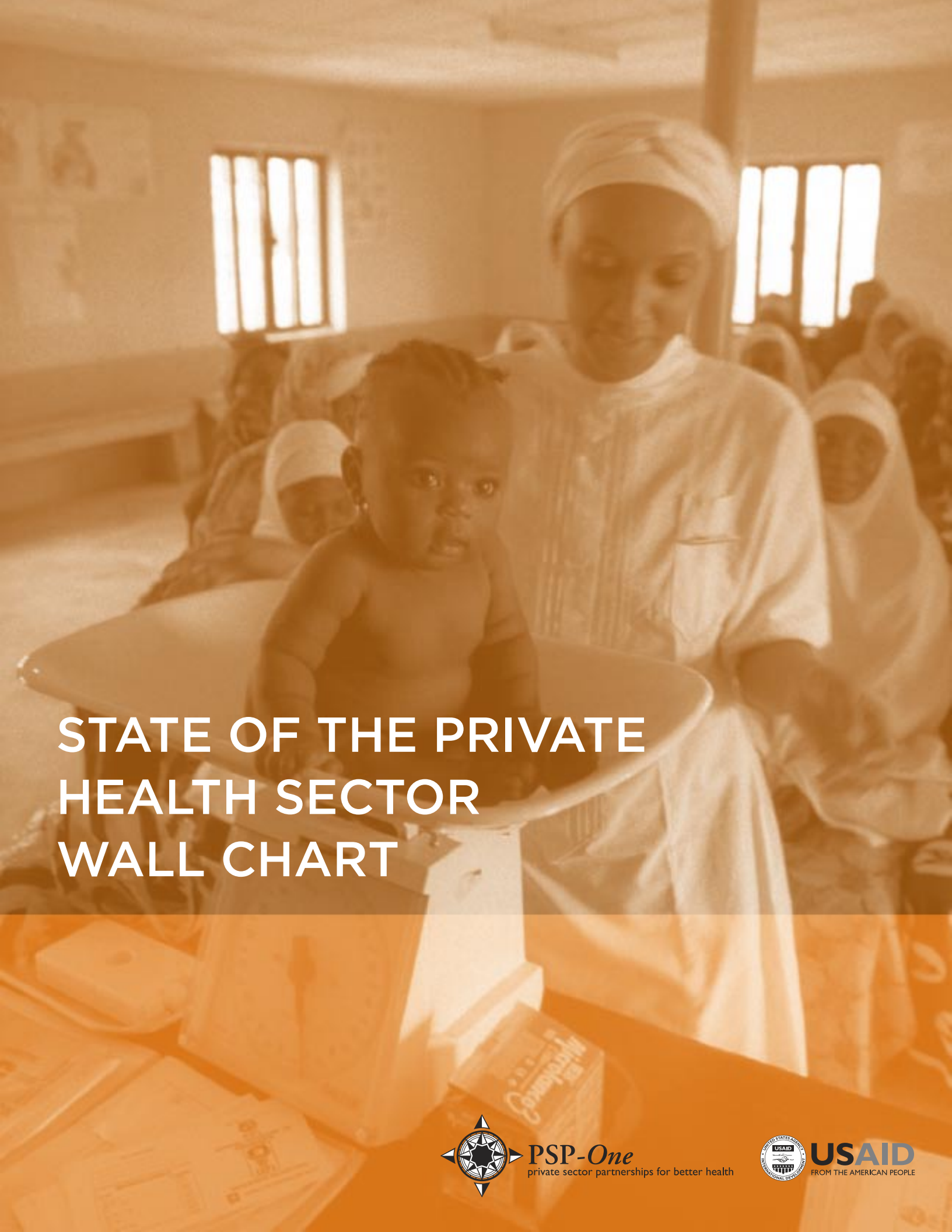


STATE OF THE PRIVATE HEALTH SECTOR WALL CHART

PSP-*One*
private sector partnerships for better health

USAID
FROM THE AMERICAN PEOPLE

STATE OF THE PRIVATE HEALTH SECTOR

WHY INVOLVE THE PRIVATE SECTOR?

Meeting healthcare needs in developing countries is an enormous challenge. Though developing country governments provide health products and services, declining or variable funding levels may limit access to and quality of care for the general population. The private health sector can succeed in responding to these unmet healthcare needs.

Moreover, consumers in several developing countries are willing to pay for healthcare in the private sector in order to obtain better or more accessible health products and services. As economies develop and incomes rise, many more consumers will have the financial means to purchase healthcare goods and services. With growing awareness among consumers that the private sector is a viable source for healthcare and products, the time is right to encourage greater private sector involvement in health to meet public heath goals.

THE PSP-*ONE* CHALLENGE

Private Sector Partnerships-*One* (PSP-*One*), a flagship project of the U.S. Agency for International Development, is working to foster private sector efforts to help address important reproductive health needs, such as family planning and HIV/AIDS prevention. The project is designed to encourage greater private sector delivery of high-quality and affordable health products and services in the developing world. Over the life of the project, PSP-*One* will bring together the best that the international health community and commercial sector have to offer to address longstanding private sector challenges, develop and implement new approaches, and scale up proven strategies.

THE *STATE OF THE PRIVATE HEALTH SECTOR WALL CHART*

The private health sector—what it is, what it does, and what drives it—is still not well understood by the international public health community. In fact, some regard the private health sector with caution. One of PSP-*One*'s challenges is to create a shared vision by clearly defining the private health sector and its potential role in providing essential health services and products in the developing world. The *State of the Private Health Sector Wall Chart* is the first tool in a series of tools from PSP-*One* that facilitates public/private dialogue and responds to the interests and concerns of both the public and private sectors for effective delivery of health services. This *Wall Chart* offers key concepts and definitions to establish a common language describing the private health sector. In addition, this *Wall Chart* integrates global demographic, economic, and policy data to provide a "snapshot" of the private health sector in selected developing countries.

