the Private Sector in Health

iHEA 8th World Congress Pre-Symposium

July 9th, 2011 | Toronto, Canada

Symposium Abstracts

Presentations and posters

the Private Sector in Health

iHEA 8th World Congress Pre-Symposium **Toronto, Canada** **July 9th, 2011**
Sheraton Center, Toronto

AGENDA

8:30 – 9:00 AM	Registration (Pick up nametags from registration desk)	Foyer
9:00 – 9:10 AM	Welcome: **Dominic Montagu**, Global Health Group at the University of California, San Francisco	Essex
9:10 – 10:00 AM	Opening Keynote: **Timothy Evans**, Dean at the James P. Grant School of Public Health at BRAC University and ICDDR,B	Essex
10:00 – 10:30 AM	Coffee (sponsored by USAID-funded SHOPS project)	Foyer
10:30 – 12:00 AM	**PARALLEL SESSIONS**	
	1A. MEASURING THE PRIVATE SECTOR **Chair: Onil Bhattacharayya** • Importance of the private sector for outpatient healthcare in LMICs (**Dominic Montagu**) • What factors explain the trends in the use of the private sector in developing countries? (**Karen Grepin**) • Experience in Conducting Private Health Sector Assessments to Inform Policy Reform (**Barbara O'Hanlon**)	Essex
	1B. GOOD, BAD, OR INDISTINGUISHABLE: QUALITY OF CARE IN THE PRIVATE SECTOR **Chair: Peter Annear** • Quality of underground health care: A case study of Indian Rural Medical Practitioners (**Barun Kanjilal**) • Unraveling the Quality and Utilization of HIV Counseling and Testing Services Offered by the Private Sector in Zambia (**Ilana Ron**) • Supportive Supervision, an Effective Interim Regulatory Measure for Private Health Sector Services in Ethiopia (**Tesfai Gabre-Kidan**) • Improving Quality of Women's Health and Family Planning Services in Jordan's Private Health Sector **(Nagham Abu Shaqra)**	Conference Room B
	1C. RECENT EVIDENCE AND POLICY IMPLICATIONS **Chair: Birger Forsberg** • The Emergence of Private For-Profit Medical Facilities and Their Roles in Medical Expenditures in China (**Xiaohui Hou**) • The Role of the Public and the Private Facility-based Delivery Care in Developing Countries: The Case of Bangladesh from Universal Coverage Perspective (**Shakil Ahmed**) • The private sector role in the supply of antimalarial drugs: evidence from ACTwatch and implications for initiatives to improve ACT access (**Kara Hanson**) • The role of the private sector's service provision among people living with HIV/AIDS in Vietnam: exploring the change between 2005 and 2010 (**Ha Nguyen**)	Conference Room C
12:00 – 1:00 PM	LUNCH (sponsored by USAID-funded SHOPS project) –pick up from Main Hall	Foyer
12:40 – 1 PM	**WB/IFC Publication Announcement:** Healthy Partnerships - How Governments Can Engage with the Private Sector to Improve Health in Africa	

1:00 – 3:00 PM	**PARALLEL SESSIONS**	
	2A. PUBLIC VERSUS PRIVATE **Chair: Gustavo Nigenda** • The District of Columbia's Shift from Providing Public Health Care Services to Purchasing Services from Private Providers, 1999-2009 (**Gina Lagomarsino**) • Physician Density in a two-tiered public/private Health Care System (**Martin Gächter**) • An empirical analysis of dual practice by medical specialists in Australia (**Terence Chai Cheng**) • Ahead of its time? -The case of public hospital conversion in Jakarta (**Shita Listya Dewi**)	Essex
	2B. THE PRIVATE SECTOR ROLE IN THE OVERALL HEALTH SYSTEM **Chair: Edith Patouillard** • Firm-Level Perspectives on Public Sector Engagement with Private Healthcare Providers : Survey Evidence from Ghana and Kenya (**Joanne Yoong**) • Public-private partnerships: potential collaboration for the provision of ambulatory care in the Mekong region, Vietnam (**Duc Ha Anh**) • Making Better Use of the African Private Health Sector through More Effective Regulations (**Richard Feeley**) • A Comparison of Health Outcomes in Public vs. Private Settings in LMICs (**Dominic Montagu**)	Conference Room B
	2C. THE PRIVATE SECTOR ROLE IN MCH SERVICES **Chair: Peter Berman** • Effect of an Expansion in Private Sector Provision of Contraceptive Supplies on Horizontal Inequity in Modern Contraceptive Use: Evidence from Africa and Asia (**David Hotchkiss**) • Impact of the reproductive health vouchers program in Kenya on out-of-pocket expenditures on services (**Timothy Abuya**) • Impact of a Reproductive Health Voucher Program on Private Providers in Developing Countries: A Cross-Sectional Evaluation (**Ben Bellows**) • Private Delivery Care Across Developing Countries: Trends and Determinants (**Amanda Pomeroy**)	Conference Room C
3:00 – 3:30 PM	**Coffee** (sponsored by USAID-funded SHOPS project)	Foyer
3:30 – 4:30 PM	Plenary Session: **What do we know? What do we need to know more about?** Chair: **Kara Hanson**; Speakers: **Barun Kanjilal, Gerry Bloom, Maureen Mackintosh, Oladimeji Oladepo and Birger Forsberg**	Essex
4:30 – 5:00 PM	**Closing Keynote: Julio Frenk,** Dean of the Faculty at the Harvard School of Public Health and Professor of Public Health and International Development, a joint appointment between the Harvard Kennedy School of Government and HSPH	Essex
5:00 – 6:30 PM	**Cocktail Hour** (sponsored by Johns Hopkins University and Future Health Systems)	Foyer

This conference has been organized by the Global Health Group at the University of California – San Francisco on behalf of the members of the Private Sector in Health Research Steering Committee.

- **Peter Annear**, University of Melbourne
- **Sara Bennett**, Johns Hopkins University (FHS)
- **Caroline Quyera**, Abt Associates
- **Peter Berman**, Harvard University
- **Onil Bhattacharyya**, University of Toronto
- **Gerry Bloom**, Inst of Development Studies
- **Karen Eggleston**, Stanford University
- **Birger Forsberg**, Karolinska Institutet
- **Kara Hanson**, London School of Hygiene and Tropical Medicine
- **Barun Kanjilal**, Institute of Health Management Research, India
- **Gina Lagomarsino**, Results for Development
- **Qingyue Meng**, Shandong University
- **Dominic Montagu**, Global Health Group, UCSF
- **Stefan Nachuck**, Rockefeller Foundation
- **Gustavo Nigenda**, Center for Health Systems Research (I.N. de S.P.)
- **Barbara O'Hanlon**, Abt Associates
- **Khama Rogo**, World Bank
- **Jesper Sundewall**, Karolinska Institute

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Presentation Abstracts

1A. MEASURING THE PRIVATE SECTOR

Importance of the private sector for outpatient healthcare in LMICs

Presenter: Dominic Montagu (University of California, San Francisco. Global Health Group)

Objectives: This study was designed to examine the importance of the private sector for outpatient healthcare in Low- and Middle-Income Countries (LMICs). The objective was to identify differences in health seeking behavior sourced from private providers between rich and poor households, in different countries and regions around the world.

Background: The private sector plays a significant role in the provision of healthcare in most developing countries. Two components of the Demographic and Health Surveys (DHS) datasets have been unexplored until now: the breakdown within the broad categorizations of 'private-formal' and 'private-informal', and the comparison within countries and regions of health seeking behaviors across income quintiles. This analysis fills these gaps.

Methods: DHS data from all 42 countries surveyed since 2003 was reviewed and data on source of treatment for children <5 in the two weeks prior to the survey was included. Source of treatment was categorized by provider type and sub-type, and these variations tracked across wealth quintiles. Quintiles were calculated using principal component analysis based on asset ownership reported within the DHS.

Results: The private sector provides the majority of outpatient care in South and Southeast Asia, half of all outpatient care in Sub-Saharan Africa, and a minority of outpatient care in Latin America and Europe. Poor households are likely to seek care from shops and informal providers, and wealthy households are likely to seek care from hospitals, doctors, or pharmacists.

Conclusions: The private sector is more important than government for outpatient care in most LMICs. The importance of specific types of private providers varies by region and by patient wealth.

Implications: An understanding of private healthcare provision and use is critical if policies and programs are to improve access, quality, and affordability of health for the poor.

Key Terms: access to care, health systems, outpatient care, policy, private sector

Authors (2): Adam Visconti (University of California, Berkeley. Medicine) and Dominic Montagu (University of California, San Francisco. Global Health Group)

1A. MEASURING THE PRIVATE SECTOR

What factors explain the trends in the use of the private sector in developing countries?

Presenter: Karen Grepin (New York University. Wagner Graduate School of Public Service)

Numerous studies have documented the important role of the private sector as the provider of choice for many health conditions in developing countries. In general, these studies have shown that private providers are playing a dominant role in many countries, are providing a range of services from primary to tertiary care, and are demanded from even relatively poor households in poor countries even when publicly provided alternatives are available. However, few studies have investigated how the current patterns of private health utilization have evolved over time and what factors may have contributed to the development of these patterns.

Using data from 178 Demographic and Health Surveys from 62 developing countries from 1985 to 2008, we explore the trends in the use of private sector for a number of important health service indicators (1) to describe the overall trends in the private sector by country, region, level of national income, urban vs. rural geography, and by type of health service provided, (2) to document which health services have seen the largest increases in the proportion of services delivered by private providers, and (3) to explore the determinants of the changes in the use of the private sector across countries various model specifications, including first differencing, fixed-effects, and related models. The health service utilization indicators that will be investigated include the choice of provider for family planning services, antenatal care, and the treatment of fever or diarrhea among children, the ownership of facilities of delivery, and the choice of retailer for medicines for the treatment of malaria and diarrhea. Individual level data on area of residence, asset ownership, level of literacy, national level data on institutional factors such as the policy environment, macroeconomic conditions, the support provided by external donors, socioeconomic factors, national governance indicators, and macroeconomic factors will be explored.

This paper will add to the growing literature on the role of the private sector by providing one of the most comprehensive reviews of the levels and trends in the utilization of the private sector by heath service in developing countries and to explore potential factors that may have lead to this growth.

