provision is desirable. People are willing to pay for health services and therefore they are not pure public goods. The market is demand driven to a larger extent. For those "public health goods" that are not, there are still important market failures, mainly related to externalities and information and public financing, but not necessarily public provision, is needed to address these failures. The

poverty aspect is also important because it can cause sub-optimal provision. Again, however, financing can in theory address this.

Furthermore, when looking to theory for guidance on organization and markets, we find that market failure should not be the only reason for government provision of services. Health care includes many types of goods. For public financing to be an effective strategy for achieving social goals, there must be:

- Potential for non-government supply to effectively enter market
- Potential for government to make and enforce contracts

Theory does not give us much of guidance, so we have to look into practical solutions, testing what works and what does not.

This is what generates the pragmatic view that theory cannot provide the answer. We need to go out there and look for it. International experience suggests both caution and boldness – there are good and bad examples. We know that Government and markets may both be faulty – especially in low-income countries. One can ask oneself, which failures are actually worse?

So to find a common ground the following synthesis is suggested:

- Overall goals should be improved health, financial protection, and satisfaction – especially for the poor – with a focus on the MDGs. The intermediate goals should be improving access and quality – "effective coverage" – and reducing high cost to households of using essential health services
- Theory does not provide general predictions favouring public or private provision of health care
- Ambulatory care services are highly contestable, but not very easily monitorable
- Private provision is widespread in many countries and it is often the main source of health care for the poor and the rural population. People therefore usually have access to health care, but quality of care is often low
- Governments should adopt a pragmatic strategy to increase effective health care coverage. The chosen strategy must be cost-effective
- Governments should also be concerned about longer-term effects on systems
- The Private Sector Program should seek to improve data and implementation evidence

Developments in public-private collaboration

Birger Forsberg, IHCAR
Paolo Belli, World Bank

The private health sector continues to grow. We can note an increasing role for private health care, not least in tertiary care and among the better off. The experience from working with the private sector, through the public sector, and with public funds, is still limited. Intervention studies are hard to finance and difficult to implement. Public Private Partnerships is on the agenda in many countries but there is slow progress. The mechanisms for collaboration between the government and the private health sector are mostly contracting and franchising. There is increasing awareness that achieving adequate capacity to work in public-private partnerships require capacity building in **both** the public and the private sector.

Why should we focus on the private sector? Because of its importance in health financing and in service provision – also for the poor. Looking at, for example, India we can see that the private health sector is estimated to provide about 81% of ambulatory care and 57% of in-patient care. Its significance for reaching the MDGs is therefore evidently immense. Figure 1 gives us an overview of the utilisation of outpatient services in different states in India.

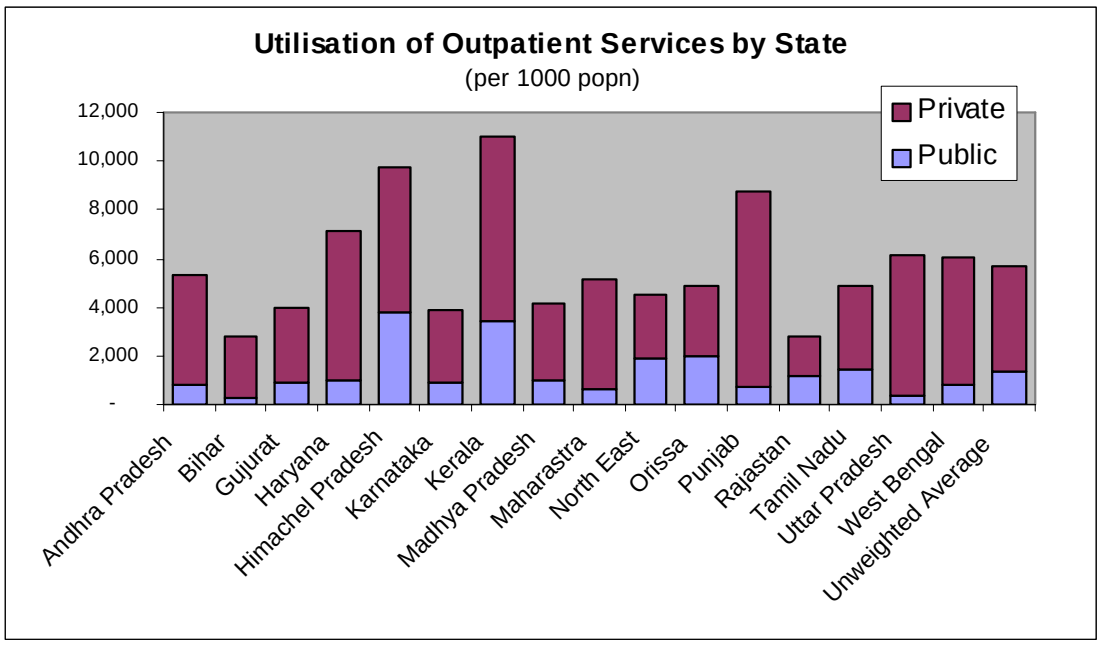


Figure 1: Utilisation of outpatient services by state

In India, we can also see that a large part of the out of pocket spending on health care goes to the private sector (Figure 2). The private health sector therefore plays an important role in health financing.

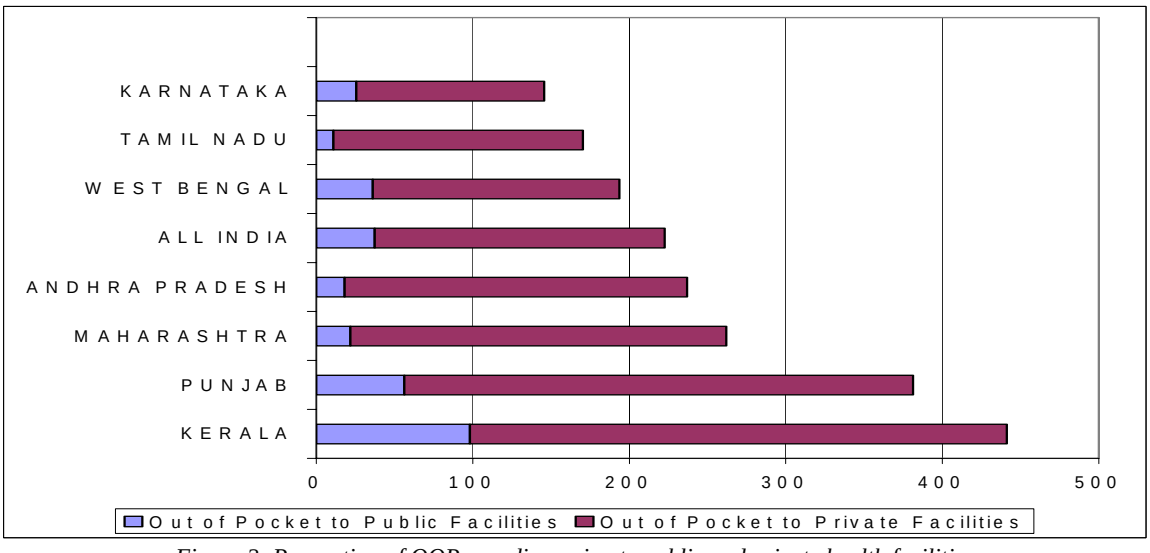


Figure 2: Proportion of OOP spending going to public and private health facilities

Issues of relevance for public-private collaboration:

- There is resistance to collaboration between the public and the private sector. The government is a strong contributor to this resistance because government officials feel

like they are giving up power if they hand over implementation, and resources, to the private sector. They need strong incentives and assurance that they do not have to give up control. This can be addressed by looking at what drives the policy makers, what the incentives are and through this analysis motivate them to work with the private sector.

- Private sector is less inclined, than expected, to work with the government and the public sector. We need more information on the incentive structure for the private sector as well as how they are willing to collaborate with the public sector and the government.

- There is no clear international agenda based on consensus among international and national donors on how the private sector can be further included in public health. International interaction on the private health care sector needs to be intensified to more strongly acknowledge the private sector in program planning and support.