DEFINITIONS OF COMMON PRIVATE HEALTH SECTOR TERMS

Defining "the private sector" is an important first step in the process of reaching a common understanding of the private health sector. The private health sector is a large and diverse group, comprising both for-profit and not-for-profit entities that lie outside the public health sector. The private sector covers a wide range of health sector entities, including private practitioners, clinics, hospitals, and laboratories and diagnostic facilities; nongovernmental organizations (NGOs); faith-based organizations; shopkeepers and traditional healers; pharmacies; and pharmaceutical wholesalers, distributors, and manufacturers.

Commercial sector is a common term also used to describe the private sector. The commercial sector, however, is a subset of the private health sector and is synonymous with for-profit entities. The term commercial sector is used to distinguish for-profit from not-for-profit entities.

The following definitions highlight other key concepts needed to understand the state and evolution of the private health sector.

KEY PRIVATE HEALTH SECTOR CONCEPTS

For-profit

A for-profit healthcare company can earn a profit, which is defined as revenues in excess of expenses. A for-profit healthcare organization has wide discretion on how to spend profits. This distinguishes it from a not-for-profit corporation, which can only spend profits on the purpose for which it was formed.

Franchise

A franchise is a commercial mechanism for replicating a successful business strategy. Key components generally include a common business format, a branded identity, and a quality assurance system. A franchise is a business arrangement whereby a franchisor develops a system for conducting an activity and provides franchisees with the "know-how" to conduct the activity. A franchise operation offers additional benefits, ranging from a defined and exclusive territory and the use of a common name to a full-fledged operational structure with centralized management services, such as advertising, financial accounting, marketing, and procurement. In the case of healthcare service providers in a clinic franchise system, a network of private practitioners offers a uniform set of services at a predefined cost and standard of care.

Market segmentation*

Market segmentation is the process of dividing diverse populations into smaller subgroups that are similar in characteristics, needs, and likely responses to marketing or service delivery efforts.

Nongovernmental organization (NGO)

An NGO is an organization or institution that is entirely or largely independent of the government. Although an NGO can technically be a for-profit organization, the term is generally used to describe an organization whose primary goal is social and supports a public good.

Not-for-profit

A not-for-profit healthcare provider does not have profit maximization as a goal. Instead, it uses all revenues available after normal operating expenses to accomplish its purpose. Not-for-profits in healthcare are typically NGOs, community- and faith-based organizations, or other charitable organizations.

Private provider networks

Networks are an affiliation of health service providers grouped together under an umbrella structure or parent organization. Networks may be organized according to a variety of arrangements. The details of the arrangements vary widely, but often include oversight by a parent organization and members' commitment to standards, quality, a given service mix, and prices. Private provider networks include professional associations as well as franchises.

Public/private partnership

A public/private partnership is any explicit joint program or project involving public and private collaboration to provide health services and products. Such partnerships can take the form of public sector subsidies to the private sector. In addition, public sector governmental or development agencies can also contract with private service providers or producers and distributors of products and commodities. Typical public/private partnership activities include social marketing; direct provision of healthcare; or any collaborative activities to improve the quality, outreach, and coverage of health services and products.

Social franchise

A social franchise is a type of network that uses some of the principles and practices of a commercial franchise; however, its main goal is to achieve social objectives. Social franchises typically receive funds from government or international donors to subsidize the cost of providing services to a broad population at prices they can afford.

Social marketing

Social marketing is the use of commercial marketing techniques to achieve a social objective. Social marketers combine product, price, place, and promotion to maximize product use by specific population groups. In the health arena, social marketing programs in the developing world traditionally have focused on increasing the availability and use of health products, such as contraceptives or insecticide-treated nets. Different models of social marketing have been used in developing countries with varying levels of donor funding. While some of the models rely heavily on donor support, others include built-in exit strategies that depend on the commercial sector to ensure sustained product supply.

Total market approach (TMA)

A total market approach brings together all parties interested in providing reproductive health/family planning and other health services. TMA emphasizes equity and growth of the whole reproductive health/family planning market by ensuring the delivery of high-quality products and services in a range of prices aimed at specific populations, determined through market segmentation. In addition to stimulating supply, TMA focuses on generating demand among underserved population groups through various social marketing and communication approaches.

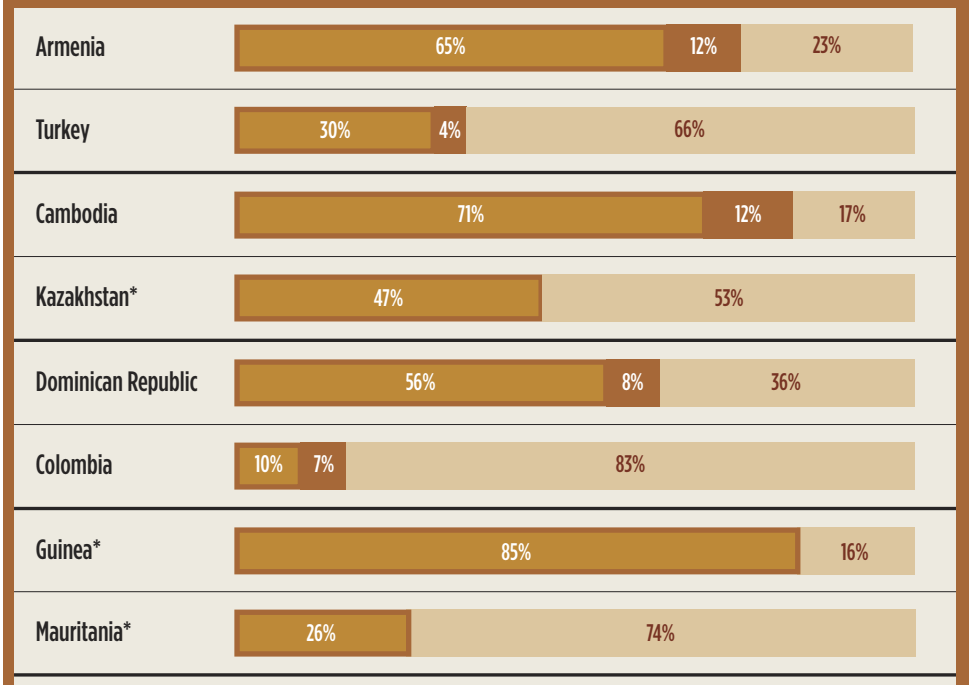
*Definition of market segmentation is adapted from the following publication: Berg, R. May 2000. *Initiating Public/Private Partnerships to Finance Reproductive Health: The Role of Market Segmentation Analysis.* Working Paper Series No. 7. Washington, DC: Futures Group International/POLICY Project; v, 14 p.