Key Terms: health service utilization, health systems, private health providers

Authors (2): Karen Grepin (New York University. Wagner Graduate School of Public Service) and Jing Dong (New York University)

1A. MEASURING THE PRIVATE SECTOR

Experience in Conducting Private Health Sector Assessments to Inform Policy Reform

Presenter: Barbara O'Hanlon (OHanlon Health Consulting LLC. SHOPS Project)

Background: Increasingly, the potential role of the private health sector has been at the center of discussions on public–private partnerships as the private health sector is seen as an opportunity to increase access and quality of health services as well as a means to address the deficit in human and financial resources in the health sector. Yet, developing country governments and donors have little information on the type and number of private health providers, and the volume and quality of services delivered by this sector. Given that partnering underlies the promotion of Public Private Partnerships (PPP), gathering this information is critical for the creation of PPP policies, establishment of PPP units and implementation of PPPs in health.

Objectives: Several donors have sponsored private sector assessments (PSA) in over 13 African countries with the goal of providing accurate information on the scope and size of the private health sector and its actual contribution to key health areas such as FP/RH and HIV/AIDS. The study aims to document the methodology used to carry out a PSA, facilitate dialogue to inform policy based on the PSA and glean lessons learned from the multiple applications to strengthen the overall PSA approach.

Methods: The study offers a two-part framework – the first focuses on analyzing the private health sector while the second centers on how managing the policy dialogue (PD) process. The study outlines the steps to carry out the PSA including data sources, data collection approaches, data sources and dimensions of analysis. Also, the study details tasks to secure key stakeholders buy-in, design and structure the PD process, build consensus on policy reforms enabling the private sector and actions to sustain PD. Spread through-out the study are case studies and lessons learned from the multiple country applications.

Conclusions: Field experiences in 11 countries demonstrate that a) PSAs should initially provide an overview of the private sector. A few PSAs utilized extensive, sophisticated and costly analytical approaches yet the results were never used or related to country identified priorities; b) PSAs are powerful tools to raise awareness on private sector contribution in health. Sharing PSA findings, was in many cases, the first time both public and private sectors discussed objective information the private sector and reach agreement on private sector contribution to health goals; c) PSAs should include PD process. Dialogue has been is instrumental in creating consensus on policy changes needed to enable the private sector policy. PD helps stakeholder groups agree on private sector role, prioritize actions, and define a reform agenda; d) - PSAs that identify and recommend opportunities for PPPs have helped donors and governments quickly put into place partnerships.

Implications: The combined PSA and PD approach has demonstrated success in influencing policy design and reform processes. It has also been influential in “fast tracking” PPPs in health. Moreover, it can be easily applied to other regions.

Key Terms: data collection and methodology, policy dialogue, private health sector assessments, public-private partnerships
Authors (3): Allison Gamble-Kelley (Independent consultant) , Sara Sulzbach Sulzbach (Abt Associates Inc. SHOPS Project) and Barbara O'Hanlon (O'Hanlon Health Consulting LLC. SHOPS Project)

1B. GOOD, BAD, OR INDISTINGUISHABLE: QUALITY OF CARE IN PRIVATE SECTOR

Unraveling the Quality and Utilization of HIV Counseling and Testing Services Offered by the Private Sector in Zambia

Presenter: Ilana Ron (Abt Associates Inc.. International Health)

Background: In 2009, researchers from the USAID-funded PSP-One project implemented a multi-method research study to assess the quality of HIV counseling and testing (CT) services in Zambia. The study examined CT services in the public, private, NGO and Mission sectors in Copperbelt and Luapula, two main urban and rural provinces in Zambia. While there is adequate data addressing the types and extent of services offered by these sectors, not enough is known about the quality of HIV services across these four sectors, especially in the private for-profit sector. In addition, the study sought to quantify and establish the profiles (e.g., socio-economic status) of clients choosing to access services in each sector. We were particularly interested in understanding why a client chose to access services in one sector over another.

Methods: The study used five primary data collection methods to gauge quality of CT services: close-ended client interviews with clients exiting CT sites; open-ended client interviews; interviews with facility managers; review of service statistics; and an observation of the physical environment for CT in each site. Over 400 clients and 87 facility managers were interviewed from close to 90 facilities. Sites were randomly selected and results are generalizable at the provincial level. The sample included a diversity of private for-profit types of facilities including large mining hospitals; workplace sites; small, independently owned private providers, and franchised VCT sites.

Results: Key results show that the private sector performs at high levels of quality in some key variables, even though this sector is not adequately integrated into the Zambian national response to HIV. However, across all four sectors, there is significant underperformance-- less than 1/3 of clients across all sectors received counseling on sexual partner reduction and only 4% of clients received counseling about disclosing test results to their partners. The private for-profit sector showed the highest utilization by clients for CT services.

In terms of client profiles, the NGO sector attracts the most educated clients, and low educated Zambians receive CT services in all sectors at very low rates (7% overall). There is a significant difference in the age distribution of clients accessing services-- the youngest clients (aged 15–24) are most likely to visit NGO sites, while the oldest clients (aged 35 and older) are most likely to visit the private sites.

Conclusions: The private for-profit sector provides CT services on par in quality with the other sectors. The majority of clients in all sectors reported being "very satisfied" with their CT services, even for low-quality services. Most clients did not receive counseling on partner reduction or disclosure of HIV test results to partners. In a generalized HIV epidemic where multiple concurrent sexual partners are a significant problem for transmitting the disease, risk- reduction methods and discussion should be a main focus of pre-test and post-test counseling across all sectors. Results demonstrate that while there are some significant quality concerns for HIV CT services across Zambia, the private for-profit sector is performing at similar quality levels to the rest of the health system.

Key Terms: HIV prevention, private sector, quality

Authors (3): Obiko Magvanjav (formerly of Abt Associates Inc.) , Wenjuan Wang (ICF Macro. Demographic and Health Research) and Ilana Ron (Abt Associates Inc.. International Health)

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Authors (3): Obiko Magvanjav (formerly of Abt Associates Inc.) , Wenjuan Wang (ICF Macro. Demographic and Health Research) and Ilana Ron (Abt Associates Inc.. International Health)

1B. GOOD, BAD, OR INDISTINGUISHABLE: QUALITY OF CARE IN PRIVATE SECTOR

Supportive Supervision, an Effective Interim Regulatory Measure for Private Health Sector Services in Ethiopia

Presenter: Tesfai Gabre-Kidan (Private Health Sector Program (Abt Associates Inc. - Ethiopia))

The private health sector (PHS) in Ethiopia was sidelined for two decades from providing public health services, which are primarily donor supported. Public-Private-Mix- DOTS (PPM-DOTS) was successfully piloted in two of nine regions and has since been expanded to 219 sites. The concern is that the PHS will not/cannot be regulated. Hence, the care will be of varying caliber, quality and integrity. This concern is also shared by ardent supporters of the PHS.
The USAID|Private Health Sector Program (PHSP) works closely with the Ethiopian Food, Medicine and Healthcare Administration and Control Authority (EFMHACA) on national healthcare standards. EFMHACA will oversee licensure and accreditation of healthcare providers, but will take several years to put into effect. In the interim, the supportive supervision (SS) performed by PHSP with the Regional Health Bureaus (RHBs) and Woreda offices can serve as a model to maintain sound practice, dispel misperceptions, and restore user and government confidence. Extensive SS is performed where a team of Woreda representatives and PHSP experts visit private facilities quarterly. The team reviews health services at the facility level, and findings are captured on a Personal Digital Assistant (PDA). The PDA data is analyzed on-site and feedback provided to service providers and owners. Lab External Quality Assessment (EQA) with on-site training is also provided. Finally, an official report is prepared by PHSP and shared with RHBs, Woredas and facilities.

The following are important findings: 1. critical drug, test kit and reagent shortages that would affect treatment outcome were rectified on time in many health facilities by simply reporting the findings to the respective Woredas. 2. PHSP redistributed anti-TB drugs from over-stocked facilities to under-stocked ones. 3. Workplace sites using commercially-purchased AFB reagents without expiration and manufactured dates were linked to Woredas to get supplies with proper dates of use. 4. Expired drugs were collected as soon as identified and taken to the Woreda offices for proper disposal. 5. Facilities providing TB services using untrained staff due to high staff attrition were provided on-site coaching and mentorship pending formal training. 6. TB/HIV facilities were required to record referrals in order to facilitate referral tracking; PHSP held referral advocacy workshops, prepared referral log book and distributed to all facilities. 7. Four rounds of EQA were conducted in private and work place clinic laboratories in four regions, October 2009-December 2010; 6137 slides were reviewed. The overall discordance rate dropped from 2.1% in round I, to 0.7% in round IV. The national standard for false positive and negative is set at <2% and <5% respectively.

In conclusion, the introduction of the SS model has progressively improved quality of care and clinical outcomes of services provided by the PHS, an environment that is not yet regulated. PHSP is pioneering the implementation of a replicable SS model that would foster integration of the public and private health care systems. This will serve as an important policy advocacy intervention to build trust and confidence in the PHS, and speed up the national healthcare standards finalization.

Key Terms: policy advocacy, Quality improvement, regulation
Authors (2): Semunegus Mehret (Private Health Sector Program (Abt Associates Inc. - Ethiopia)) and Tesfai Gabre-Kidan (Private Health Sector Program (Abt Associates Inc. - Ethiopia))

1B. GOOD, BAD, OR INDISTINGUISHABLE: QUALITY OF CARE IN PRIVATE SECTOR

Improving Quality of Women's Health and Family Planning Services in Jordan's Private Health Sector

Presenter: Nagham Abu Shaqra (Abt Associates Inc. Private Sector Health Systems)

Background: In Jordan, 54% of women seek family planning care from private sector providers (JPFHS 2009). However, private providers in Jordan fall outside of the supervision purview of the Ministry of Health and are not subject to any systematic licensure or quality assessment body to guarantee the quality of the services they provide. Despite research showing that 86% of women agree that modern contraceptive methods are more effective than "traditional" methods, the modern contraceptive prevalence rate is only 42%. A recent survey showed that less than half of women believe oral contraceptives are safe. The 2009 Jordan Population and Family Health Survey confirmed that modern contraceptive prevalence rates and fertility rates have remained just above 40% and just under four children per woman over the past decade. Additionally, while incidence rates of breast cancer in Jordan are similar to other parts of the work, the median age of women afflicted by cancer is younger, 45 as opposed to 65, and only 30% of cases are identified during early stages.

Objectives: To improve the quality of family planning and reproductive health care services offered in the private sector, the Private Sector Project for Women's Health in Jordan (PSP Jordan) aimed to change provider behavior. It used an integrated approach to behavior change that focused on knowledge, attitudes, and practices.