What can the Private Sector Program contribute with?

Peter Berman, IHSP at HSPH

The important role of private health care provision is widely recognized. There is an increasing openness of governments and international organizations to explore new strategies. The policy discussion concerning the private sector has moved forward and there is a well-developed story on theory and concepts. Also, there are an increasing number of field programs developing public-private innovations.

However, there are still a number of knowledge gaps that need to be addressed. More specific measurements of "who is doing what for whom" are needed – i.e. more information is needed on the detailed patterns of access and utilization. Also, more specific measurements of the intermediate outcomes, especially quality and total financial burden on households are required. Finally, there is need for better designed and evaluated interventions with assessments of result and cost of different strategies for increasing effective coverage.

The work that the World Bank has done in this area (primarily by Wagstaff et al) is good, but is based almost solely on the Demographic and Health Surveys. Aspects of quality for example are difficult to measure and we need more information and different methods for assessing quality. We also need more information on cost-effectiveness since it is crucial in policy and decision-making.

So the Private Sector Program can contribute by:

- Focusing on specific health problem clusters
- Focusing on priority health problems of four types, child infections, women's health, adult communicable disease and adult non-communicable diseases
- Bringing together a wide range of measurement methods – provider-level data, exit surveys, household data, and policy-level data.
- Linking diagnostic research with interventions (Phase 2)

The focus of the PSP is on activities in participating countries. It is not a "multi-centred study", it is rather a set of collaborating activities in a range of interesting countries. The program should seek some comparability between the countries, but the first priority is to gather new knowledge and innovation in each country.

Harnessing the private sector for public health – The Greenstar experience

Imran Zafar, Greenstar Social Marketing, Pakistan

Greenstar Social Marketing is a mission-driven, non-profit Pakistani institution dedicated to public health through social marketing. Greenstar has agreements and strong ties with the Ministry of Health and Ministry of Population Welfare. Greenstar operates under a joint venture agreement with Population Services International (PSI) and they also have strong ties with private sector health providers, commercial distribution and service providers. Greenstar Pakistan views engagement with the private sector and social marketing as critical to the implementation of many of their health and population strategies.

The Greenstar Program

The Greenstar program offers a number of services and products, mostly in the family planning area. Services include, for example, family planning counselling, reproductive health counselling, emergency contraception, post-abortion care and STI management.

Greenstar operates mainly on a franchise basis where Greenstar's role, as franchisor, is to identify, select and recruit existing providers, conduct training and certification, supply products, conduct monitoring, research and evaluation and to promote the services. Greenstar's role as promoter is of high importance to the providers for increasing their number of clients. As the franchisor, Greenstar has strong accountability and therefore works a lot with quality assurance among the participating providers.

The responsibility of the franchisee, or health provider, on the other hand is to provide a package of counselling and health services following franchise quality and price guidelines. They should also provide/prescribe affordable, quality health products and participate in referral system. For the support and the brand name, the franchisee pays a fee to Greenstar.

The Greenstar operations have led to an expanded access to quality health products and services. It has also led to an increase in the quality of care given. This in turn has generated higher client flows, increased equity and better targeting of the poor. It has also allowed for more cost-efficient use of public health resources through market segmentation.

Lessons Learned

Greenstar has noted a number of problems during the course of the project. First, it is difficult to change franchise image – it is likely to be more effective to start franchise marketing with a broad family health image. Second, it is difficult to change habits and expectations – it is likely to be effective to initiate with fees at the outset. Third, it is difficult to regulate pricing and cancel franchisee contracts – there is need for establishing price norms and to create greater competition. Furthermore it has been showed that the provider selection is critical. The provider should have interest in the activity and underutilised capacity. Adequate marketing support is also critical for success. The establishment of Management Information Systems (MIS), including record keeping by franchisees is important but represents a major challenge since other mechanisms than those traditionally used for MIS may be required.

With regard to the products, experience show that umbrella brands and line extensions for related product groups are the most effective. Also, the distribution system is a key part in achieving success in sales. It needs to be reviewed continuously and improved when

necessary. The logistics and procurement need adequate and specialized human resource support.

Challenges and the future

There are a number of important challenges for Greenstar in the future, namely:

- ⇒ Strengthen franchisor – franchisee relationship
- ⇒ Use existing infrastructure to expand product and service portfolio
- ⇒ Raise funding to increase rural coverage and infrastructure
- ⇒ Convert latent demand into active demand
- ⇒ Expand health safety nets with HMO/insurance schemes
- ⇒ Provide soft loans to service providers to upgrade facilities
- ⇒ Assess and, if feasible, expand the pilot program of leasing public sector facilities and community network
- ⇒ Continue to advocate for public sector commodity supply for Social Marketing

Photo by Greenstar

Regulating dual job holding amongst public sector health workers in developing countries

Stephen Jan, London School of Hygiene and Tropical Medicine

Dual job holding among medical professionals, primarily doctors, commonly occurs in developing countries. It basically refers to public sector health workers who also run private practice on the side.

The London School of Hygiene and Tropical Medicine currently runs a study on the regulation of dual job holding amongst medical professionals in low and middle-income countries (LMIC). Studies that have examined this activity have tended to associate it with the unauthorized use of public resources and corruption. Two commonly cited problems are the misappropriation of public sector resources (e.g. stealing drugs and conducting private practice while on duty in the public sector) and the diversion of patients from public to private services (e.g. referring patients from the public sector facility to their own private clinic).

However, there has generally been a lack of analysis of the underlying reasons for such activity beyond the individual incentives of medical professionals. An important feature of dual practice as it is carried out in LMICs is that it is driven by a lack of resources in the public sector, and low pay. It is also generally poorly regulated, with regulations either absent, or when present, vague or hampered in their implementation by low regulatory capacity and a lack of political will to regulate dual practice. Appropriate regulation of dual job holding therefore has to be formulated with consideration given to these above issues.

By influencing the behaviour of individuals, groups and organizations, regulation can be seen as a major element in the institutional context in which such activities are carried out. The implementation and sustainability of such institutions, particularly in settings where regulatory capacity is weak, relies *inter alia* on the co-operation of relevant stakeholders and some degree of incentive associated with compliance. This can restrict somewhat the options. Implementation should be based on sound public policy. Public policy, in turn, needs to be rooted in certain social objectives like access to services, quality of care and minimization of the abuse of public sector resources. The regulatory measures considered in relation to these are bans, exclusive contracts, limited dual practice, price and quality controls, incentive–based payments and measures aimed at strengthening the influence of professional reputation.

How private providers can contribute to TB control?

Knut Lönnroth, WHO

The current situation of the tuberculosis burden is that morbidity and mortality burden remains high, there are links to the HIV/AIDS epidemic, poor and marginalized groups are most affected, it is a common disease in productive ages and it contributes to a disease-poverty trap.

The public sector health care is currently not adequately meeting the demand for treatment of tuberculosis. Quality services are not accessible to all, they are non-responsive to individual needs and they often carry high indirect costs. The private sector on the other hand also has shortfalls. Technical quality is poor and treatment is expensive and often not completed.

Therefore, a stronger involvement of private providers in the treatment of tuberculosis, or a Public-Private Mix (PPM) of DOTS (the internationally recommended TB control strategy), could provide interesting opportunities for:

⇒ Improving technical quality in the private sector
⇒ Increasing case detection through involvement of providers that receive people with TB symptoms
⇒ Utilize private providers to improve access and decrease indirect costs to patients

Figure 3 gives an idea of the increase in PPM projects in the last few years.