In all regions, consumers spend a substantial amount of personal resources in the private health sector.

Many individuals and families in the developing world turn to the private health sector for healthcare products and services. The graph below—presenting country data from West Asia, South Central and Southeast Asia, Caribbean and Latin America, and Sub-Saharan Africa—displays the highest and lowest private spending shares of health expenditures in those regions. As the graph shows, the public/private mix varies widely within each region, but consumers in all regions spend a substantial amount of personal resources in the private health sector.

Across regions, the private share (private and out-of-pocket expenditures combined) ranges from 17 to 47 percent at the low end and from 64 to 85 percent at the high end. In all cases, a large share of private spending is out-of-pocket spending by consumers. Further examination of the data in the *Wall Chart* (not displayed here) reveals that even the poor spend their own resources on private sector health services and products. These data suggest that consumers value the private sector as a source for healthcare services and products.

PUBLIC AND PRIVATE (INCLUDING OUT-OF-POCKET EXPENDITURE) SHARES OF TOTAL HEALTH EXPENDITURES, HIGH AND LOW, BY REGION



Out-of-pocket expenditure.
Other private expenditure.
General government (public) expenditure on health.

Note: The sum of general government (public) and private expenditures on health may exceed 100% because of rounding.

Source: World Health Organization.

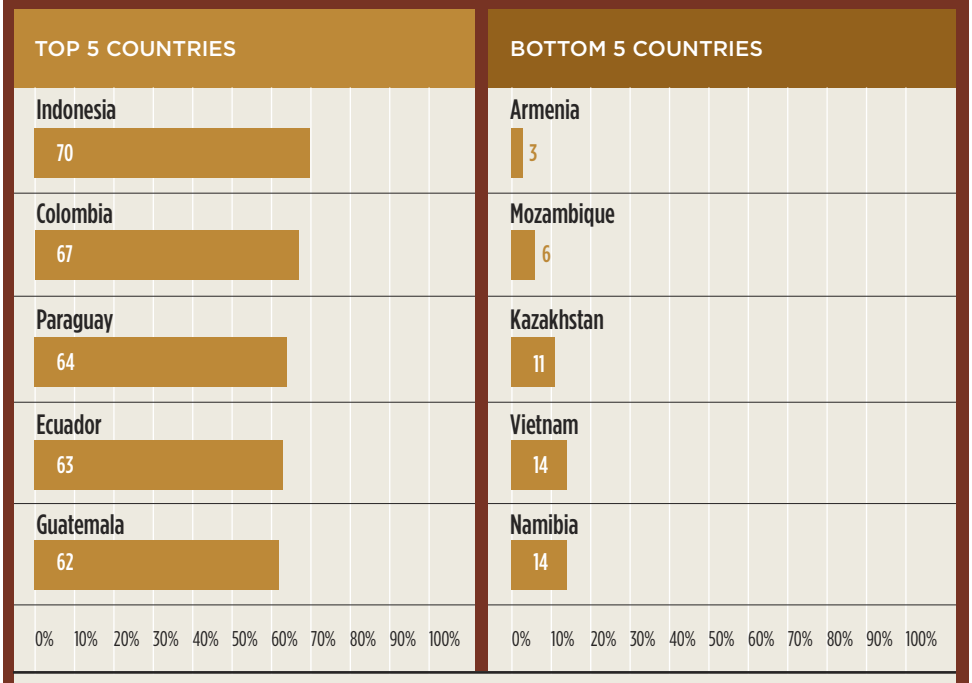
* If no private expenditure information is shown in a bar graph, this indicates that out-of-pocket expenditure accounts for 100% of private expenditure in a given country.

The private health sector is thriving in many parts of the developing world.

According to the *Wall Chart* data, the private sector is increasingly present in every region of the developing world, but is particularly strong in Latin America where NGOs and other commercial entities play a critical role. The graph below presents the top five countries with the highest percentage of married family planning users of reproductive age obtaining family planning services and products in the private health sector. In all of these countries, more than 60 percent of married FP users rely on a private source—clinic, hospital, pharmacy, shop, or NGO—to meet their family planning needs.

In contrast, smaller percentages of married FP users obtain their services and products from the private health sector in countries located in some of the poorest regions of the world. The percentage is as low as 3 to 14 percent in these countries. It is also interesting to note that some of the countries with the lowest percentages, such as Armenia, Kazakhstan, and Vietnam, are emerging countries transitioning from a state-controlled to a more open economy.