Methods: The project designed and implemented the EQuiPP approach – Enhancing Quality in Private Providers. This three-pronged methodology includes classroom and clinical training, the use of evidence-based medicine and detailing, and a quality assurance certification process.
1. Clinical training. PSP developed a set of training courses focused on family planning that complemented classroom lectures with hands-on training.
2. Evidence based medicine round table workshops. In partnership with Bayer Schering Pharma, PSP conducted lectures on research evidence on oral contraceptives for OB-GYN specialists and general practitioners. The trainers encouraged the physicians to present information to patients based on science rather than their own experiences. The sessions were followed by detailing visits.
3. PSP offered four certification tracks. Following the successful completion of the program, doctors were recognized in a public ceremony and their names were publicized in local newspapers.

Conclusions: More than 1,000 providers participated in one or more PSP training programs. Results of the program include increased confidence and quality in counseling of patients about modern family planning methods – 97% of participating providers address rumors and misconceptions about modern methods and 93% counseled in a private area. Eighty percent of participating providers said they discussed FP with their clients in the past week, improved from 60% at baseline. Just over 81% were willing to prescribe combined oral contraceptive (COC) pills to nulliparous women, improved from 55% at baseline. There is room for improvement, some doctors prescribed COCs when they were contraindicated and only 70% asked a woman to describe her reproductive plans as part of counseling.
Key Terms: private health providers, quality improvement, women's health and family planning
Authors (5): Reed Ramlow (Abt Associates Inc.. Private Sector Health Systems), Mays Halassa (Abt Associates Inc.. Private Sector Health Systems); Iten Ramadan (Abt Associates Inc.. Private Sector Health Systems), Nagham Abu Shaqra (Abt Associates Inc.. Private Sector Health Systems) and Maha Shadid (Abt Associates Inc. Private Sector Health Systems)

IC. RECENT EVIDENCE AND POLICY IMPLICATIONS

The Emergence of Private For-Profit Medical Facilities and Their Roles in Medical Expenditures in China

Presenter**:** Xiaohui HOU (the World Bank Group. Human Development)

Background: The health care delivery system in China, which is dominated by state hospitals, is being increasingly challenged by public concerns: it is too expensive and too inaccessible, a complaint commonly phrased as "kai bin nan, kan bin gui" in Chinese. As the penetration of for-profit hospitals has gradually increased, there is a growing need for policy research to assess their impact on medical spending from the patient perspective.

Structures: This presentation has three parts:

- First, it discusses the evolution and development of market conditions and government policies that have favored the emergence of proprietary medical facilities in China. Excess and differentiated demand for medical services, the existent profitability and supply of the investment capital in health care market, and favorable government policies have encouraged the entrance of proprietary facilities in health care market.

- Second, the paper further analyzes why nonprofit health organizations are not an optimal organizational form in the current Chinese health care market.

- Third, using panel data at the provincial level in China, this paper examines the impact of the penetration of for-profit hospitals on average medical expenditures for both outpatient and inpatient services in public general hospitals. Based on fixed-effect model estimates, the study shows that the penetration of for-profit hospitals has lowered the average medical expenditures for both inpatient and outpatient services across regions, especially for pharmaceuticals.

Policy Implications: Together with other results, this study finds no evidence that private for-profit hospitals drive up average medical expenditures while serving their profit-maximization objectives. Rather, they help increase the market supply of health care, which in turn better serves the increasing demand.

Key Terms: China, For-Profit Hospitals, Market

IC. RECENT EVIDENCE AND POLICY IMPLICATIONS

The Role of the Public and the Private Facility-based Delivery Care in Developing Countries: The Case of Bangladesh from Universal Coverage Perspective

Presenter: Shakil Ahmed (The University of Melbourne. Nossal Institute for Global Health)

Background: In Bangladesh, as many other developing countries, public health facilities together with facilities run by private care providers and non-governmental organizations (NGOs) are the main sources of facility-based delivery care at the district level. Ensuring universal access to facility-based delivery care is essential for accelerated implementation of maternal and newborn continuum of care and to achieve Millennium Development Goal (MDG) 4 and 5. Developing countries are facing challenges to achieve MDG 4 and 5 and to ensure universal coverage. Policy-makers need to understand the role and relative importance of public-and private-sector delivery care providers in the design, resource allocation and implementation of universal maternal health coverage strategies. Policy makers sometimes overlook these issues in developing country settings.

Objective: To assess the relative role of the public and the private sectors in the delivery care by examining household utilization and expenditure patterns associated with socio-economic status.

Methodology: In total, 13,200 women were independently selected from 4 rural districts following a probability proportion to size sampling methodology. A target woman was one who delivered a baby (live birth) during the twelve months preceding the survey. Data on socio-economic status, use of public/private health facility and expenditure for facility-based delivery care were collected from the target women. The retrospective cross-sectional survey was conducted during May-July 2008.

Results: About 15% of the women interviewed used public-private health facilities for delivery. About 8.5% of women used an identified public facility as the source for facility-based care (n=1124). The private sector was the source for 6.3% of delivery care (n=836) and 42.7% of the facility-based delivery care. The findings demonstrated a positive relationship between socio-economic status and use of a mixed public-private health care system. There was evidence suggesting that high socioeconomic households use private facility for delivery more than the poor. The average cost per delivery at facility was US$ 80 and US$ 196 for the public and the private sectors respectively. In the case of caesarian sections, the households paid a much higher price on average (US$ 238) for a private facility than for a public facility (US$ 165). The average financial burden for the poorest households for private delivery services was 2.66 times higher that imposed by the public delivery care services.

Conclusion: The private sector is playing an important role in facility-based delivery care. Given that a relatively high proportion of the richer households use private care providers and poor households generally have a high financial burden for facility-based delivery care, policy-makers should carefully examine how to achieve an optimal public-private mix in the facility-based delivery care to accelerate universal health coverage, equity in health service-delivery and health care financing, and improved maternal and neonatal health status. The findings have implications in health financing and health systems policy-making and particularly in the proper allocation of scarce health resources and health systems strengthening.

Key Terms: Bangladesh, Delivery care, Developing countries, Facility-based delivery care, Role of public-private facility, Universal coverage

Authors (2): Peter Annear (The University of Melbourne. Nossal Institute for Global Health) and Shakil Ahmed (The University of Melbourne. Nossal Institute for Global Health)

IC. RECENT EVIDENCE AND POLICY IMPLICATIONS

The private sector role in the supply of antimalarial drugs: evidence from ACTwatch and implications for initiatives to improve ACT access

Presenter: Kara Hanson (London School of Hygiene and Tropical Medicine. Global Health and Development)

In an era of growing interest in public-private partnerships in health care, the operation of private markets has become increasingly important for the delivery of public health interventions, including malaria treatment. Around half of fevers among under-fives are currently treated in the private sector. However, because of its high cost and limited availability in the retail sector, only a small share of patients receive the recommended artemisinin-based combination therapy (ACT). A number of recent initiatives aim to improve access to effective treatment by providing subsidised ACTs through the retail sector. Most prominent among these is the Affordable Medicines Facility for Malaria (AMFm) which began operations in pilot countries during 2010. However, there continues to be controversy about such initiatives, with some arguing that the subsidy will be captured by middle-men in the distribution chain, that market power in the private sector will lead to continued problems of affordability and inaccessibility by the poor, and that widespread availability of ACTs without improving access to diagnosis will result in mis-use of ACTs and fuel the development of resistance. It remains unclear whether the private sector can deliver much needed improvements in malaria treatment, and what combination of price subsidies and complementary interventions (eg. provider training, demand generation, regulatory changes) will best support this.

ACTwatch is a 5 year programme of data gathering and synthesis with the objective of providing policymakers with evidence on trends in availability, price, use and distribution chain for anti-malarial drugs in 7 countries, using standardized, representative survey methodologies. Annual outlet surveys are supplemented by household and supply chain surveys in Benin, Cambodia, DRC, Kenya, Madagascar, Nigeria, Uganda and Zambia, representing a range of different market conditions and disease settings. These data provide unique evidence on the role of the private sector in anti-malarial supply, and some of the challenges which interventions to increase access, such as AMFm, will need to address in order to dramatically improve coverage.

The most up-to-date information from ACTwatch will be presented, including evidence from household surveys on ACT coverage and the private sector share of total antimalarial utilization; outlet survey information about pricing and availability of ACTs and other antimalarial drugs including artemisinin monotherapies; and supply chain survey information about price mark-ups at different levels of the supply chain and the range of business practices that influence both price and availability to end users. The implementation of the AMFm co-payment will be situated in the context of this evidence, and the approach to evaluating the impact of AMFm will be presented.

Key Terms: ACTs, AMFm, malaria, medicines, private retail sector

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IC. RECENT EVIDENCE AND POLICY IMPLICATIONS

The role of the private sector's service provision among people living with HIV/AIDS in Vietnam: exploring the change between 2005 and 2010

Presenter**:** Ha Nguyen (Abt Associates Inc.. International Health)

Background: Over the last 5 years, external financial assistance for HIV/AIDS in Vietnam has increased dramatically, from US$18 million in 2004 to nearly US$90 million in 2010. While this influx of donor funding has substantially increased access to HIV prevention and treatment services, Vietnam still has relatively low coverage rates for key HIV/AIDS services (e.g. only 30% of advanced stage AIDS patients received anti-retroviral therapy as of 2007).

In order to reach the goal of universal access to comprehensive HIV prevention, treatment, care and support, it is important to understand how such large infusions of HIV/AIDS funds affect access to health care services for people living with HIV/AIDS (PLWHA). This requires a holistic approach, looking not only at public providers, which are typically the principal beneficiaries of donor assistance, but also the private providers, which play an important and expanding role in many developing countries, including Vietnam.

Objectives: The objective of this study is to describe the role of the private sector's provision of health services for PLWHA in Vietnam and how it changed vis-à-vis major donor funding influx between 2005-2010. In particular, we document the use private versus public sources of supply for HIV counseling and testing, preventive products, outpatient and inpatient care, and self-medication among PLWHA in these two years. The study also describes the socio-economic profile of the PLWHA who tend to rely more on private services and assesses how this changed over time.

Methods: The data for this analysis come from two separate nationally representative surveys of PLWHA conducted in 2005 and 2010. The sample size includes 700 PLWHA in 13 out of 64 provinces in 2005 and 1200 PLWHA in 17 provinces in 2010. The surveys contain detailed information concerning the individual's health status, socio-economic profile, HIV/AIDS progression, and utilization of and expenditures on HIV/AIDS services. The questionnaires are rather comparable between the two surveys.