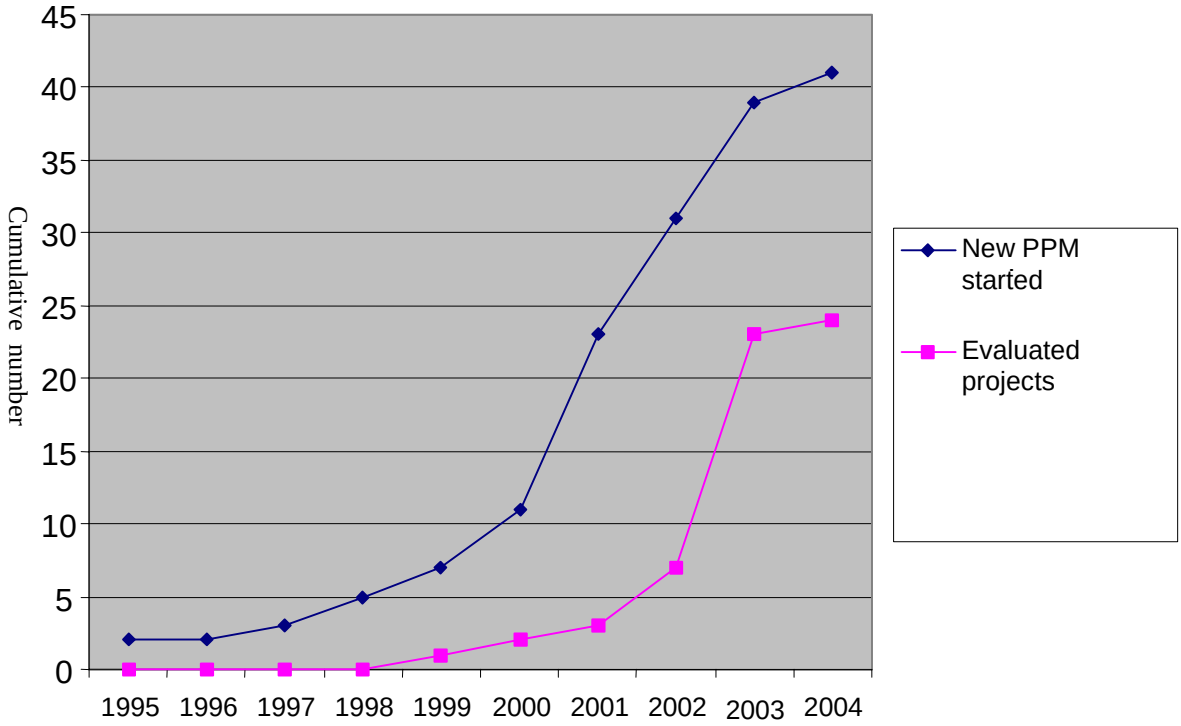


Figure 3 The PPM DOTS evidence base

In table 1 we can see that PPM DOTS have shown remarkable results in India. The figure shows the increase in case detection since PPM was first initiated.

PPM Site	Baseline Rate	Increase	Evaluation Approach
Hyderabad	50/100,000	23%	Compared to neighbouring district
Delhi	60/100,000	36%	Change controlled for trend in other district
Kannur	25/100,000	15%	Change in same district
Lalitpur	54/100,000	61%	Change in same district
HCMC	100/100,000	18%	Change controlled for trend in other district
Punalur	25/100,000	50%	Change in same district
Thane	50/100,000	14%	Change in same district
Mumbai Zone IV	55/100,000	19%	Change in same district

Table 1: Increase in case detection (registration in DOTS programme) in different PPM projects.

In order to achieve a successful Public-Private Mix for DOTS, a number of requirements need to be fulfilled. First, the technical infrastructure needs to be in place. This means that there has to be a referral and information system and a capable structure for supervision and quality control. Second, training of participating providers as well as supervisors has to be conducted. Third, trust has to be established between all stakeholders. Hence, substantial time should be invested in dialogue where there has to be openness about potential conflicts of interest. Fourth, the government has to deliver TB drugs to private providers free of charge and these should be dispensed to patients free of charge. Fifth, the government also has to finance most operations such as training and surveillance. Finally, the incentive structure needs to be reviewed to ensure that there are adequate incentives for the providers involved. In short we can say that a Public-Private Mix for DOTS means increased public financing of, and influence over TB services delivered by private providers.

The following steps are essential in the PPM DOTS implementation process at local level:

i. Ensure government commitment or strong local enthusiasm
ii. Conduct mapping to locate available providers and review their current practice. Examine health seeking pattern of the people
iii. Develop local PPM model options
iv. Conduct dialogue with all stakeholders to agree on which PPM model option to use and define roles and responsibilities
v. Establish an implementation and evaluation plan
vi. Conduct recruitment, training and certification

More information is still needed in many areas of PPM DOTS. WHO has therefore suggested putting together a research agenda covering the most important areas. They are:

⇒ Equity in access and financial protection
⇒ Diagnostic delay
⇒ Business analysis: financial and non-financial incentives
⇒ Scaling up and sustaining PPM DOTS
⇒ Effectiveness of different types of private providers in PPM DOTS

Thursday, 13 May

Private health sector development policy in China

Jiangbin Qu, Centre for Health Management & Policy, Shandong University, China

In China, the development of the private health sector is determined by (a) overall social and economic policies, (b) policies with regard to the private sector and (c) health sector policies.

With regard to (a), overall political development the first phase was from 1949-1955 when the People's Republic was established. In that phase economic ownership was private, state, or collective. During that phase private health institutions accounted for 57 % of all health institutions. The next phase ran from 1956-1958 when ownership was transformed. After that, the state and collective economy dominated the national economy, and private economic activities were gradually restricted. At the end of this period, the proportion of private health institutions decreased to 5.8%. The third phase was from 1966-1976 during the Cultural Revolution. In that phase, the pure socialism concept led to eradication of any forms of private economies and all health institutions were owned by state and collective bodies.

After the end of the Cultural Revolution, the market-oriented economic reform period started and it still goes on. In that phase, the theory of social market economics was set up. It opened up to various forms of ownership and distribution through public, private and cooperative systems. It meant that the private health sector was officially allowed to be developed.

With regard to (b), overall policies for private sector development, the Eleventh National Congress of the Communist Party in 1978 formulated the theory of social market economics. This policy promotes and provides the opportunity for development of the private economy. The Fourteenth National Congress of the Communist Party 1992 adopted the objectives of social market economic system reform and the private economy was recognized as a vital component of the economy. At the Sixteenth Congress of the Communist Party 2003, multi-forms of ownership and management were designed to be a pillar in long-term development of the economy.

With regard to (c), health policies for development of the private health sector, the first important steps were taken in 1980 when The Ministry of Health allowed private health practice. In 1985, The State Council adopted a health reform agenda that encouraged private practice. In 1988, the Ministry of Health adopted guidelines for the qualification, reward and punishment of private health practice. In 1989, qualifications and requirements for public health workers who wanted to work in private hospital in their spare time were regulated. In 2000, The Ministry of Health, The Ministry of Finance and The State Planning Committee adopted Implementation Guidance on Classified Management of Health Institutions. These guidelines divided the health institutions in China into "non-profit" and "for-profit". Also in 2000, a policy was adopted by the Ministry of Finance and the Ministry of Health for the revenues of these non-profit and for-profit institutions. In 2002, the State Council took a policy that seeks to mobilize social resources for the rural health system, and to strengthen the role of the non-governmental and private health sector for improving the rural health service system.

Overall, economic reforms and policies now continue to seek to create more space for the private health sector. The current health sector reform is focusing on how the ownership

structure of public hospitals can be changed. Other important factors are that WTO rules and domestic capital development is likely to accelerate the development of the private health sector.

Photo by Jesper Sundewall

Recent experiences with public-public & public-private partnerships in Tamil Nadu and Kerala

D. Varatharajan, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerala, India.

V. R. Muraleedharan, Foundation for Sustainable Development (India), Indian Institute of Technology (Madras), Chennai

The Indian Health System has developed tremendously over the last 60 years. In 1941 there was one hospital for every 148,000 persons and one dispensary for every 123,000 persons. Corresponding numbers in 2001 were 67,000 and 36,000, respectively. The number of hospital beds per person in the same time period has increased three-fold. The number of medical colleges has gone up from 27 to 181 in the same period. The population has at the same time increased three times, from 319 to 1012 million. Even so the doctor per population ratio has increased from 0.16/1000 to 1.3/1000. Evidently, there has been a substantial increase in health care provision in the country over these years. Life expectancy has at the same time increased from 27 to 61 years.