PERCENTAGE OF FAMILY PLANNING USERS (MWRA) OBTAINING FP FROM THE PRIVATE SECTOR



MWRA = Married women and women in consensual union of reproductive age (ages 15 to 49).

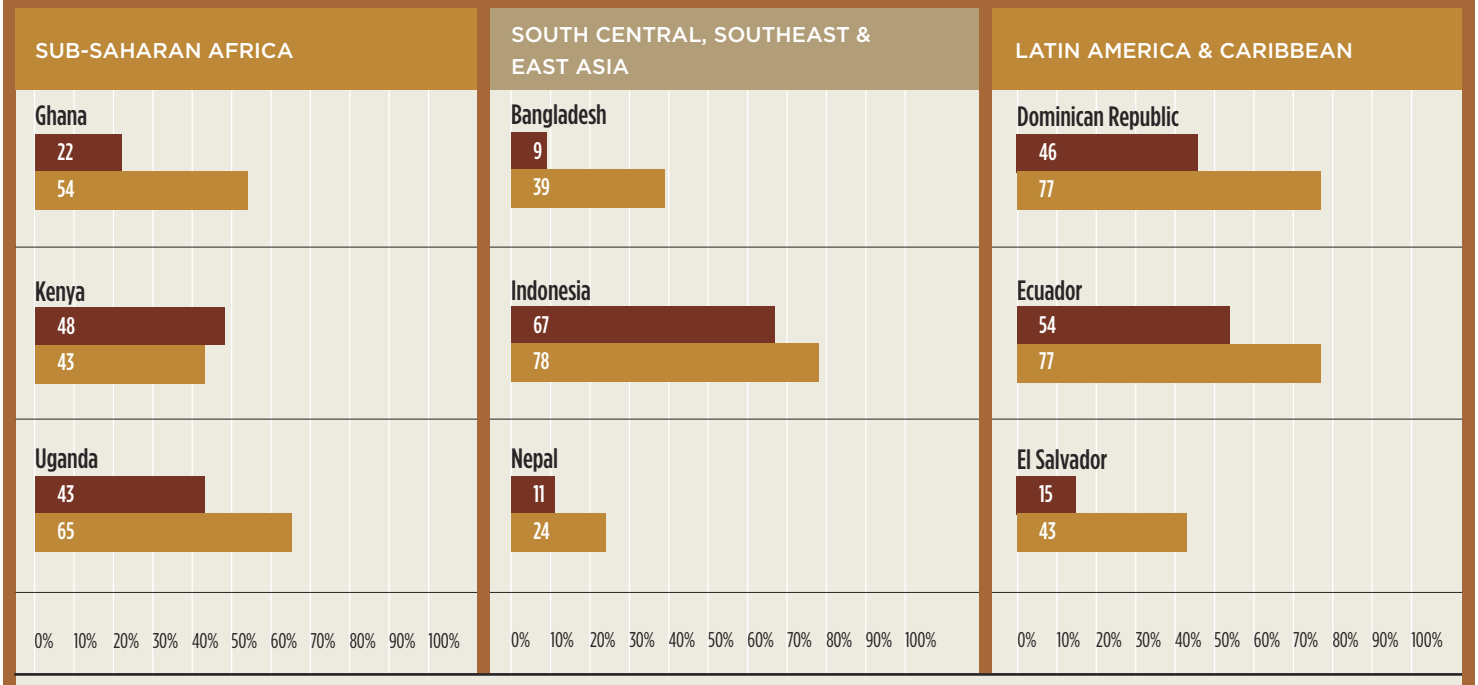
Sources: *Demographic and Health Surveys*, ORC Macro; *International Reproductive Health Surveys*, CDC.

The private health sector has an opportunity to play a larger role in providing long-acting and permanent contraceptive methods.

The graphs below display the percentage of MWRA using long-acting and permanent contraceptive methods (LAPM) versus short-acting contraceptive methods (SAM). LAPM are defined as methods that can prevent pregnancy for at least 1 year and include the intrauterine device (IUD), female and male sterilization, and implants. In contrast, short-acting contraceptive methods provide protection for a shorter period of time. SAM comprise oral contraceptives; injectables; female and male condoms; the diaphragm; and foams, jellies, and other vaginal methods. For the purposes of our analyses, we have excluded non-purchased short-acting methods, such as fertility awareness-based methods.

As shown in the graphs below, SAM users are more often likely to rely on the private sector for their methods than LAPM users. One plausible explanation is that SAM are more accessible (both in terms of proximity to a source and availability of products) in the private sector than they are in the public sector. Furthermore, while some consumers obtain LAPM in the private sector, the low cost of these methods in the public sector may attract women who could otherwise afford to pay the private-sector prices. The high up-front costs of LAPM in the private sector versus lower initial costs for SAM may also deter women from using LAPM. Thus, there may be a significant opportunity to expand the supply of LAPM for consumers who can pay in the private sector.

THE PERCENTAGE OF LONG-ACTING AND SHORT-ACTING CONTRACEPTIVE METHODS USERS (MWRA) OBTAINING THEIR RESPECTIVE METHODS FROM THE PRIVATE SECTOR IN SELECT COUNTRIES



MWRA = Married women and women in consensual union of reproductive age (ages 15 to 49).
LAPM = Long-acting and permanent contraceptive methods.
SAM = Short-acting contraceptive methods.

Total % current LAPM users (MWRA) obtaining LAPM from the private sector.
Total % current SAM users (MWRA) obtaining SAM from the private sector.

Sources: *Demographic and Health Surveys*, ORC Macro; *International Reproductive Health Surveys*, CDC.

Fostering favorable market conditions through a supportive policy environment is central to achieve a greater private sector role in healthcare.