Bivariate analysis is performed to describe the use of private versus public sector for HIV counseling and testing, purchasing of preventive products, outpatient and inpatient care, and self-medication, among PLWHA in 2005 and 2010. Multivariate probit regression is conducted to estimate the choice of private providers as a function of various socio-economic characteristics. The differential changes between the two time periods among different wealth groups are explored with an interaction term of time and wealth quintiles. The analyses adjust for complex survey design and sampling weights. Analysis results will be available in April 2011.

Discussion: Understanding the role of the private sector in HIV/AIDS service delivery is particularly important in a country like Vietnam, where high levels of stigmatization may decrease the willingness of PLWHA to seek care at public facilities. Despite potential challenges with regulatory oversight and quality control, efforts to combat the HIV/AIDS epidemic need to address the private sector more explicitly to speed up progress toward universal coverage targets. The current study provides evidence to inform such efforts.

Key Terms: HIV/AIDS, private provision, Vietnam
Authors (2): Douglas Glandon and Ha Nguyen

2A. PUBLIC VS. PRIVATE

The District of Columbia's Shift from Providing Public Health Care Services to Purchasing Services from Private Providers, 1999-2009

Presenter**:** Gina Lagomarsino (Results for Development)

In the late 1990s the city of Washington, D.C. faced a crisis in the health delivery system serving its large low-income population. Its public hospital and associated clinics were offering poor quality care at high cost per patient. Low-income residents had poor access to primary and specialty care and relied heavily on emergency departments. Health outcomes were abysmal.

Starting in 1999, the District initiated a series of reforms to expand health coverage and shift from directly providing health care to purchasing services from private providers. The city closed its public hospital, transferred control of public clinics to a private nonprofit organization, and created a new health coverage program to pay for health services for uninsured low-income residents at private hospitals and clinics.

Ten years later, the District of Columbia currently has one of the lowest uninsured rates in the US. Public financing has helped stabilize and strengthen private community health centers. Low-income District residents have a choice of six private hospitals—the same hospitals used by the city's high-income population.

The District's successes and challenges in redesigning the health care system for low-income residents provide important lessons for developing countries who struggle with troubled public delivery systems. To be sure, some of the District's circumstances were unique: as a federal district that was under US Congressional control, local political opposition to closing the public hospital and clinics, including strong hospital employee union opposition, was neutralized. But the District's experiences in shifting its role to a purchaser of health care services rather than an operator of a public provider system highlight common opportunities and pitfalls.

- Providing access to health services via insurance coverage is a viable option for governments, as an alternative to providing services through a public hospital and associated clinics. The shift to "buying" from "making" health services is a challenge, but a manageable one. Either approach can work well or poorly, depending on choices in design, financing, implementation, and ongoing management.
- However, key to the success in "buying" health care is the existence of a functioning health care delivery system—a network of providers (primary care, specialists, diagnosticians, and so on) willing and able to serve low-income patients, and able to communicate with each other and coordinate care. The District's coverage program had difficulty recruiting providers, especially specialty physicians. Access to primary and specialty care is still inadequate, and the city is still struggling to create an integrated model of care.
- While health coverage and financial protection have improved, health outcomes are still poor. The District's health care system is still struggling to improve health outcomes by focusing on chronic diseases, increasing primary care usage and reducing reliance on emergency departments and other hospital-based care.

The key lessons for privatization and coverage expansion alike are that changes in health care financing cannot succeed to their fullest without supportive changes in delivery of care and complementary efforts in public health and other areas that greatly affect health status.

Key Terms: coverage expansion, District of Columbia, privatization
Authors (4): Gina Lagomarsino (Results for Development Institute) , Barbara Ormond (Urban Institute) , Randall Bovbjerg (Urban Institute) and Jack Meyer (Health Management Associates)

2A. PUBLIC VS. PRIVATE

Physician Density in a two-tiered public/private Health Care System

Presenter: Martin Gächter (University of Innsbruck. Economics & Statistics)

The following paper examines the driving factors of the location decisions of private physicians in the Austrian two-tiered public/private health care system. Empirical explanations of physician density in the outpatient sector of the health care system often use the physicians' workforce as a homogeneous aggregate. However, in many health care systems such an approach masks important differences between private and public physicians (e.g. in terms of patients' access to the physician, freedom of location decision, mechanisms of remuneration) and might lead to biased health policy conclusions (e.g. for physician capacity evaluations). In this paper, we therefore focus on the distribution of private physicians in the Austrian two-tiered health care system. Specifically, we want to study the economic interaction between the density of private general practitioners and specialists and their private and public counterparts.

Previous empirical work on geographical disparities in physician density uses different theoretical models, econometric estimation strategies and data sets. Within these studies, we are able to identify three different main approaches:

(i) a research focus on the aggregate outcome of physician's location decisions (see Newhouse et al. 1982; Noether 1986; Nocera and Wanzenried 2002; Rosenthal et al. 2005);
(ii) studies focused on the location decisions of physicians per se, e.g. based on survey data (see Dionne et al. 1987; Kristiansen and Forde 1992; Bolduc et al. 1996; Carpenter and Neu 1999);
(iii) finally, empirical as well as theoretical work on market forms and competition among physicians (see Wong 1996; Atella and Deb 2008; Schaumans 2008). Our research basically follows the first line of research and contributes to the empirical research on geographical differences in physician supply while taking into account the literature on individual decisions of physicians as well as competition issues in the specific case of Austria.

For our macro-level-analysis we use a panel data structure from 121 Austrian counties from 2002 - 2008. By applying a Hausman-Taylor regression model, we find a complementary relationship of private specialists to private general practitioners. Interestingly, this complementary effect between private physicians works in both causal directions. Based on the results of previous literature, we therefore conclude that private physicians establish networks to cooperate in terms of mutual referrals etc. On the contrary, the density of private GPs is negatively influenced by the density of public GPs, indicating a competitive relationship between the public and private outpatient sector among GPs. Moreover, the existence of a hospital in a district increases the density of private specialists significantly, while we observe a reversed effect on the density of private GPs. The economic interdependence between the private and the public sector as well as the increasing importance of private physicians in general imply important consequences for policy makers in the social insurance fund with respect to the preparation of future physician capacity plans, as the capacities of private physicians have not been taken into account in the past.

Key Terms: Hausman-Taylor Estimator, Physican Competition, Physician Location, Private Sector of the Health Care System
Authors (4): Hannes Winner (University of Salzburg. Economics and Social Sciences) , Engelbert Theurl (University of Innsbruck. Economics & Statistics) , Peter Schwazer (University of Innsbruck. Economics & Statistics) and Martin Gächter (University of Innsbruck. Economics & Statistics)

2A. PUBLIC VS. PRIVATE

An empirical analysis of dual practice by medical specialists in Australia

Presenter**:** Terence Chai Cheng (University of Melbourne. Melbourne Institute of Applied Economic and Social Research)

Medical practitioners who work concurrently in the public and private sectors are common in many developed and developing countries, although the forms of dual practice vary widely and are poorly understood. The type and extent of dual practice is likely to be influenced by system-level factors such as the way the health system is organised and financed, regulatory structures, remuneration and incentive schemes; as well as individual-level factors such as physicians' specialty and preferences for public and private work.

This paper examines and describes dual practice by medical specialists in Australia using the first wave of the Medicine in Australia: Balancing Employment and Life (MABEL) study, a longitudinal survey of doctors in Australia. Using information on the reported number of hours worked in a variety of work settings (e.g. public hospital, private practice, tertiary education institution), we describe the practice patterns of medical specialists. Our analysis indicates that medical specialists, compared with general practitioners, specialist registrars and hospital doctors, are much more likely to work in multiple work settings. Approximately 68% and 36% of specialists reported working in at least two and three work settings respectively.

Using a multivariate regression framework, we further investigate the factors that are associated with the decision to work only in the public sector, only in the private sector or both sectors. In addition to personal characteristics such as age and gender, job characteristics (e.g. self reported job satisfaction, percent of hours worked in education activities), remuneration (sources of income, earnings), business relationship with private practice and contract type (e.g. practice principal, salaried) and medical specialty are significantly associated with the decision of work sector.

We use the results to discuss and frame important medical workforce policy questions that face Australia and other countries. Such questions include how to ensure an adequate balance of doctors working in general practice and specialist roles; and how to ensure a sufficient supply of doctors to work in the public hospital system. These policy challenges face both developed and developing countries and our results point to potential factors which are amenable to policy intervention, enabling policy-makers to encourage forms of dual practice that contribute to improving efficiency and equity in health care systems.

Key Terms: Dual practice, medical specialists, private sector

Authors (3): Anthony Scott (University of Melbourne. Melbourne Institute of Applied Economic and Social Research) , Catherine Joyce (Monash University. Department of Epidemiology and Preventive Medicine) and Terence Chai Cheng (University of Melbourne. Melbourne Institute of Applied Economic and Social Research)

2A. PUBLIC VS. PRIVATE

Ahead of its time? -The case of public hospital conversion in Jakarta

Presenter: Shita Listya Dewi (Faculty of Medicine, Universitas Gadjah Mada . Center for Health Service Management)

Background: The Jakarta Special Capital Territory government owned and managed five public hospitals and spent roughly Rp 400 billion per year for operational cost. The government of Jakarta saw inefficiency in public hospital management, poor services, huge investment, and no management flexibility as they were restricted by rigid government entities rules and regulations. The Jakarta government wished to give more financial and managerial authority to hospital and in turn expected an improved quality and services. Also, they wanted to experiment role changes from ownership and incumbency to regulating and stewardship. This paper aimed to present a case of experiments undertaken by the Jakarta Special Capital Territory concerning the ownership and management of a hospital, and how the sociopolitic contexts play a significant role in this regard.

Method: This is an exploratory research using qualitative method. The informants are selected using purposive sampling. Data are collected from literature studies and retrospective interview with the policy makers in the government of Jakarta, and former directors of the respective hospitals.

Discussion: In 2004, Jakarta government enacted local regulations (Perda) to enable three kinds of experiments: 1. Built a new hospital to be owned and operated by a limited company established by the government of Jakarta; 2. Converted one existing public hospital to be privately-owned and managed by a limited company established by the government of Jakarta; 3. Converted a quasi public hospital (half-owned by the government, half-owned by not-for-profit foundations) to limited company established by the government of Jakarta, the Ministry of Religion, and the foundation (previous owner). The three hospitals were managed privately and delivered quality services to private and public patients. The public patients were covered by the Jakarta government social health insurance scheme.