Today, there are 163,000 Rural Health Centres and 43,000 hospitals and dispensaries in the country. 45% of the latter are private. 29% of hospital beds are in private facilities. Of government hospitals and dispensaries 37% are in the rural areas where 72% of the population lives. Out-patient services are predominantly private with an estimated 82% of out-patients going to private providers.

The private institutions are numerous but small. There are 26,000 private institutions and 200,000 beds in total. The average bed strength in private facilities is 31 as compared to 94 for public hospitals. Only 7% of private hospitals/nursing homes have bed capacity of 75 or more. The private sector is more prevalent in urban areas. However, due to intense competition, the private sector is now moving towards semi-urban and rural areas.

Out of institutional deliveries, an estimated 55% are conducted in private facilities. The government is however the main provider of preventive services, supplying 90% of immunizations and an estimated 70% of ante-natal services.

Urban-rural disparities are striking in the Indian health system. For instance, an urban bed serves 455 people, while a rural bed serves 10,000. An urban doctor serves 2,000 people while a rural doctor serves 20,000. There are significant differences between states in this regard. In Kerala the urban–rural disparity with regard to beds is 2 times, while it is 36 times in Madhya Pradesh. For doctors per person the disparity is 3 times in Kerala and 18 times in Madhya Pradesh.

Utilization patterns with regard to the private and the public sector differ between different socio-economic groups. Where there are many poor people, utilization of government facilities is high. Those with better education, belonging to higher or dominant caste and who hold more assets, on the other hand, prefer private providers. Low-income groups are catered by small sized hospitals, while middle-income groups prefer medium sized ones. Multi-specialty hospitals owned by corporations, cater to upper classes.

In the private sector most providers seek to apply modern (allopathic) medicine (80%). Around 20% of private providers follow traditional medicine schools of thought, like ayurveda, homeopathy, and sidha.

Studies have shown that a client's choice of provider depends on the following factors:

- ✓ Functioning of government institutions
- ✓ Adequacy of care
- ✓ Location
- ✓ Staff behaviour
- ✓ Price differential between government and non-government
- ✓ Ability to pay
- ✓ Tastes & preferences
- ✓ Comparative Advantage

Generally, the non-government sector is appreciated because the quality of care is perceived as being better, opening hours are more convenient (evenings), location often more accessible, treatment and reception more personalized and waiting times shorter.

The comparative advantages of the public sector are that it can make more use of economies of scale, care is free (officially), some services are only available in the public facilities, it has mechanisms in place to address medico-legal cases, it supports and operates large teaching hospitals and usually is staffed with formally trained and qualified nurses.

What then can partnerships between the private and the public actors achieve? Both government and non-government sectors operate at sub-optimal level. Government institutions are too big and non-government institutions are too small. Partnerships provide an opportunity for private providers with excess capacity to operate services at a lower cost. Contracting out of public services to private actors would give rise to competition among bidders. This could enhance supply side efficiency. More involvement of the private sector in public care provision may also enlarge the choice for clients and enhance the chance for the non-governmental sector to provide hybrid or mixed public goods. Partnerships may also promote increased transparency in prices, quantity, quality and managerial decentralization and enable hospital-based expertise to be shared with community services.

The following partnerships in India exist or have been tried:

- o Private practice run by government doctors
- o Hiring of private doctors/specialists to serve government facilities in under-served areas
- o Reimbursement to private providers for treatment costs
- o NGO/private involvement in national programs/disease surveillance
- o Provision of primary care by industrial units
- o Concession/provision of land, water and electricity by government and duty-free import of equipments
- o Control of government institutions by local self-government
- o Industrial/NGO adoption of government institutions
- o Drug delivery to government institutions
- o Contracting out of laundry, high-tech equipment, equipment maintenance, and AIDS advertisement

A more detailed example of partnership is from Tamil Nadu where industrial participation in public health care provision was initiated in 1997. The conceptual basis for the project was the assumption that efficiency improves if local industrial units manage Primary Health Centres (PHC). In the project, the first step was to prepare a list of PHCs requiring face-lift. Secondly, industrial units located in the neighbourhood were identified and contacted. Subsequently, PHCs were transferred using one of three sub-models of management:

✓Sub-model-1. Complete adoption
✓Sub-model-2. Adoption excluding staff
✓Sub-model-3. Adoption excluding staff & medicine/equipment

By June 2002, 34 industrialists/other bodies had adopted 70 (5%) out of 1,411 PHCs in Tamil Nadu. Sub-model 2 and 3 were applied. No providers preferred sub-model 1. Support in the form of medical kits, equipment, construction & maintenance, of buildings, and furniture was given by the government. The total amount spent on the project by June 2002 was Rs.9.2 million (US $ 0.2 million) which is less than 1% of govt. exp. on health. The mean value spent per PHC was Rs. 0.13 million (US $ 2,825) with a range of Rs. 2,000 (US $ 44) – 1.0 million (US $ 21,750).

The impact of the program can be summarized as follows:

- The program helped to activate idle asset capacity about 10 times
- Annual client load went up by 8.9% per annum (5.9-20.5%)
- Patients now have to spend ½ hour to receive the same level of care that previously took them 2 days to receive
- It facilitated local supervision of government institutions
- Industrial employees who used the PHCs benefited

Some form of inter-sectoral linkage is developing now, ultimately benefiting the rural community. By openly serving the community, the private health industry shows that it is part of the community where it is located and gains better support from the local community. If the PHC manages to improve client load, it would serve as an advertisement for the industry.

Another example of private public partnership is the Medical Service Corporation in Tamil Nadu. It was also initiated in 1997. It was based on the concept of subsidizing drugs in PHCs. The purpose was to relieve rural patients of the financial burden of care. The government channels the drug procurement and distribution to government healthcare institutions including PHCs through Tamil Nadu Medical Service Corporation (TNMSC). In the program, each PHC is given a fixed annual budget and is required to maintain a passbook and order the drugs and supplies as per its needs from the list of drugs/supplies provided by TNMSC.

A third example of interest in this context is the political decentralization that has taken place in India since 1997. The underlying assumption for this decentralization is that the local community has the capacity to manage PHCs and improve their efficiency and accountability. This process was studied in Kerala for its impact on management and priority setting. Through various constitutional amendments in 1993 and the Kerala Panchayati Raj Act in 1994 the ground was laid for devolution of 35-40% of the Ninth Plan resources to programs drawn up by local government bodies (Panchayats). In the year 2000, the transfer of institutional responsibilities from central to local level was completed.

The results of the program has been that a need-based resource allocation through bottom-up approach has been established and that the Panchayati Raj control has provided opportunities for government health care units to have a "liquid reserve" for local priorities. However, data indicate that the actual expenditures by panchayats are low. Formally, panchayats control 11% of government expenditures but share only 3% of actual government expenditures. Also, panchayats appear to give lower priority to health care than the central level. Of planned allocations, 2.7% went to health at state level, but only 1.8% at panchayat level. Of the locally controlled resources, proportionally more went to ayurveda than to allopathic care. Lastly, a disappointment has been that panchayats have not looked beyond the resources provided to them through the state plan. They have so far not attempted to mobilize additional resources for health or other vital services. One reason for this may be that there has been lack of advice and training of panchayat members to prioritise, seek assistance through projects and utilize available resources in a cost-effective manner.

From these experiences it can be concluded that public-private partnership to supply medicines and supplies to the government health care system in Tamil Nadu has been successful, while the other two partnerships have met with limited success.

Photo by Jesper Sundewall

Private pharmacies and drug Vendors – How can they contribute to health improvements?