The private health sector, especially commercial entities, responds to market conditions, profit opportunities, and perceived risks of profit and loss. There is a strong relationship between a developing country's policy environment and market conditions conducive to private sector growth. The *Wall Chart* highlights data on the more pressing policy and economic barriers that influence the private health sector, such as the following:

- Perceptions of corruption,
- General financing constraints,
- Obstacles to firm financing,
- Tax and regulatory constraints, and
- Price controls.

Creating a favorable policy environment for the private health sector is critical. Therefore, it is important to identify incentives that will encourage both commercial organizations and NGOs to enter and remain in the reproductive health/family planning market and to facilitate policy changes that minimize the private health sector's risks while generating new prospects for profits.

SOCIODEMOGRAPHIC INDICATORS

	Population mid-2005 (millions)	Urban (%)	Poverty headcount ratio at $1 a day (PPP)	Literacy rate, adult total (%)	Total fertility rate	Adult HIV prevalence (%)	Infant mortality rate (per 1,000 live births)
SUB-SAHARAN AFRICA							
Benin	8.4	40	–	40	5.9	1.9	105
Burkina Faso	13.9	17	45	–	6.2	4.2	81
Côte d'Ivoire	18.2	46	11	48	5.2	7.0	118
Ethiopia	77.4	15	23	42	5.9	4.4	100
Gabon	1.4	81	–	–	4.3	8.1	57
Ghana	22.0	44	45	74	4.4	3.1	64
Guinea	9.5	33	–	–	5.9	3.2	94
Kenya	33.8	36	23	84	4.9	6.7	77
Malawi	12.3	14	42	62	6.5	14.2	100
Mali	13.5	30	–	19	7.1	1.9	133
Mauritania	3.1	40	26	41	5.9	0.6	97
Mozambique	19.4	32	–	46	5.5	12.2	119
Namibia	2.0	33	–	83	4.2	21.3	51
Nigeria	131.5	44	–	67	5.9	5.4	100
Rwanda	8.7	17	52	69	5.7	5.1	107
Tanzania	36.5	32	–	77	5.7	8.8	68
Uganda	26.9	12	85	69	6.9	4.1	88
Zambia	11.2	35	64	80	5.7	16.5	95
Zimbabwe	13.0	34	–	90	3.8	24.6	62
NORTH AFRICA, WEST ASIA & EUROPE							
Albania	3.2	42	2	99	2.0	–	8
Armenia	3.0	65	13	99	1.3	0.1	36
Egypt	74.0	43	3	–	3.2	<0.1	37
Jordan	5.8	79	2	91	3.7	<0.1	22
Morocco	30.7	57	2	51	2.5	0.1	40
Tunisia	10.0	65	2	73	2.1	<0.1	21
Turkey	72.9	65	2	87	2.4	–	38
SOUTH CENTRAL, SOUTHEAST & EAST ASIA							
Bangladesh	144.2	23	36	41	3.0	–	65
Cambodia	13.3	15	34	69	4.5	2.6	95
India	1,103.6	28	35	61	3.0	0.9	60
Indonesia	221.9	42	8	88	2.6	0.1	46
Kazakhstan	15.1	57	2	99	2.0	0.2	61
Nepal	25.4	14	–	44	3.7	0.5	64
Philippines	84.8	48	15	93	3.5	<0.1	29
Vietnam	83.3	26	2	90	2.2	0.4	18
LATIN AMERICA & CARIBBEAN							
Bolivia	8.9	63	14	87	3.8	0.1	54
Brazil	184.2	81	8	86	2.4	0.7	27
Colombia	46.0	75	8	92	2.6	0.7	26
Dominican Republic	8.9	64	2	84	2.9	1.7	31
Ecuador	13.0	61	18	91	3.3	0.3	29
El Salvador	6.9	59	31	80	3.0	0.7	25
Guatemala	12.7	39	16	70	4.4	1.1	39
Haiti	8.3	36	–	52	4.7	5.6	80
Honduras	7.2	47	21	80	4.1	1.8	32
Nicaragua	5.8	59	45	77	3.8	0.2	36
Paraguay	6.2	54	16	92	2.9	0.5	37
Peru	27.9	73	18	85	2.7	0.5	33