The conversions of the quasi public hospital and the newly built hospital were considered as successful. However, problem occurred in the previously fully public hospital. The former employees (i.e. civil servants) were unsatisfied with the changes in the human resources policy and started to raise issues against privatization. They petitioned for judicial review on the base that the Perda was against the Labor Act, and that there was no Act served as the legal framework for this regulation. Despite the fact that almost 80% of the patients were paid through Jakarta government social health insurance, they argued that privatization jeopardized the social function of a hospital. In 2005, the High Court revoked the Perda, and the hospitals were converted back to public hospitals.

Policy implications: Later, the government of Indonesia enacted new regulations related to hospital management. The Government Regulation no. 23 (2005) enables public hospital that meets financial and managerial capacity requirements to become a public service agency in order to give them more financial and managerial authority. In regards to ownership, the Hospital Act (2009) forbids the government to convert government-owned hospital to be privately-owned hospital. In regards to its management, the Public Service Act (2009) allows public services provision(including health services) to be managed and operated by private corporation, independent agency or government-owned entity.

Key Terms: Conversion Ownership Public-Private
Author (1): Shita Listya Dewi (Faculty of Medicine, Universitas Gadjah Mada. Center for Health Service Management)

2B. THE PRIVATE SECTOR ROLE IN THE OVERALL HEALTH SYSTEM

Firm-Level Perspectives on Public Sector Engagement with Private Healthcare Providers : Survey Evidence from Ghana and Kenya

Presenter: Joanne Yoong (RAND)

Across the developing world, the private sector has an undeniable presence in healthcare. In sub-Saharan Africa, in particular, almost 60% of total health expenditures in 2005 came from private sources, with private providers estimated to have captured approximately half of that spending (IFC, 2008). For developing country policymakers, given the size and activity of the private health sector, a policy of engagement is a necessary step towards achieving large-scale improvements in public health. The central question is how to best interact with the private sector in a manner that produces desirable outcomes by leveraging its potential to expand access and increase efficiency, while minimizing harm to consumers. Lagomarsino et al. (2009) argue that it is important for policymakers to remain focused on effective public stewardship i.e. setting and enforcing the rules and incentives that define the environment and guide the behaviors of health-system players, an issue on which there is relatively strong consensus and hence opportunity for progress.

In this paper we provide new evidence about government engagement with private sector providers in two countries, Ghana and Kenya, through the lens of survey data collected from a sample of private providers. To structure the discussion, we outline a general framework for conceptualizing government engagement, which provides context for our study motivates our survey sample. We report results from the Health Provider Assessment Survey, which includes 542 private health facilities in Ghana and Kenya. We asked firms about their experiences interacting with the government, including government monitoring, technical and financial assistance, and subsidies or direct purchases of services. We also consider regulations and incentive programs designed to increase health care access, especially to low-income or rural communities.

Overall, the picture of public sector engagement that emerges in Ghana and Kenya is quite limited. Much government attention appears to be focused on the domain of quality rather than access or equity. Direct technical assistance is more prevalent across all types of capacity building than financial sponsorship of such activities, possibly due to logistical feasibility or ease of control. Many firms report receiving incentives to promote quality or being subject to regulation and inspection to ensure quality, but fewer report being involved with interventions to support expansion of access and equity outcomes. In particular, with respect to providing credit or facilitating private credit, the government's hand is almost absent. When contrasting the approach across provider types, it appears that across all types of interventions, in both countries, pharmacies are relatively excluded. Consistent in both countries, government support for capacity building seems largely confined to clinics. Pharmacies reported virtually no financial support, and significantly less technical assistance.

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Lagomarsino,G., de Ferranti.,D., Pablos-Mendez, A., Nachuk, S., Nishtar,S. and Wibulpolprasert, S. " Public stewardship of mixed health systems" The Lancet, Volume 374, Issue 9701, Pages 1577 – 1578.

Key Terms: access, equity, government engagement, private facilities
Authors (4): Joanne Yoong (RAND), Connor Spreng (World Bank Group) , Neeraj Sood (University of Southern California) and Nicholas Burger (RAND)

2B. THE PRIVATE SECTOR ROLE IN THE OVERALL HEALTH SYSTEM

Public-private partnerships: potential collaboration for the provision of ambulatory care in the Mekong region, Vietnam

Presenter**:** Duc Ha Anh

Objectives: To explore the possibility for collaborating with private providers for the provision of ambulatory care at the primary level in the Mekong region, Vietnam.

Methods: We employed both qualitative and quantitative methods. Qualitative methods comprised focus group discussions with local health officials and in-depth interviews with managers of private providers. Quantitatively, we conducted facility surveys and exit surveys of clients in 10 districts of 5 provinces in the Mekong region.

Results: Findings from focus group discussions showed a favorable attitude towards partnerships with private providers, but revealed some key challenges including relatively weak capacity for regulation, monitoring, and quality assurance. The facility survey found private providers relatively well staffed and equipped, as well as substantially involved in the provision of health services. When interviewed, private providers expressed a strong willingness to collaborate in providing ambulatory care. Finally, the exit survey results indicated that 80% first sought treatment at a private facility, though the majority lived closer to a public provider, and that over two-thirds made this choice based on quality of care. Clients who sought care at both a public and private facility were more satisfied with the latter.

Conclusions: Public-private collaboration in provision of ambulatory care at the primary level should be on the health policy agenda in Vietnam. If implemented, the capacity to effectively manage such partnerships should be improved and a quality assurance system established.

Key Terms: Public-private collaboration in provision of ambulatory care at the primary level should be on the health policy agenda in Vietnam, the capacity to effectively manage such partnerships should be improved and a quality assurance system established

Authors (4): Lora Sabin , Rich Feeley III , Thien Duong Duc and Cuong Le Quang

2B. THE PRIVATE SECTOR ROLE IN THE OVERALL HEALTH SYSTEM

Making Better Use of the African Private Health Sector through More Effective Regulations

Presenter: Richard Feeley (Boston University School of Public Health. International Health)

Background: Sub-Sahara African governments face complex and difficult challenges in meeting their population's health needs. Although the region accounts for 11 percent of the world's population and 24 percent of the global burden of disease, the region commands less than 1 percent of global health expenditures. To improve public health, African governments must marshal all the resources available in the health sector - public and private alike. Increasingly, African governments and donors recognize that achieving equity in access to health care requires engaging the commercial and non-profit private health sector. To harness private resources, governments must play an active stewardship role, facilitating public-private collaboration through an enabling policy environment. An effective regulatory framework that encourages a greater private sector role is a balancing act, considering private sector market realities while at the same time ensuring expanding coverage of quality health services.

Objectives: The study targets developing country policymaker practitioners working to harness the private health sector. This study presents a "road map" on how to review and analyze the most important laws governing the private sector and proposes solutions to overcome policy barriers.

Methods: Based on field experience, the study offers simples tools to analyze the policy environment: i) a step-by-step process to assess regulatory systems stressing design and enforcement; ii) a checklist focused on critical regulatory areas; and iii) examples of regulations enabling the private health sector.

Conclusions: Multiple policy assessments point towards seven key areas that most directly impact the private health sector, for example: health professional and facility licensing; quality of drug supply; consumer protection; and enforcement mechanisms and capacity. Regulatory weaknesses affect both healthcare providers and their patients. Common regulatory weaknesses in the African region--poorly defined/overlapping scopes of work, insufficient accommodation for human resource constraints, overly restrictive regulations-- increase health costs and negatively affect quality of care. There are successful African examples how to address these policy gaps.

Implications: The principle lessons in considering implementing regulatory reform include: •Policy reform is a balancing act requiring governments weigh private sector market realities with the public sector concerns. •Changing laws or regulations is a long-term investment, requiring years of work to yield results. Timing also plays an important role in policy change. •The majority of regulations affecting private sector participation are centered in seven areas. Focusing on these core areas can greatly maximize existing private sector resources. •Enforcement has been neglected in policy reform and merits more attention. Reforming enforcement systems requires political commitment, adequate resources for regulatory agencies, and skilled management with trained staff. •Local ownership is critical for the long-term success of legal reform. A participatory process- although time consuming- ensures reforms reflect the concerns and perspectives of all health actors and increases the likelihood of implementation. •Now is the moment to introduce the consumer voice into regulatory frameworks. Policymakers and professional associations increasingly recognize the importance of integrating patient rights and consumer protection within law and policy.

Key Terms: Africa, enforcements, legal and regulatory barriers, private health sector policy barriers, private sector policy assessment, public sector stewardships, regulatory strategies **Authors** (4): Yuksel Sezgin (CUNY) , Angela Stene (Abt Associates, Inc. SHOPS Project) , Barbara O'Hanlon (O'Hanlon Health Consulting LLC. SHOPS Project) and Rich Feeley (Boston University School of Public Health. International Health)

2B. THE PRIVATE SECTOR ROLE IN THE OVERALL HEALTH SYSTEM

A Comparison of Health Outcomes in Public vs. Private Settings in Low- and Middle-Income Countries

Presenter**:** Dominic Montagu (University of California, San Francisco. Global Health Sciences)

Objectives: This review compares health outcomes in private versus public care settings. It seeks to summarize what is known regarding the relative morbidity or mortality outcomes that result from treatment by public or private providers in low- and middle-income countries (LMICs).

Background: Private healthcare providers deliver a significant proportion of healthcare in LMICs. Poorer patients get sick and go without care more frequently, and spend more of their incomes on private healthcare than the wealthy.

Design and Evaluation Methods: We conducted a systematic review of studies evaluating the impact of public and private healthcare provision. We performed meta-analyses on data within identified studies, in order to estimate the effects of type of healthcare provision on identified health outcomes.

Results/Outcomes and Challenges/Solutions: Twenty-one studies met our inclusion criteria and explicitly compared health outcomes between public and private sectors. Of those, 17 were cohort studies, from nine countries. Eleven studies were conducted in lower-middle-income countries and 10 studies from upper-middle-income countries. Eighteen studies were conducted in urban settings. Fifteen of the 21 studies provided mortality for a health outcome, and studies examined a wide range of diseases.

A meta-analysis of all studies exploring the impact of healthcare type and mortality showed that patients in a private healthcare setting are less likely to die than patients in a public healthcare setting (OR 0.60; 95% CI 0.41–0.88).

Conclusions: More evidence is needed to compare health outcomes between the public and private sectors. This is particularly true in low-income countries where no eligible studies met our inclusion criteria.

Implications: By some measures, the majority of healthcare services in Asia and Africa are provided by the private sector. Without evidence to demonstrate whether this care is better or worse than publicly provided services, regulators and policy makers are challenged to define appropriate roles for private providers within broader health system planning.