Lamphone Syhakhang, Food and Drug Department, Ministry of Health, Lao PDR

The People's Democratic Republic of Laos has a population 5.1 million people and a GDP per capita of USD 322. Life expectancy at birth is 59 years and the infant mortality rate is 82 per 1000 live births. The background on pharmaceutical services is that from 1975 up to the 1980s, drugs were free in public services, but they were not always available. At the same time, there was growth of the informal sector with individual practitioners and peddlers selling drugs without a license. In 1986, a new economic policy was adopted under which the government encouraged the establishment of private pharmacies. In a few years after 1986 about 2,000 private pharmacies were established. They were so called class 3 pharmacy headed by a non-pharmacist. The number of informal practitioners providing drugs today is unknown. Only a few drug peddlers remain today.

The impact of these developments is both positive and negative. On the positive side can be mentioned that access to essential drugs has increased in the private sector. This may have improved the health situation. On the negative side is that drug sellers prescribe and dispense drugs and that many of them have opened a clinic in their pharmacies without a license. This has lead to irrational use of drugs. The quality of drugs is generally poor (22% of 300 samples were substandard in an investigation in 1999). It has been found that sellers buy drugs from illegal and unknown sources, e.g., traffickers and peddlers. Community members are not fully aware of the risks with using poor quality drugs.

In order to improve the situation, efforts have been made to improve the services of pharmacies. Tools and guidelines for pharmacy inspections, including indicators to measure the practice of pharmacies, have been developed and drug sellers have been trained in Good Pharmacy Practice.

During inspections, the following things are assessed:

1. The order in the pharmacy
2. Absence of banned drugs
3. Availability of Essential Drugs with international non-proprietary name and correct labelling
4. Quality of drugs and date of expiry
5. Quality of billing
6. Drug dispensing practices
7. Knowledge of drug sellers on material and diarrhoea drugs
8. Perception of antibiotics
9. Availability of essential materials for good dispensing practices
10. Presence of technically trained staff

Pharmacies in all provinces have been inspected and information to drug sellers based on the results of these inspections have often been given on the spot. Fines have been imposed in the case of violations of the regulations.

A special study on pharmacy practice before and after training of drug sellers and continuous monitoring and inspection was carried out in Savannakhet province. It showed improvements after the intervention, especially with regard to order in the pharmacy, availability of material

for dispensing and information given to clients. There was also less mixing of drugs at one and the same sales occasion. However, there were also indicators for which little change was seen.

The Ministry of Health has collected data on quality of drugs from 1997 to 1999 and found a significant reduction of substandard drugs from 46% in 1997 to 22% in 1999.

In another study, knowledge and perceptions of drug quality among drug sellers and consumers were assessed. Results showed that drug sellers had poor knowledge on storage conditions. Less than half (44%) knew how to correctly read and interpret a label but 77% could read the expiry date. 58% of drug sellers bought drugs from illegal and non-authorized sources. Most drug sellers trusted companies and government to provide them with only good quality drugs. Among consumers, 64% thought that drugs are of good quality and 73% did not worry about the quality at all. 89% never heard about fake drugs or drugs with lower amount of active ingredients. One of the interviewees (a man in a rural area) summarized this: "I don't know anything about fake or substandard drugs. It's like playing a flute for a buffalo"

The presentation leads to some questions for discussion:

- What could be the best method to assist private health providers to effectively contribute to improved health? There is no clear evidence that training and information change attitudes and behaviour of drug sellers. Results from other country studies have showed that knowledge and practice is not the same.

- How to sustain positive intervention results and spread the interventions over the country? Inspections and monitoring of pharmacies and enforcement of regulations are costly. How can poor countries like Laos effectively build up such a system throughout the nation?

Strengthening public-private partnership: The case of Uganda

Sam Agatre Okuonzi, National Council for Children
Joseph Konde-Lule, Institute of Public Health, Makerere University

Uganda has always had four distinct but parallel health systems since 1960s. These are public, missions (private not for profit, PNFP), private and traditional systems. The systems appear to have operated alongside each other without any problem until 1990s when health sector reforms were introduced. The reforms were introduced to address a crisis in the health sector. There was declining public expenditure, which meant less access and quality of health care for the majority. This led to inequitable and inefficient health services. As a result health and health service indicators stagnated or even worsened over the past 20 years.

Against the backdrop of a failing public health system, the Government and its partners became more aware of the role of the private sector; particularly of its large contribution to health services and the relatively better quality of services it provided. Studies and surveys were therefore conducted to characterize the private sector in health. At least 40% of all health services were found to be provided by PNFPs. The modern, privately provided services were similar to those of the public sector in variety and range, but up to 73% of the staff of small clinics and drug shops were neither qualified nor licensed to provide the services. However, most of the bigger clinics and maternity homes were found to be operated by government health professionals on part time basis.

Over 80% of people in Uganda were found to use a private or traditional facility as a first point of contact when seeking health care. Most of the first contacts with the health care system were drug shops. Traditional medicine was found to include spiritual healing, herbal treatment, bone setting, birth attendance, and “false teeth” extraction. Complimentary traditional medicine was found to consist of Chinese, Ayurvedic (India), Reiki, Chiropractics, Homeopathy and Reflexology. Health facility inventory indicated that 49% of the population were living within 5km radius of a facility that could provide a complete package of basic services.

Barriers to private sector development included an intimidating legislation, and lack of capital for equipment and physical facilities. Some extent of collaboration existed between public and private sectors in the provision of immunization, oral rehydration therapy, health education, training and referral.

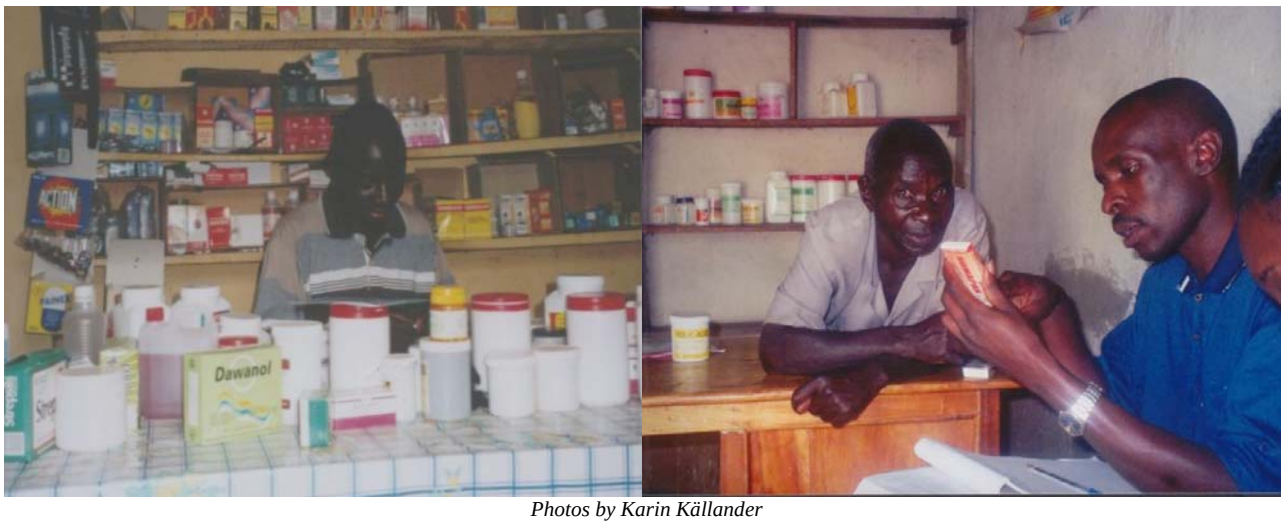
A Public-Private Partnership policy formulation is in progress in Uganda and a draft policy is now in place. The policy process has been a collaborative effort with the participation of all sections of the private sector plus representatives of consumer associations. The policy goal is to build one national health system where the public and private sectors complement each other. The objective is to establish a functional integration of the health system while maintaining a pluralistic health care delivery system. The partnership is based on 8 principles: capacity building, equity, access, efficiency, quality, sustainability, complimentarity and continuity of care.