ECONOMIC INDICATORS

	GNI per capita, PPP (current international $)	Number of television sets (per 1,000 people)	Number of radios (per 1,000 people)	Total expenditure on health as % of GDP	General government expenditure on health as % of total expenditure on health	Private expenditure as % of total expenditure on health	Out-of-pocket expenditure as % of private expenditure on health	External resources for health as % of total expenditure on health
SUB-SAHARAN AFRICA								
Benin	1,110	12	445	5	44	56	90	66
Burkina Faso	1,180	79	433	4	46	54	99	6
Côte d'Ivoire	1,390	61	185	6	22	78	95	2
Ethiopia	710	6	189	6	45	55	66	30
Gabon	5,700	308	488	4	41	59	100	3
Ghana	2,190	53	727	6	41	59	100	19
Guinea	2,100	47	52	6	16	85	100	10
Kenya	1,020	26	221	5	44	56	80	16
Malawi	600	4	–	10	41	59	43	38
Mali	960	33	180	5	51	49	89	18
Mauritania	2,010	99	–	4	74	26	100	3
Mozambique	1,070	14	–	6	71	29	37	39
Namibia	6,620	269	–	7	70	30	21	5
Nigeria	900	103	–	5	26	74	90	6
Rwanda	1,290	–	–	6	57	43	65	33
Tanzania	610	45	406	5	55	45	83	27
Uganda	1,440	18	–	7	28	72	52	29
Zambia	850	51	179	6	53	47	75	19
Zimbabwe	2,180	56	362	9	52	48	47	3
NORTH AFRICA, WEST ASIA & EUROPE								
Albania	4,700	318	–	6	39	61	100	4
Armenia	3,770	229	–	6	23	77	84	19
Egypt	3,940	229	–	5	37	63	92	2
Jordan	4,290	177	–	9	46	54	74	5
Morocco	3,950	167	–	5	33	67	74	2
Tunisia	6,840	207	158	6	50	50	83	1
Turkey	6,690	423	470	7	66	34	88	0
SOUTH CENTRAL, SOUTHEAST & EAST ASIA								
Bangladesh	1,870	59	–	3	25	75	86	14
Cambodia	2,060	8	–	12	17	83	85	5
India	2,880	83	–	6	21	79	99	1
Indonesia	3,210	153	–	3	36	64	76	2
Kazakhstan	6,170	338	–	4	53	47	100	1
Nepal	1,420	8	–	5	27	73	92	9
Philippines	4,640	182	–	3	39	61	78	3
Vietnam	2,490	197	–	5	29	71	88	2
LATIN AMERICA & CARIBBEAN								
Bolivia	2,450	121	–	7	60	40	81	7
Brazil	7,480	349	–	8	46	54	64	1
Colombia	6,520	303	549	8	83	17	57	0
Dominican Republic	6,210	–	–	6	36	64	88	1
Ecuador	3,440	237	422	5	36	64	88	1
El Salvador	4,890	233	481	8	45	55	94	1
Guatemala	4,060	145	–	5	48	53	86	4
Haiti	1,630	6	18	8	39	61	70	16
Honduras	2,580	119	–	6	51	49	85	8
Nicaragua	2,400	123	–	8	49	51	96	9
Paraguay	4,740	218	–	8	38	62	89	2
Peru	5,090	172	–	4	50	50	79	5

HEALTH INDICATORS

	Modern contraceptive prevalence rate	% current FP users (MWRA) obtaining FP from the private sector	% current FP users (MWRA) obtaining FP from the private sector by socioeconomic status			% richest current FP users (MWRA) obtaining FP from the public sector	% current LAPM FP users (MWRA) obtaining LAPM from the private sector	% current SAM FP users (MWRA) obtaining SAM from the private sector	% non-contracepting MWRA citing the private sector as a source to obtain FP		Unmet need for FP (%)
			Poorer/Poorest	Richer/Middle	Richest				Poorer/Poorest	Overall Total	
SUB-SAHARAN AFRICA											
Benin	7	29	*	25	38	50	*	35	2	5	27
Burkina Faso	9	22	23	16	25	73	*	27	3	4	29
Côte d'Ivoire	7	47	–	–	–	–	*	57	–	47	28
Ethiopia	6	17	*	18	20	78	26	16	*	17	36
Gabon	12	51	52	45	59	34	*	53	33	36	28
Ghana	19	47	39	48	53	45	22	54	9	13	34
Guinea	4	34	*	33	42	52	8	38	2	6	24
Kenya	32	44	33	38	61	39	48	43	18	25	25
Malawi	26	29	24	27	38	61	56	22	22	27	30
Mali	6	31	21	23	41	51	*	38	8	12	29
Mauritania	5	*	*	*	*	*	*	*	–	–	32
Mozambique	12	6	*	*	14	74	*	10	4	5	18
Namibia	43	14	*	*	31	67	33	8	7	13	25
Nigeria	8	48	41	46	51	27	*	60	4	8	17
Rwanda	4	18	*	*	32	58	*	27	*	3	36
Tanzania	20	*	*	*	*	*	45	19	*	17	22
Uganda	19	40	19	37	53	37	43	65	16	22	35
Zambia	23	28	14	19	43	54	55	28	14	17	27
Zimbabwe	50	16	*	13	34	63	27	15	3	11	13
NORTH AFRICA, WEST ASIA & EUROPE											
Albania	8	30	–	–	–	–	*	66	–	–	68
Armenia	22	3	*	*	*	78	*	5	*	1	12
Egypt	57	49	39	46	64	31	43	61	27	38	11
Jordan	41	–	–	–	–	–	–	–	–	–	11
Morocco	55	40	26	40	64	32	14	47	42	57	10
Tunisia	53	–	–	–	–	–	–	–	–	–	–
Turkey	43	–	–	–	–	–	–	–	–	–	–
SOUTH CENTRAL, SOUTHEAST & EAST ASIA											
Bangladesh	47	33	15	33	60	37	9	39	9	20	15
Cambodia	19	39	–	–	–	–	16	45	–	20	33
India	43	23	9	18	46	52	15	76	8	23	16
Indonesia	57	70	62	73	78	21	67	78	33	50	9
Kazakhstan	53	11	10	12	10	84	9	20	10	11	9
Nepal	35	15	7	12	28	66	11	24	19	27	28
Philippines	33	31	18	31	53	43	22	38	17	26	17
Vietnam	64	14	–	–	–	–	5	44	–	11	5
LATIN AMERICA & CARIBBEAN											
Bolivia	35	38	16	38	58	39	29	48	9	17	23
Brazil	70	–	–	–	–	–	–	–	–	–	–
Colombia	64	67	57	71	76	21	56	87	62	73	6
Dominican Republic	66	54	–	–	–	–	46	77	–	53	11
Ecuador	59	63	–	–	–	–	54	77	–	–	8
El Salvador	–	20	–	–	–	–	15	43	–	–	9
Guatemala	34	62	–	–	–	–	57	71	–	44	23
Haiti	22	50	35	49	73	22	42	54	21	28	40
Honduras	51	54	–	–	–	–	57	51	–	–	11
Nicaragua	66	33	18	32	55	42	34	32	11	30	15
Paraguay	61	64	–	–	–	–	41	77	–	–	84
Peru	50	17	5	15	41	56	18	17	3	12	10