Key Terms: health outcomes, health systems, LMICs, policy, private sector, systematic review

Authors (5): George Rutherford (University of California, San Francisco. Global Health Sciences) , Katie Drasser (University of California, San Francisco. Global Health Sciences) , Mudita Tiwari (University of California, San Francisco. Global Health Sciences) , Andrew Anglemyer (University of California, San Francisco. Global Health Sciences) and Dominic Montagu (University of California, San Francisco. Global Health Sciences)

2C. THE PRIVATE SECTOR ROLE IN MCH SERVICES

Effect of an Expansion in Private Sector Provision of Contraceptive Supplies on Horizontal Inequity in Modern Contraceptive Use: Evidence from Africa and Asia

Presenter: David Hotchkiss (Tulane University. Global Health Systems and Development)

Background: One strategic approach available to policy makers to improve the availability of reproductive and child health care supplies and services as well as the sustainability of programs is to expand the role of the private sector. However, critics of this approach argue that increased reliance on the private sector will not serve the needs of the poor, and could lead to increases in socio-economic disparities in service use. The purpose of this study is to investigate whether the expansion of the role of private providers in the delivery of one type of reproductive health supplies, modern contraceptive supplies, is associated with increased horizontal inequity in modern contraceptive use.

Methods: The study is based on multiple rounds of Demographic and Health Survey data from four selected countries (Nigeria, Uganda, Bangladesh, and Indonesia) in which there was an increase in the private sector supply of contraceptives. In order to investigate horizontal inequity in modern contraceptive use in each of the surveys, we standardized the measure of modern contraceptive use for family planning need in relation to household wealth. This was done using the indirect method of standardization, as suggested by the World Bank, where need-standardized modern contraceptive use is obtained by adding the overall sample mean of the indicator of modern contraceptive use to the difference between actual and need-predicted modern contraceptive use. Estimates of need-predicted modern contraceptive use were computed using probit regression models. Once need-expected and need-standardized use was obtained, we calculated their respective concentration indices. The method of indirect standardization "corrects" the actual distribution by comparing it with the distribution that would be observed if all women had not their levels of the non-need variables but the same mean values of the non-need variables as the entire population. The concentration index of need-standardized contraceptive use provides a measure of horizontal equity.

Results: Overall, the results of the study suggest that the expansion of the private commercial sector supply of contraceptives in the four study countries was not associated with increased inequity in the use of modern contraceptives. In fact, in three of the four study countries (Nigeria, Uganda, and Indonesia), inequity actually decreased over time; while in the fourth study country (Bangladesh), inequity fluctuated.

Conclusions: The results offer support to the premise that, in the area of family planing services and supplies, government strategies that promote the role of the private commercial sector can help facilitate the achievement of equity objectives. While the public sector remains an important source of supply for poor women, who may lack the physical and financial accessibility to private outlets that sell modern contraceptives, our results also suggest that the private commercial sector can also be an important source of supply to poor women without leading to increased inequity in modern contraceptive use. Social marketing programs are likely to have played an important role in expanding the use of private suppliers among poor women.

Key Terms: equity, family planning, private sector

Authors (3): Mai Do (Tulane University. Global Health Systems and Development) , Deepali Godha (Tulane University. Global Health Systems and Development) and David Hotchkiss (Tulane University. Global Health Systems and Development)

2C. THE PRIVATE SECTOR ROLE IN MCH SERVICES

The impact of the reproductive health vouchers program in Kenya on out-of-pocket expenditures on services

Presenter: Timothy Abuya (Population Council. Reproductive Health)

Background: The Kenya Government has implemented a public-private reproductive health vouchers program since 2006 with funding from the German Development Bank. Vouchers were made available through distributors appointed by the voucher management agency to poor women in Kisumu, Kitui, and Kiambu districts, and in Korogocho and Viwandani informal settlements in Nairobi for safe motherhood services and long-term family planning methods at a subsidized cost. Additional vouchers were freely available for women seeking gender-based violence services.

Objective: This paper examines facility- and community-level associations between exposure to the program and out-of-pocket expenditures for reproductive healthcare. It specifically compares out-of-pocket expenditures on antenatal care, delivery, post-natal care, and family planning services among: (1) voucher users and non-users at the facility; and (2) communities that have been exposed to the program and those that have not had such exposure.

Data and methods: The data are from baseline surveys implemented by the Population Council between February and November 2010 as part of a project aimed at evaluating the impact of the program on reproductive health behaviours and status in five countries. In Kenya, data were collected both at the facility and household levels in voucher and non-voucher areas. Facility-level data included observations of client-provider interactions, client exit interviews, service provider interviews, record reviews, facility inventory, and service statistics. The household survey was conducted among women and men of reproductive age (15-49 and 15-54 years respectively) living within five kilometre-radius of the facilities included in the study. This paper uses information collected from women in the household survey and client exit data from the facilities. A total of 2,527 women were interviewed in the household survey while 1,852 exit interviews were conducted with women seeking antenatal care (661), family planning (318), and post-natal care services (873). Analysis entails cross-tabulations with Chi-square tests.

Results: Results from client exit interviews show that 10% of voucher users paid for antenatal care compared to 72% of non-users ($p<0.01$). A similar pattern is noted for delivery (9% of users compared 70% of non-users; $p<0.01$), post-natal care (9% of users versus 35% of non-users; $p<0.01$), and family planning services (19% of users compared to 69% of non-users; $p<0.01$). However, there were no significant variations between voucher users and non-users in the amount paid for antenatal care ($p=0.08$), delivery ($p=0.79$), and post-natal care services ($p=0.27$). Variations at the community level do not show similar impact on out-of-pocket expenditures. For example, 84% of women from communities exposed to the voucher program reported paying for antenatal care services compared to 68% of those from non-exposed communities ($p<0.01$). In contrast, there were no significant variations in the proportions of women from exposed and non-exposed communities paying for delivery (54% versus 58%; $p=0.34$), post-natal care (28% versus 26%; $p=0.65$), and family planning services (78% versus 81%; $p=14$).

Conclusion: The Kenya reproductive health vouchers program is associated with reduced likelihood of paying out-of-pocket for clients seeking services at the facilities. However, its population impact on reducing out-of-pocket expenditures on the services at the community level appears limited.

Key Terms: output-based services, reproductive health, vouchers; **Authors** (5): Ben Bellows (Population Council. Reproductive Health) , Rebecca Njuki (Population Council. Reproductive Health), Charlotte Warren (Population Council. Reproductive Health) , Francis Obare (Population Council. Reproductive Health) and Timothy Abuya (Population Council. Reproductive Health)

2C. THE PRIVATE SECTOR ROLE IN MCH SERVICES

The Impact of a Reproductive Health Voucher Program on Private Providers in Developing Countries: A Cross-Sectional Evaluation

Presenter**:** Ben Bellows (Population Council), Carinne Meyer (University of California, Berkeley. Public Health)

Background: In 2006, the Ugandan Ministry of Health, with support from the German Development Bank (KfW), launched an output based aid (OBA) voucher program to incentive the use of reproductive health services at private health facilities. We independently assess the effect of the OBA program on providers and facilities.

Methods: We administered a semi-structured survey to 76 providers from 22 private OBA facilities and 13 private non-OBA facilities and used tests of association and logistic regression analysis to assess the impact of the OBA program on facility re-investment, job satisfaction and competitive pressure.

Findings: At OBA facilities, 100% (56/56) of providers reported an increase in facility revenue in the past year as compared to control facilities where 30% (6/20) of respondents reported an increase in the past year ($p<0.001$). This relationship remains significant controlling for type of facility and level of provider. The most frequently cited re-investment categories were medication, supplies, salaries and equipment. Using an adapted job satisfaction scale, providers at OBA facilities reported a non-significantly higher average satisfaction score (23.1) than providers at control clinics (21.6). Staff level was an effect modifier for job satisfaction. Job satisfaction was significantly higher at OBA facilities for upper and mid-level providers but lower for low-level providers. Only low-level providers at OBA facilities where salaries were increased reported higher job satisfaction scores than low-level control providers (24.4 vs. 21.3, $p=0.01$). Control providers reported feeling more competitive pressure than OBA providers (95% vs. 64%, $p=0.012$). This relationship remains significant controlling for type of facility and level of provider.

Interpretation: The findings of this evaluation indicate that OBA programs have a positive impact on health facilities and providers allowing providers to re-invest in their facility, gain clinical experience and provide higher quality services to their patients. But there are several managerial adjustments targeting all levels of providers that are required in order for facilities to take full advantage of OBA programs. Further research on the impact of OBA program on the level and type of re-investment and the determinants of providers' satisfaction levels may offer guidance on such adjustments in the future.

Key Terms: output-based aid, private sector health financing, vouchers

Authors (3): Benjamin Bellows (Population Council) , John Irige (The AIDS Support Organization (TASO), Uganda. Clinical Care) and Carinne Meyer (University of California, Berkeley. Public Health)

2C. THE PRIVATE SECTOR ROLE IN MCH SERVICES

Private Delivery Care Across Developing Countries: Trends and Determinants

Presenter**:** Amanda Pomeroy (John Snow, Inc., Center for Health Information and Monitoring and Evaluation (CHIME))

Over the past two decades, multilateral organizations have encouraged increased engagement with private health care providers in developing countries. As these efforts progress, there are concerns that private delivery care may have adverse effects on maternal health. Currently available data do not allow for an in-depth study of the direct effect of privatization on maternal health. However, as a first step, we can use Demographic and Health Surveys (DHS) data to examine a) trends in growth of delivery care provided by private facilities, and b) determinants of private sector use within the health care system. To construct trends, this study uses DHS from 16 sub-Saharan African, Asian, and Latin American countries, selecting those countries with one DHS in phase 4 (1997–2003) and one in phase 5 (2003–present).

For a subset of eight countries, we examine determinants of a mother's choice to deliver in a health facility and then, among women delivering in a facility, their decision to use a private provider. Determinants of use are grouped by socioeconomic characteristics, economic and physical access and by actual/perceived need.

Results show a significant trend toward privatization of delivery care over the 13 years covered in the study but there is considerable variation in the characteristics driving this increased use across countries. Differences seem to follow regional lines and level of wealth, as measured by GDP per capita(2007 dollars). In three African countries where average GDP per capita is low, socio-demographic characteristics are associated with use of private delivery care. In Bolivia and four Asian countries where the average GDP per capita is relatively higher, economic indicators and perceived need are more relevant. In the former group this may suggest complementarity to public facilities (e.g. private delivery services cover populations that may not be reached by public services), while in the latter it may mean competition. These results warn against making generalizations on the effects of privatization on maternal health use.