The partnership with the private sector will entail integration of the health system; formalization of responsibilities for public and private sector actors; amendment of laws and enactment of new laws, memoranda of understanding, including agreements and contracts; registration of private health care providers, accreditation of private health care providers; and sharing information through a common health information system.

For the private sector in particular, the following strategies have been conceived: to develop centres of excellence in both private and public sectors for specialized services; develop herbal and ordinary pharmaceutical industries; develop "tourist medicine" to attract clients who want to visit Uganda while also getting medical services; privatise Grade A wings of Government hospitals; establish manufacturing of medical equipment and supplies; and establish a loan scheme for entrepreneurs wishing to enter the health service industry.

More studies are required to identify the most appropriate forms of public private partnership in health. That is why the PSP study for Uganda has been conceived. Its objectives are to:

1) Perform a census of health care providers particularly focusing on informal and traditional services;
2) Describe the range and quality of services;
3) Describe health seeking behaviour and how this relates to the health care distribution;
4) Quantify the burden of illness handled by different providers;
5) Study the effect of policy and regulation on the private sector;
6) Study public – private competition, linkages, collaboration and referral practices; and
7) Identify different forms of partnership and private sector interventions to contribute significantly to achievement of health sector objectives.



Photos by Karin Källander

Regulating private health care actors – opportunities and limitations: The case of Vietnam.

Nguyen Hoang Long, Health Policy Unit, Ministry of Health, Hanoi

The health care system in Vietnam is a mix of public and private sectors, organized in three levels; central, provincial and basic (including districts, communes and villages). By 2003, there were 25,327 private clinics and facilities, including 7 general hospitals, 2 specialized hospitals, 10 joint-venture hospitals, 1,075 polyclinics, 15,814 specialized clinics. Better-off provinces have more private health facilities.

The forms of Private Health Practices are

- Hospitals
- Clinics
- Delivery homes
- Other health services (injection, I.V. etc.)
- Patient transport service
- Pharmaceutical Trade Companies
- Pharmacies
- Drug outlets (company's branches)
- Drug Quality Control Laboratories
- Drug Storages

An estimated 60% of out-patient visits in Vietnam take place in the private sector. Patients that come usually seek help for common diseases and suffer from mild ailments. Also, people with diseases that are connected to a social stigma, like sexually transmitted infections and tuberculosis, tend to seek care in the private sector. The private providers get easy for-profit cases and provide easy for-profit services.

Why do people then often prefer private services? Because the private providers offer a warm reception and staff attitudes are good. The opening hours in the evening are also more convenient. Generally, they are located closer to home. Waiting times are shorter and there are no administrative procedures. There are less hidden payments and payments may be more flexible as debts or in kind payments are accepted. Finally, private services offer more privacy.

With development of the private sector, access to health services has improved and the population has more choices for health care. The private providers play an important role in dealing with common diseases. Their presence also reduces the workload on public facilities. With increased access and more choices, the private sector may also contribute to reduce indirect expenses (e.g., travel costs).

As far as shortcomings are concerned, some private health facilities have provided services beyond the allowed services. Quite many facilities do not fully meet operational conditions (e.g. space, requirements, lighting, hygiene, equipment, sterilization standards etc). Quality and fee of private services are still poorly controlled. Provider induced demand (tests, medicines etc.) is quite common. Collaboration between public and private health sectors is limited. Participation of the private providers in preventive health and health promotion is low.

Some of the regulation challenges are:

- Unlicensed private providers, especially low-qualification ones (e.g. nurses, assistant doctors)
- Poor collaboration of private providers (only 26% of private providers participated in PHC activities when requested/mobilized)
- Poor recording and reporting
- Poorly controlled and low quality of services (poor sterilization facilities, lack of essential drugs, insufficient professional knowledge etc).
- Unregulated fees

Some of the short-comings in the present regulation and supervision system are that laws, regulations and instructions are imperfect and that the health inspection systems are weak. Also, there are no incentives created for the private providers to provide good services, nor effective policies for collaboration between the public and the private sector.

Some future policy directions could be to

- Promote more strongly the development of the private sector, especially private hospitals in urban areas
- Develop and consolidate regulations (e.g., public – private mix facilities, dual medical practice etc.)
- Strengthen monitoring, supervision and inspection
- Promote public-private collaboration in achieving health goals
- Involve private sector more in primary and preventive health care activities

Questions for discussion:

- How to measure and ensure quality of private providers' services (including efforts to reduce provider induced demand)?
- What mechanisms could be used to promote participation of private providers in preventive and health promotion activities, and in achieving common health goals?
- Is it necessary to control private service fees? If so how?

Private-public collaboration involving NGOs in Zambia – Lessons learnt

Pamela Nakamba-Kabaso, Department of Economics, University of Zambia
Webby Wake, Department of Economics, University of Zambia

There is considerable growth of interest in the collaboration between the public and the private sector providers in the health sector in Zambia. However, there is limited evidence as to which approaches work best in low-income countries. In Zambia, the government has collaborated with mission health services in the provision of health care for a considerable period of time. This can provide insights into how the public sector can work with the private sector for improved health services delivery.

The paper will therefore present the experience of this collaboration in terms of achievements relating to division of labour geographically and the interaction around key health programs like HIV/AIDS and TB control.

The background is that parallel health care systems were developed in Zambia. On the one hand, church health services were developed with the native population in rural areas as target group. On the other hand, a colonial government medical system was established, which primarily targeted European settlers and the urban population. Collaboration between the government and the mission/church services was established early, even if the collaboration was less defined. For instance, a platform for dialogue was developed and the government even gave limited financial support to the mission services. However, there was no clear policy statement for the government on the role of the church in the health sector.

After independence the parallel health system continued. CMAZ and later CHAZ (Churches Health Association of Zambia), an umbrella body for church health institutions, was created. Roles still remained unclear, and government tended to look to church institutions as "rich cousins". With health reforms in the early 90s, church institutions were viewed as allies in the realization of visions of the reforms and a Memorandum of Understanding was signed between CHAZ and the government.

Today, the mission services comprise all levels of care: 1st and 2nd level referral hospitals, health centres, and training schools. In the country as a whole, missions run 34% of all hospitals and 4% of the health centres. They provide more than 50% of formal health services in rural areas and about 30% countrywide. 80% of enrolled nurse students go to training schools run by CHAZ members. Public and church facilities function as a unified referral system. Church health facilities provide a basic package of care according to level of care as defined by National Health services Act and Ministry of Health policy.

In relation to the mission the government:

- Deploys all medical staff and pays their salaries
- Pays salaries for Commissioned Daily Employees (CDEs) employed by church
- Funds church facilities' running costs - same level as public facilities irrespective of other sources of income
- Funds certain capital projects
- Funds training institutions

In addition, the government provides treatment guidelines, drugs and monitoring and supervision for TB and HIV/AIDS control.

The role of the church institutions is to manage church facilities on behalf of government. This role is reinforced by the following comparative advantages of the churches:

- Better quality health provision
- Long experience of working with communities.
- Experience in attracting and working with donor funds
- Ownership of infrastructure

Lessons learnt are that the public sector has been able to use church institutions as a means of achieving its health priorities without compromising the institutions' missions/objectives.

Questions for discussion

⇒ It has been stated from both the Government and CHAZ that the collaboration has been very successful. Are there any demerits to such collaboration?

⇒ How can the collaboration be improved upon? Are there transferable elements or is such collaboration unique to private not-for profit institutions?

Alternative private providers – How does the public sector deal with them? The case of India.

R.K Chandorkar, Department of Community Medicine, R D Gardi Medical College, Ujjain
V.K. Mahadik, R D Gardi Medical College, Ujjain

There are various kinds of alternative private providers (APP) in India, ranging from 5000-year old Ayurveda to the recently introduced colour and aroma therapists. A genuine alternative private provider has a degree or diploma from a school of another medical thinking than the allopathic. Around 20 different groups of such APPs can be defined. However, in the group Alternative private providers is also included all those practicing medicine, traditional or modern, without formal training or qualification.