Health Indicators are continued on next page

HEALTH INDICATORS (CONTINUED)

	Number of physicians (per 100,000)	Number of midwives and nurses (per 100,000)	Number of total units sold in the OC market (millions)	Total value of pharmaceuti-cal retail market (millions US$)	% women who sought care at private source for child with diarrhea		% women who sought care at private source for child with fever/cough		% women who delivered a child in the past 5 years, citing a private sector health source	
					Poorer/Poorest	Overall Total	Poorer/Poorest	Overall Total	Poorer/Poorest	Overall Total
SUB-SAHARAN AFRICA										
Benin	6	28	–	–	9	11	28	30	7	14
Burkina Faso	4	30	–	–	5	5	25	20	*	1
Côte d'Ivoire	9	46	–	–	–	11	–	13	–	*
Ethiopia	3	21	–	–	13	14	7	11	*	0
Gabon	29	–	–	–	11	18	16	27	8	18
Ghana	9	84	–	–	23	25	39	37	5	11
Guinea	9	47	–	–	*	5	*	5	*	1
Kenya	13	90	–	–	12	15	45	48	13	18
Malawi	1	26	–	–	17	20	36	40	14	18
Mali	4	15	–	–	11	12	20	25	15	18
Mauritania	14	72	–	–	*	*	*	*	*	*
Mozambique	2	28	–	–	*	3	*	3	*	*
Namibia	30	284	–	–	*	*	*	8	3	5
Nigeria	27	119	–	–	25	25	59	63	6	16
Rwanda	2	21	–	–	*	6	6	9	2	3
Tanzania	2	37	–	–	*	*	*	*	*	*
Uganda	5	9	–	–	28	35	59	65	11	19
Zambia	7	113	–	–	8	10	28	26	9	10
Zimbabwe	6	54	–	–	*	*	18	28	17	15
NORTH AFRICA, WEST ASIA & EUROPE										
Albania	139	404	–	–	–	–	–	–	–	–
Armenia	353	524	–	–	*	*	*	*	*	*
Egypt	212	276	7.9	689.3	34	42	40	50	15	30
Jordan	205	275	0.2	97.9	–	–	–	–	–	–
Morocco	48	100	8.6	548.1	*	22	27	44	*	9
Tunisia	70	287	2.0	321.5	–	–	–	–	–	–
Turkey	124	295	6.0	4,289.5	–	–	–	–	–	–
SOUTH CENTRAL, SOUTHEAST & EAST ASIA										
Bangladesh	23	24	–	–	26	34	34	42	*	3
Cambodia	16	85	–	–	–	41	–	65	–	2
India	51	62	16.0	4,587.2	50	57	46	55	5	18
Indonesia	16	49	22.1	1,939.5	41	50	53	61	13	32
Kazakhstan	330	620	–	–	*	*	*	*	*	*
Nepal	5	26	–	–	21	28	25	33	*	3
Philippines	116	621	–	–	9	16	21	30	3	16
Vietnam	53	75	–	–	–	37	–	46	–	4
LATIN AMERICA & CARIBBEAN										
Bolivia	73	107	–	–	7	10	12	20	2	10
Brazil	206	52	81.4	5,035.0	–	–	–	–	–	–
Colombia	135	237	7.4	999.7	11	16	22	30	10	22
Dominican Republic	188	184	0.4	186.6	–	10	–	23	–	25
Ecuador	148	166	1.2	421.7	–	–	–	–	–	–
El Salvador	127	66	–	–	–	–	–	–	–	–
Guatemala	90	405	–	–	–	18	–	22	–	10
Haiti	25	11	–	–	*	6	8	11	3	13
Honduras	83	26	–	–	–	–	–	–	–	–
Nicaragua	164	107	–	–	*	10	11	23	*	8
Paraguay	117	20	–	–	–	–	–	–	–	–
Peru	117	67	0.8	310.4	4	8	7	14	2	8

POLICY INDICATORS

	Corruption Perceptions Index (10 = low corruption; 0 = high corruption)	General financing constraints (% reporting indicator as a "moderate" or "major" obstacle)	Obstacles to firm financing (% reporting indicator as a "moderate" or "major" obstacle)		Tax and regulatory constraints (% reporting indicator as a "moderate" or "major" obstacle)			Price controls (10 = no controls; 0 = wide-spread controls)
			Collateral	Access to credit	Business registration	Customs	High taxes	
SUB-SAHARAN AFRICA								
Benin	3.2	–	–	–	–	–	–	2
Burkina Faso	–	–	–	–	–	–	–	–
Côte d'Ivoire	2.0	72	65	76	26	66	88	6
Ethiopia	2.3	81	70	51	10	56	71	–
Gabon	3.3	–	–	–	–	–	–	2
Ghana	3.6	81	45	50	23	40	64	6
Guinea	–	–	–	–	–	–	–	–
Kenya	2.1	63	49	53	45	54	83	6
Malawi	2.8	63	66	56	9	53	84	6
Mali	3.2	–	–	–	–	–	–	6
Mauritania	–	–	–	–	–	–	–	–
Mozambique	2.8	–	–	–	–	–	–	–
Namibia	4.1	22	37	24	9	19	63	6
Nigeria	1.6	73	41	56	37	74	71	6
Rwanda	–	–	–	–	–	–	–	4
Tanzania	2.8	77	70	66	46	66	91	6
Uganda	2.6	74	67	68	20	48	86	6
Zambia	2.6	75	60	51	22	40	86	4
Zimbabwe	2.3	68	40	33	33	67	93	2
NORTH AFRICA, WEST ASIA & EUROPE								
Albania	2.5	61	46	28	13	46	76	6
Armenia	3.1	85	17	15	22	29	89	–
Egypt	3.2	–	46	47	30	57	58	4
Jordan	5.3	–	–	–	–	–	–	4
Morocco	3.2	12	–	–	–	–	–	4
Tunisia	5.0	78	23	51	10	25	35	6
Turkey	3.2		46	39	19	26	83	6
SOUTH CENTRAL, SOUTHEAST & EAST ASIA								
Bangladesh	1.5	35	50	71	51	74	–	6
Cambodia	–	52	32	–	22	17	68	–
India	2.8	60	51	32	26	50	68	4
Indonesia	2.0	80	54	38	42	35	66	0
Kazakhstan	2.2	–	64	43	40	40	89	–
Nepal	2.8	57	–	–	–	–	–	4
Philippines	2.6	–	56	36	34	49	76	4
Vietnam	2.6		–	–	–	–	–	–
LATIN AMERICA & CARIBBEAN								
Bolivia	2.2	57	85	70	71	77	86	8
Brazil	3.9	55	67	31	62	59	98	5
Colombia	3.8	55	63	41	61	66	93	5
Dominican Republic	2.9	81	61	54	31	50	82	4
Ecuador	2.4	65	68	71	68	65	87	6
El Salvador	4.2	65	79	51	60	53	75	8
Guatemala	2.2	81	75	66	62	72	83	6
Haiti	1.5	71	60	66	30	50	80	2
Honduras	2.3	72	67	43	69	57	81	6
Nicaragua	2.7	–	75	37	52	49	84	6
Paraguay	1.9	74	–	–	–	–	–	6
Peru	3.5		61	44	64	48	89	6