Key Terms: delivery care, maternal health, Privatization, regional trends

Authors (3): Soumya Alva (ICF Macro), Marge Koblinsky (John Snow, Inc.) and Amanda Pomeroy (John Snow, Inc. CHIME)

Poster Abstracts

The Role of the Private Sector in Reaching Universal Health Care in the Philippines: Existing Models, Prospects, and Constraints

Presenter: Oscar Picazo (Philippine Institute for Development Studies. Health Group)

Following the global push for universal health care (UHC), the new President Benigno S. Aquino announced that his government is determined to achieve UHC within three years, and that public/private partnerships (PPP) will be a hallmark of his administration. The UHC goal is now contained in DOH Administrative Order No. 36, s. 2010. At this time, the Philippine Institute for Development Studies received a grant from the Rockefeller Foundation to work with the Center for Health Market Innovations coordinated by the Results for Development, a Washington, D.C.-based organization, to conduct an inventory of health market innovations (HMI) and to select those with significant potential. This paper reports on the findings of the inventory, and their implications in achieving UHC.

Method: (1) Extensive search using the Internet, published and gray literature, press releases, and information from key informants. (2) Classification using a typology prescribed by CHMI in consultation with its partner-institutions undertaking similar inventories. (3) Short-listing of the HMIs using pre-determined criteria by a panel of 70 local stakeholders from the academe, government, NGOs and industry. (4) Documentation of the short-listed HMIs.

Findings: The first stage of the study ends in mid-2011. The inventory currently contains 117 discrete HMIs: (a) 32% involve delivering care, e.g., franchises, chains, networks, mobile health services, and pharmaceutical sales; (b) 19% involve facilitating care, e.g., information technology, innovative processes, and new-generation pharmaceutical logistics; (c) 20% involve financing care, e.g., voucher programs, health service contracting, and cross-subsidy programs; (d) 16% involve regulating and incentivizing care, e.g., accreditation, supportive policy/legislation, and pay-for-performance programs; and (e) 13% involve promoting care, e.g., social marketing, health education programs, and provider training.

Prospects: Private sector does finance and provide significant level of health care. In 2007, 63% of total health expenditures (THE) came from private sources, while only 27% came from government. However, only 10% of THE came from health insurance compared to 53% from out-of-pocket expenditures (OPE), one of the highest OPE proportions in the region. In 2009, 60% of the total hospitals were privately-owned, although private hospitals account for fewer beds in total. About 48% of inpatients were confined in private hospitals.

Constraints: (a) Local-level and industry data on private health spending and delivery should be gathered. (b) The existing typology should be made more rigorous to classify the full range of HMIs and to understand the economic principles underlying them. (c) A national strategy and policy on HMIs in promoting public health goals should be crafted. (d) More impact evaluation needs to be done to objectively verify the social benefits and costs of these schemes. (e)The absence of a 'Private Health Desk' at DOH and local government units should be addressed.

Key Terms: Health market innovations, Philippines, public/private partnerships

Authors (3): Val Ulep (Philippine Institute for Development Studies. Health Group) , Rouselle lavado (Philippine Institute for Development Studies. Health Group) and Oscar Picazo (Philippine Institute for Development Studies. Health Group)

Evaluating the effectiveness of social franchising model: Meeting the need of family planning needs in rural and underserved Pakistan

Presenter: Syed Khurram Azmat (Marie Stopes Society Pakistan. Senior General Manager, Technical Services)

Background: Pakistan ranks as one of the poorest and most populous countries in the world with approximately 172.8 million people where 29% of people living below poverty. The lack of awareness of health right results in the limited accessibility of reproductive and family planning services in a country where 276-500 women die out of per 100,000 live births, very low modern contraceptive prevalence (CPR) – 22 % and 25% of the married women are living with unmet need for contraception. To address this gap especially among the poor and underserved, Marie Stopes Society (MSS) launched an innovative Social franchising model ensuring the accessibility of high quality and affordable family planning and reproductive services in an equitable manner through employing a voucher-based system for long-term family planning method. This present study is the first-ever such intervention conducted in Pakistan to evaluate the effectiveness of social franchising through a voucher-based system for long-term family planning method in the rural and underserved population.

Objective: The pilot study aimed to assess and evaluate the effectiveness of social franchising model in meeting the need of reproductive health services in rural Pakistan

Methodology: A quasi-experimental mixed method design with sequential implementation was used in two intervention and two control districts of Sindh and Punjab provinces of Pakistan. In intervention districts a total of sixteen (16) private providers where taken on-board. The need of targeted communities was assessed qualitatively through sixteen (16) Focus group discussions. By the initiation of services, a quantitative pretest population based household survey was conducted with 4960 married women of reproductive age (MWRA) group, followed by midline qualitative interviews with service providers and their field worker marketing. After the intervention of eighteen (18) months, the study was completed and a quantitative population based posttest survey with 4000 MWRA and the present findings are based on this same posttest survey.

Findings: The findings documented of the total respondents 99.9% in intervention and 93% in control group were Muslims and majority (30.8%) of respondents in control and 28.4% in intervention were aged between 25-30 years. In addition, 69 % respondents of control group and 49% of intervention had no education. Importantly, the majority of respondents documented their monthly income between 3000-6000 Pakistan Rupees – 64 % intervention and 61% control. A significant increase was observed about the knowledge of contraception in intervention versus control group - 88.4% at pretest and 96% at posttest (p-value <0.001). Similarly, a marked change was observed in the percentage of ever users with 34% at pretest and 62% at posttest (p-value <0.001). Most importantly, the CPR in the intervention group has markedly increased from only 27.2% at pretest to 48.0% at posttest (p-value <0.001); however, no significant changed is documented in control group where CPR was unchanged - 28.0% at the pretest and 29% at the posttest (p-value 0.369).

Conclusion: Findings of the pilot study revealed a significant affect of social franchising model in increasing contraceptive prevalence by increasing accessibility to quality and affordable family planning services in the underserved communities. However, a comprehensive study at a bigger scale should be conducted to strengthen the existing body of knowledge.
Key Terms: Evaluation, Long-term family planning method, Pakistan, Reproductive Health, Rural and underserved, Social Franchising, Voucher-based
Authors (2): Waqas Hameed (Marie Stopes Society Pakistan. Deputy Senior Manager, Research and Metrics) and Syed Khurram Azmat (Marie Stopes Society Pakistan. Technical Services)

Knowledge, influence and accountability: improving the performance of health markets

Presenter: Gerald Bloom (Institute of Development Studies. Knowledge, Technology and Society Team)

The spread of markets for pharmaceuticals in low and middle income countries has been much more rapid than the development of institutional arrangements to provide access to reliable information and/or trustworthy advisors and influence the behavior of the providers and users of these products. This has led to well-known problems with high levels of expenditure, the overuse of dangerous products and public goods problems with the emergence of treatment resistant antiviral and antimicrobial agents. This paper presents the findings of review of literature and scoping study. It presents a framework for analyzing the health knowledge economy, which influences decisions about the use of pharmaceuticals. It identifies major changes in the organization of this knowledge economy in low and middle income countries. These include the rapid spread of the mass media, mobile telephones and the internet, the growth in the number of agencies producing content on pharmaceutical use for these media and the recent emergence of knowledge intermediaries that offer access to expert knowledge on a number of issues including pharmaceutical use. The paper argues that these developments in the health knowledge economy could have a big impact on patterns of use of pharmaceuticals. They present major opportunities for enabling people in countries with poorly organized health systems to gain access to reliable advice and improve their use of pharmaceutical products. They also open up opportunities for powerful groups to influence the development of markets for pharmaceuticals in their own interest. The paper concludes with an outline of an agenda for research and a discussion about the regulatory challenges emerging from the rapid change in the organization of the health knowledge economy.

Key Terms: governance, knowledge intermediaries, regulation

Author (1): Henry Lucas (Institute of Development Studies. Knowledge, Technology and Society Team)

The Implications of a Growing Private Sector for the Public Health System in Indonesia

Presenter: Rooswanti Soeharno (ADB. Social Sector)

The Indonesian health system has undergone a dramatic transformation over the past twenty years: maternal mortality and child mortality has fallen from 97 to 44 and from 390 to 228 (from 1991 to 2007) respectively; nutrition has improved as indicated by achieving halve of the prevalence of underweight in under-five children (from 31% in 1989 to 18.4 in 2007); communicable diseases are increasingly being brought under control; and there is a gradual transition occurring from communicable to chronic diseases; already, various cancers are the main causes of death in the country. In the health system, an intensive village health awareness program (Desa Siaga) is bringing healthy behaviors to increasing numbers of people; the network of hospitals and health centers is increasingly being expanded into remote and underserved areas; and efforts are being made to increase the quality and competence of health workers. While these are encouraging and important trends, much still remain to be done.

Demands are still high and public resources are stretched thin. With public-private practice allowed among public health workers and with a growing private sector that parallels and complements public service, there is increasing discussion about partnerships between public and private provision. The number of private health providers has risen over the past 10 years, and it is likely to continue growing. Over the same period, the share of the public sector in Total Expenditure in Health (TEH) has increased from 35% to 47%, with a substantial increase in 2005 when a health financing scheme for the poor (Askeskin) was introduced. Despite a corresponding decline in private spending, the share of private spending still accounts for more than half of THE. Public spending is mainly consumed by administration (31%), followed by curative care (19%), based on available data from the most recent national health accounts.

Looking at the trends in utilization, deliveries offer a good illustration of the increasing role of the private sector. Deliveries in private health facilities have increased from 31% to 36 % over the 2002/2003 to 2007 period, and deliveries in public facilities have gone up from 9% to 10% over the same period of time – reflecting an increase in facility-level deliveries and a stronger increase in deliveries in private facilities. Over the same time period, home deliveries have declined from 59% to 53%.

What do these trends mean? This paper looks at the implications of a growing private sector for the public health system. It discusses its implications for care, for the future development of the public system, and it looks for common ground – where and how can fruitful collaboration develop, and what does it mean for the client. The analysis is based on partial data, and in many instances qualitative assumptions are used, drawing on experience from other countries.