In Ujjain, a detailed identification of all health care providers has been made. The results are given in table 2.

System	Qualified Doctors		Formally Trained Providers (Allied)		Untrained Providers		Total
	Public	Private	Public	Private	Public	Private	
Allopathic	195	364	751	556	00	360	2226
APP							
Ayurvedic	35	84	00	11	00	15	135
Homeopathic	00	24	00	12	00	10	46
Untrained Dai's	00	00	00	02	00	612	614
Unknown Qualification	00	00	00	00	00	24	24
Other APPs	00	00	00	05	00	141	146
Total	**220**	**472**	**751**	**586**	**00**	**1162**	**3201**

Table 2: Total Distribution of Health Providers in Ujjain District

The study has shown that about 59% of all health care providers are unqualified APPs. They are the only health care providers in 95% of the villages surveyed. At least 60% of them do no have basic knowledge of any system of medicine or any disease. They give injections to 80% of their patients.

Thus the APPs play a major role in health care. At the same time they are practically the only health providers in rural areas, meaning that nearly 85% of the Indian population is dependent on them for primary health care. They are well known to the population and have long-term relationship with the population. All these factors make them important health providers.

There is hardly any relation between APP and the public health sector. They are not invited to participate in public health activities or national health programs, nor have they any knowledge about these programs. All this has led to the present state of poor public health in rural areas. There are hardly any laws, rules and regulations to control them, nor is there any administrative or political will to control and regulate them or to involve them in public health programs, for instance through training.

The task ahead for the public sector is very difficult and gigantic. To improve the situation, the public sector has to implement the following:

i. Identify the APPs
ii. Frame suitable laws to weed out the illiterate, unscrupuls practitioners among them
iii. Train them in public health activities and also develop systems of continuous monitoring and evaluation that will improve their quality
iv. Develop a system whereby they are gradually phased out and replaced by qualified persons
v. Frame laws that prevent new untrained APPs to start practice
vi. Involve NGOs, Medical and Nursing Colleges in monitoring and training of the APPs

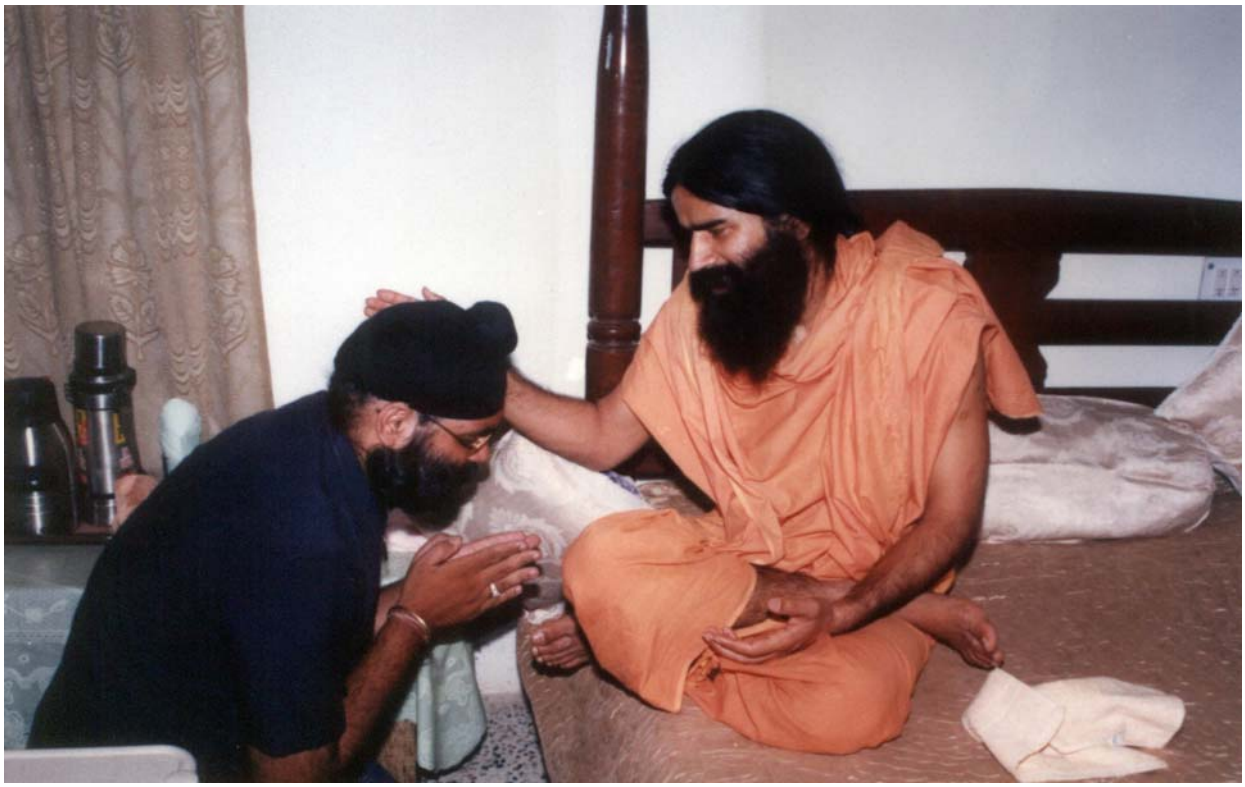


Photo by Balkrishna Neema

The situation and role of the non-government medical provider in the cities in China

Liang Haocai, Department of Health Management, School of Public Health, Sun Yat-sen University of Medical Sciences, Ghuangzhou

China is a transitional and developing country. The medical care has transferred very slowly because of insufficient marketization. There are great gaps between urban and rural areas where people in urban areas, in general, have higher health expenditure, better medical insurance, and an overall higher health level. Government hospitals are allowed to charge fees for examinations and drugs. Hence, in government run hospitals, fees for clinical examinations and drug sales cover 90 % of the expenditure. The grants from the government only account for 10 % of hospital expenditure. The community health services are developing slowly. One reason for this is that the Urban Department of Public Health supports the fees in the public hospitals and they wish to maintain the monopolistic position that the public hospitals currently have. The effect of this system is that around 80% of the clients find it very expensive to see a doctor and they are therefore dissatisfied.

In order to overcome this phenomenon, the state government suggests to:

1. Reform the system of health services in cities, dividing the hospitals into not for-profit and for-profit and encourage the development of the for-profit hospitals.
2. Encourage a more rapid development of community health services.

Due to the traditional management model, where the government establishes and run the hospitals, the effect of the reform is not given. In this case, the government suggest, referring to the experiences from reform in private enterprises, to quicken the marketization of hospitals. Hospitals will be given more power and responsibility over their investments. The government should encourage the development of non-government hospitals and allow for competition between private and government hospitals.

The non-government-run hospitals can play the following role:

i. 1.Assisting the poor in gaining access to medical care
ii. 2.Helping the unemployed workers to obtain employment
iii. 3.Encourage private capital investments in the health sector
iv. 4.Promoting reform of the health service system in cities

In order to develop the non-government providers the functions of the government should change, from service provider to policy, legislation and regulation. The government should also focus more on strengthening monitoring and supervision.

Friday, 14 May

Group work

On Thursday afternoon, the participants were divided into three groups to work on ideas for phase two of the program – the intervention phase. For the exercise, each group assumed that they had generated data on the private providers through implementation of the proposals that have been developed for Phase 1B. Now they had to decide on an intervention and show how they were going to evaluate that intervention. Each group was given one provider group to work with. Group one looked at private allopathic providers, group two looked at alternative, less than fully qualified, providers and group three looked at drug vendors/pharmacies.

The task for each group was to:

1. Agree on <u>one</u> intervention aimed at the provider group.
2. Describe broadly the design of the intervention:
   - Who will be engaged?
   - In what activities?
   - Who will run the project?
   - Who will work in the project?
   - What will they do?
   - Resources required (manpower only, not funds at this stage)?
   - Expected changes/effects on behaviour, output and possibly outcome?
3. Discuss the indicators to select for evaluating the effects of the intervention.
4. Describe briefly the research methodology (data collection methods etc.) to be used.

Group work presentations

Group 1 – Private allopathic providers

Intervention: Train the private providers to offer voluntary counselling and testing (VCT) to their clients (specifically for HIV/AIDS)

Setting:
- Provincial town in a developing country
- Population = 100,000 people
- Eligible facilities = 86 (50 doctors, 20 nurses, 16 Clinical officers)

Strategies:
- Train all providers in VCT skills through 3 day workshop
- Free HIV testing will be offered to their clients for a period of 2 years by the government hospital in the town (cost to be covered by either the research or the control program or other party)

Indicators:
- Number of people, age 15-45 who accept VCT in the town per month
- Fraction of providers who actively participate in the program (refer clients for testing). Other provincial towns will be used as control areas.
- Monitor behaviour change among those tested

Data collection

- Blood samples will be collected from all acceptors by the providers
- All samples will be sent to the hospital laboratory in the town
- Analysis of acceptor trends will be done, based at the hospital
- Studies of behaviour change among acceptors will be designed

Group 2 – Alternative, less than fully qualified, providers

Intervention: Training of traditional healers in Zambia

Background

- 40,000 registered tradition healers in Zambia
- Umbrella body TPHAZ
- Health seeking behaviour – people go to traditional healers even when modern practitioners are available

Focus on child infections – fever

- To be backed by a detailed situation analysis

Intervention – training

- In basic interventions for child infections – when to refer
- To be tailored along lines of a social franchise scheme – provide symbolic recognition
- To target both traditional healers and families
- To provide incentives to traditional healers for referrals

Indicators – Focus on changes in behaviour of traditional healers

- Cases of children treated appropriately i.e. no of fever cases and action taken
- Number of referrals from traditional healers

Methodology:

- Two randomised districts (rural), one of them to act as control district
- Follow-up survey in the 2 districts
- Weekly interviews with traditional healers to record cases of fever seen and action taken

Group 3 – Drug vendors/Pharmacies

Goal: To improve good pharmacy practice in a population of 100,000

Intervention: Creation of "Medicine User's Association" (MUA) combined with accreditation and monitoring process

- Study area: In each country a population of 100,000
- Academic institute should be engaged for the creation of MUA, its' design activities and social support
- Meeting with one representative from each continent to decide on above proposal with academic institutions
- Submission of draft proposal by the country representative

Creation of consumer organization should be a complement to existing government control (which are many times corrupt). This intervention will strengthen consumer power and make

them a more powerful stakeholder. The group could possibly take legal action towards pharmacists and drug sellers that are not complying and that are selling false/sub-standard/illegal drugs.

Indicators:
- GPP guidelines

Research method:
- Documentation of baseline data, demographic data and social data
- Quasi-experimental pre-project and post-project evaluation
- If possible, randomised control trial in project and control area

Expected change:
- GPP with definite indicators will be assessed and expected to achieve GPP in project area. Evaluation of GPP indicators

The way forward

Birger Forsberg, IHCAR
Peter Berman, IHSP at HSPH

The last session of the workshop was dedicated to a discussion around the current situation in each country and how the Private Sector Program should move forward in the next phase. First, the funding status for the country studies was reviewed. In three of the countries (Uganda, Zambia and India – Ujjain) full or partial funding has been secured. In China and Vietnam, funding possibilities are being explored with positive indications. In Lao PDR, phase 1A is yet to be completed and hence need for funding is not acute. Finally, in South India, the proposal for phase 1B is to be revised before funding options are further explored. It was agreed in the group to work with the goal that phase 1B should be completed within the next twelve months.

It is the intention that the IHCAR/IHSP course on working with the private sector will be held again during the next year. This time, however, the course may be held in India.

Finally, all partners are encouraged to start thinking about phase 2: Intervention and Evaluation. Possible steps in this process are:

i. Identify planned or on-going interventions in the region/state/country
ii. Initiate discussions with implementing partner and funder of intervention
iii. Start to think of evaluation design

It was suggested that the next workshop should be held at one of the partner institutions, perhaps during 2005 or early 2006.

Birger Forsberg, Peter Berman and Pär Eriksson thanked all the participants, on behalf of IHCAR, IHSP and Sida, for their active participation during the course of the workshop. Everybody agreed that there had been good discussions and all participants left the workshop with energy for moving the program forward into.

Participants at the PSP Workshop in Stockholm. Photo by Peter Bergqvist

ANNEX 1

Participants PSP Workshop – Stockholm May 12-14

PSP participants

1.	Birger Carl Forsberg	IHCAR (birger.forsberg@phs.ki.se)
2.	Bouathong Sisounthone	Ministry of Health, Lao PDR (bouathongsisounthone@yahoo.com)
3.	Göran Tomson	IHCAR (goran.tomson@phs.ki.se)
4.	Jesper Sundewall	IHCAR (jesper.sundewall@phs.ki.se
5.	Jiangbin Qu	Shandong University, China (jbqu@sdu.edu.cn)
6.	Joseph Konde-Lule	Makerere University, Uganda (jkonde@iph.ac.ug)
7.	Lamphone Sihakhang	Ministry of Health, Lao PDR (drug@laotel.com)
8.	Liang Haocai	Sun Yat-sen University of Medical Sciences, China (liancai@gzsums.edu.cn)
9.	Nguyen Hoang Long	Ministry of Health, Vietnam (longmoh@yahoo.com)
10.	Pamela Mambwe	University of Zambia (mambwe@zamtel.zm)
11.	Peter Berman	IHSP at Harvard School of Public Health (pberman@hsph.harvard.edu)
12.	Phan Thanh Thuy	Ministry of Health, Vietnam (thanhthuymoh@yahoo.com)
13.	Pär Eriksson	Sida – Health Division (par.eriksson@sida.se
14.	Qingyue Meng	Shandong University, China (qmeng@sdu.edu.cn)
15.	Ram K Chandorkar	R.D. Gardi Medical College, India (rdgmcujn@sancharnet.in)
16.	Rolf Wahlström	IHCAR (rolf.wahlstrom@phs.ki.se)
17.	Sam Okuonzi	National Council for Children, Uganda (sokuonzi@infocom.co.ug)
18.	Varatharajan Durairaj	SCTIMST, India (dvrajan@sctimst.ac.in)
19.	Vijay K Mahadik	R.D. Gardi Medical College, India (vkmahadikujn@rediffmail.com)
20.	Vinod Diwan	IHCAR (vinod.diwan@phs.ki.se)
21.	Webby Wake	University of Zambia (webbywake@zamtel.zm)
22.	Yuanli Liu	IHSP at Harvard School of Public Health (yuanliu@hsph.harvard.edu)

Guest presenters

23.	Imran Zafar	Greenstar, Pakistan (imranzafar@greenstar.org.pk)
24.	Knut Lönnroth	WHO, Geneva (lonnrothk@who.int)
25.	Paolo Belli	The World Bank (pbelli1@worldbank.org)
26.	Stephen Jan	LSHTM (stephen.jan@lshtm.ac.uk)

Other Workshop Participants

27.	Ana Paula Kallström	IHCAR (paulagil76@hotmail.com)
28.	Anastasia Pharris	IHCAR (anastasia.pharris@phs.ki.se)
29.	Bwira Kaboru	IHCAR (bwira.kaboru@phs.ki.se)
30.	Elisabeth Faxelid	IHCAR(elisabeth.faxelid@phs.ki.se)
31.	Klas Rasmusson	Sida – Health Division (klas.rasmusson@sida.se)
32.	Knut Ödegaard	IHE, Lund (ok@ihe.se)
33.	Lennart Bogg	Mälardalens Högskola (lennart.bogg@mdh.se)
34.	Mikael Söderbäck	Sida/INEC (mikael.soderback@sida.se)
35.	Nina Thelander	IHCAR (nina.thelander@phs.ki.se
36.	Saeed Sharaz	IHCAR (saeed.sharaz@phs.ki.se)