Key Terms: Health Policy, Health System, Indonesia, Private Sector

Authors (2): Hjalte Sederlof (World Bank (consultant)) and Rooswanti Soeharno (ADB. social sector)

Linking Research to Policy - The experience of initiating policy changes in Indonesia

Presenter: Shita Listya Dewi (Faculty of Medicine, Universitas Gadjah Mada. Center for Health Service Management)

Background: In 2009 we examined the recent growth of private hospital services in Indonesia to identify factors contributing to and impacting on this growth, and to explore the potential regulatory and policy responses. Our research findings showed that: (1) there is a long tradition of charitable and religious based service provision in Indonesia even before the public system is established; (2) the private hospitals account for 50% of the total hospital providers available in the health system; largely in the form of not-for-profit (NFP) Foundations (81,8%), with the remainder as for-profit Limited Company (13,8%) and NFP Community Associations (4,4%); (3) during the last 10 years, the growth of NFP hospitals has been stagnant (some converted to for-profit hospitals), while the growth of the for-profit hospitals has been doubled;
(4) there are no tax incentives for private hospitals, in particular NFP which provide charity care or social benefits. For-profit hospitals and NFP hospitals face the same tax and levies burden.
Thus we argued that there should be a policy change to support the NFP hospital.

Approach: This is an ongoing action research, using stakeholder engagement approach in two stages. First, we identified the immediate stakeholders, namely the NFP hospital associations, to engage them in the policy community dialogue. Then, we identified policy champions in the National parliament and the Ministry of Health (MOH).

The engagement activities include:
* Individual meetings with NFP hospital associations and the MOH
* One-on-one advocacy to the National Parliament members
* Arranged a study visit to Australia with delegates comprised of representatives of the NFP hospitals associations, the MOH, and the media.
* Established an informal NFP hospitals forum that meets quarterly
* Published articles and special report concerning the NFP hospital in a national newspaper
* Arranged a NFP hospitals panel presentation and discussion in the annual private hospital national conference
* Initiated digital communications including website, on-line forums and blogs targeted to the NFP policy community.
* Distributed policy briefs to the MOH and National parliament

Results: The Hospital Act (2009) finally distinguished for-profit and NFP hospitals for the first time, and acknowledged the rights to tax incentives for the NFP hospitals. Consequently, operational regulations need to be developed to give effect to this provision. One operational regulation will have to come from the MOH (to define specific criteria of NFP hospital), the other will have to come from the Ministry of Finance (to regulate the tax incentives). The NFP hospital forum convinced the MOH to establish a task force within the MOH dedicated to follow this through. The task force consists of an academic representative, representatives of the NFP hospital associations (six people), and representatives of MOH (three people). At the end of 2010 the task force developed a Brief to the Minister of Health. Currently the task force is drafting the operating regulation for MOH to define NFP hospital. The task force also has started dialogues with the MOF in 2010, and will continue to do so in 2011.

Key Terms: Not-for-Profit, Policy community, Stakeholders engagement
Author (1): Shita Listya Dewi (Faculty of Medicine, Universitas Gadjah Mada. Center for Health Service Management)

Demonstrating sustainability and impact in eye care service delivery in India - Multiple private sector models to achieve national health goals

Presenter: Abby Bloom (University of Sydney. Menzies Centre for Health Policy)

Objective: Three eye-care programs run by not-for-profit private sector organizations in India offer valuable insights into alternatives to Government-funded and operated health care. They illustrate the wide range of models available to harness the private sector for national health goals, and reveal valuable lessons and techniques that are being applied elsewhere.

Methods: Research methods included a review of the literature, field research activities and key informant interviews. Three sites where NGO, non-state provider (NSP) health programs in eye-care have been implemented over three decades were examined to understand the features of each model. We investigated each program's critical success factors, strengths, weaknesses and relationships with Government health policy and goals.

Results: These three distinct programs implemented by non-state providers to combat vision problems, which are the cause of economic hardship in India, succeeded in delivering needed services to rural populations. Each of the programs uses a business model consistent with private-sector principles while focusing on equity and increasing coverage. The two older initiatives originated as charitable foundations and evolved along commercial lines during the emergence of India as an important part of the global economy. The newest of the programs, VisionSpring, exemplifies the innovative model "social franchising". Each of the three vision care programs has evolved into a distinct, sustainable model of funding and operation. Each has forged a pragmatic relationship with government, mostly at local rather than national level. Each has made a significant contribution to meeting national public health goals. The State Governments of India have tacitly supported these programs while in some cases extracting concessions in exchange for agreement to establish or enlarge hospitals and commence operation in new locations.

Conclusions: NSPs can contribute to national health goals in a manner that diminishes inequity and is affordable to poor, rural populations, while still being financially sustainable. A range of models is available, each of which can draw on lessons and mechanisms from different contexts, but adapted to the socio-cultural exigencies of particular settings.

Key Terms: eye care, India, non-state provider, not-for-profit, vision care

Authors (2): Peter Annear (University of Melbourne. Nossal Institute for Global Health) and Abby Bloom (University of Sydney. Menzies Centre for Health Policy)

Developing a Framework for the Regulation of Public Private Partnerships in Kazakhstan: Lessons Learned for Emerging Markets

Presenter: James A. Cercone (Sanigest Internacional. President and CEO)

Over the past decade, Public-Private Partnerships (PPPs) have developed as the preferred mechanism for financing health sector infrastructure projects. The trend has recently spread to Kazakhstan where the government is looking to replace aging infrastructure and inject private sector innovation with the PPP model. Underlying the initiative to develop PPP projects is a fundamental belief that the private sector knows what it's doing and gets things right--at least better than the public sector. Previous research also illustrates that partnerships are hard to achieve, and that a suitable regulation framework is a fundamental requisite for the successful formation of PPPs (cf. Van Ham & Koppenjan, 2002; Teisman & Klijn, 2002; Hodge, 2004; Johnston & Gudergan, 2007; Petersen, 2010). Much of the literature is based on regulating the PPP procurement process, however, regulation must include all phases of development and ensure continuing supervision of the full project cycle by a government regulatory authority. The private sector can offer many advantages over traditional procurement, as long as public sector does its job in supervising and managing the overall project and the behavior of the private partner.

The evidence points to the importance of developing a regulatory framework which ensures public resources are used effectively. Countries such as Australia and the UK have developed important guidance on key elements of the PPP process, however, there are few experiences which have adapted these tools to emerging market conditions. This paper capitalizes on the work in western countries to develop a checklist of the key tools and regulatory processes that should be developed for Kazakhstan as a pre-condition for implementing PPPs in the health sector.

The development of our framework for regulating PPPs is based on the fact that in emerging markets, international partners must address not only the project risk and country risk, but also the risks posed by the lack of local managerial skills, inadequacy of institutions, absence of established objective and independent regulatory and supervisory traditions, corruption, lack of transparency, and others. In the case of the health sector, giving due consideration to adequate and transparent institutionalized rules, procedures and monitoring is not sufficient. The nature of the health sector also requires that the regulatory framework focus resources on better services, patient satisfaction and overall better outcomes in terms of health status. Therefore, the principles of a good regulatory framework should include:
1. Patient-Centered
2. Forward-thinking and risk management
3. Efficient Use of Resources
4. Integrated Care Delivery and Knowledge Transfer
5. Optimized Health Outcomes (Better Health)

Adopting a regulatory framework that has been designed for an emerging market, such as Kazakhstan, will ensure that PPPs deliver all of the anticipated benefits for the health sector. Using a comprehensive checklist approach this paper provides an easy-to-use guide for regulatory authorities in other emerging markets to properly regulate and supervise the implementation of PPP projects.

Key Terms: Health Investment and Health Sector Regulation, Public Private Partnerships (PPP)
Authors (3): Zhana Ospanova (Public Health Investment Projects Management Centre LLP, Republic of Kazakhstan. Planning, Monitoring and Evaluation of Healthcare Investments) , Hernan Fuenzalida (The World Progress Center and Sanigest Internacional. President and Senior Consulting) and James A. Cercone (Sanigest Internacional. President and CEO)

Cost Estimates for Physician and Nurse Pre-Service Education

Presenter: Eric Keuffel (Fox School of Business (Temple University). Risk, Insurance and Healthcare Management)

Rationale: It is well-established by the WHO (World Health Report, 2006) and others that the significant shortages of health workers exist throughout Sub-Saharan Africa and parts of Asia. Given limited public funding, private sector involvement (by both non-profit and for-profit entities) serve as one potential approach to improve the output of health workers. An important input for private sector investment in health education facilities is the estimated recurrent cost associated with producing health personnel at the country level. Given the paucity of data, this analysis offers a potential method for estimating the static costs associated with production of health workers in specific countries or regions.

Objectives: Estimate the average recurrent 'costs per graduate' for pre-service physician and nurses/midwife education at the country or regional level.

Methods: 'Cost per graduate' estimates are derived from a regression in which existing high-quality literature estimates of the economic costs of production at select institutions in different countries are regressed on GDP / capita. In order to validate these figures, we model total country-level expenditures for pre-service physician and nurse/midwife training via two separate methods. In the first approach (the "micro" approach) 'cost per graduate' and 'total annual production' are multiplied for each country. The total production is derived from either A) current validated measures of annual graduate production for physicians and nurse/midwives (e.g. in OECD countries) or "stock-based measurements" which account for migration, attrition and mortality. The "macro" approach calculated country-level expenditure by using UNESCO country-level data on tertiary educational expenditures (public and private) and plausible assumptions about the share of these funds directed toward medical or nurse/midwife education. Similar results in the macro and micro approaches add validity to the 'cost per graduate' regression approach.

Data: In addition to literature estimates (for cost of production), key data sources include OECD (annual production of graduates in medicine and nursing), WHO (stock of MDs, nurses, midwives; emigration of health workers; mortality;), World Bank (exchange rates, GDP/capita, GDP), FAIMER-International Medical Education Directory (duration of education estimates), UNESCO (GDP share expended on tertiary education) and other estimates from the literature or World Bank analyses.

Results: Average economic cost per physician graduate (weighted by estimated annual physician production) is $51,703 ($US, 2008) in Sub-Saharan Africa and $56,222 in Asia (excluding China and High Income Asia Pacific Countries). For nurses the estimated cost per graduate (weighted by country level annual nurse production) are $10,620 in Sub-Saharan Africa and $14,454 in Asia (same exclusions). China is an outlier given its high production and differential quality level (e.g. Master-level physicians with 3 year degrees). Country specific estimates for all countries are also calculated.

Conclusions: The 'cost per graduate' estimates are a reasonable starting point for estimating the average recurrent expenditures associated with training physicians and nurses in each country. Nevertheless, private investors should account for capital costs (for new schools or buildings) and other potential factors (labor market for instructors, unique country specific factors, economies of scale) when evaluating investment and payoff.

Key Terms: Cost, Education, Human Resources for Health, Physicians

Authors (2): Alexander Preker (World Bank) and Eric Keuffel (Fox School of Business (Temple University). Risk, Insurance and Healthcare Management)