DEFINITIONS

Sociodemographic

Population mid-2005 Estimates based on a recent census, official national data, or UN and U.S. Census Bureau projections. (PRB)

Urban Percentage of the total population living in areas termed "urban" by that country. Typically, the population living in towns of 2,000 or more in national or provincial capitals is classified "urban." (PRB)

Poverty headcount ratio at $1 a day The percentage of the population living on less than $1.08 a day at 1993 international prices. As a result of revisions in purchasing power parity (PPP) exchange rates, poverty rates cannot be compared with poverty rates reported previously for individual countries. Data showing as "2" signifies a poverty rate of 2 percent or less. Estimates are based on nationally representative primary household surveys. (WDI)

Literacy rate, adult total The percentage of adults ages 15 and above who can, with understanding, read and write a short, simple statement on their everyday life. (WDI)

Total fertility rate The average number of children a woman would have, assuming that current age-specific birth rates remain constant throughout her childbearing years (usually considered to be ages 15 to 49). (PRB)

Adult HIV prevalence The percentage of people ages 15 to 49 who are infected with HIV. (UNAIDS)

Infant mortality rate The annual number of deaths of infants under age 1 per 1,000 live births. (PRB)

Economic

GNI per capita, PPP Gross national income (GNI) per capita, based on purchasing power parity (PPP). PPP GNI is GNI converted to international dollars, using PPP rates. An international dollar has the same purchasing power over GNI as a U.S. dollar has in the United States. GNI is the sum of value added by all resident producers, plus any product taxes (less subsidies) not included in the valuation of output, plus net receipts of primary income (compensation of employees and property income) from abroad. Data are in current international dollars. (WDI)

Number of television sets Television sets refer to those in use, per 1,000 people. (WDI)

Number of radios Radios refer to radio receivers in use, for broadcasts to the general public, per 1,000 people. (WDI)

Total expenditure on health as % of GDP The sum of general government expenditure on health and private expenditure on health as a percentage of gross domestic product (GDP), which is the value of all goods and services provided in a country by residents and non-residents without regard to their allocation among domestic and foreign claims. (WHO-1)

General government expenditure on health as % of total expenditure on health The sum of consolidated direct and indirect outlays, including capital, of all levels of government, social security institutions, autonomous bodies, and other extrabudgetary funds as a percentage of the total expenditure on health. (WHO-1)

Private expenditure as % of total expenditure on health The sum of expenditures made by prepaid plans and risk-pooling arrangements; firms' expenditure on health; non-profit institutions serving mainly households; and household out-of-pocket spending as a percentage of the total expenditure on health. (WHO-1)

Out-of-pocket expenditure as % of private expenditure on health The sum of household payments to public services; the commercial sector; non-profit institutions; governmental organizations; and non-reimbursable cost-sharing deductibles, copayments, and fees-for-services as a percentage of the total expenditure on health. Out-of-pocket expenditure excludes payments made by enterprises that deliver medical and paramedical benefits to their employees and payments for overseas treatment. (WHO-1)

External resources for health as % of total expenditure on health The sum of grants and credits (with high grant components) to governments as a percentage of the sum of consolidated direct and indirect outlays (e.g., subsidies to producers, transfers to households), which include capital of all levels of government, social security institutions, autonomous bodies, and other extrabudgetary funds. (WHO-1)

Health†

Modern contraceptive prevalence rate The percentage of married women or women in consensual union of reproductive age who are currently using a modern form of contraception, such as the pill, an IUD, condoms, and sterilization. (PRB)

% current FP users (MWRA) obtaining FP from the private sector The percentage of current family planning (FP) users who are married women or women in consensual union of reproductive age (MWRA) obtaining their method from the private sector. (DHS/IRHS analyses)

% current FP users (MWRA) obtaining FP from the private sector by socioeconomic status The percentage of current family planning users (MWRA) within each socioeconomic category obtaining family planning from the private sector. See NOTES on page 13 for the definition of socioeconomic categories. (DHS/IRHS analyses)

% richest current FP users (MWRA) obtaining FP from the public sector The percentage of current family planning users (MWRA) from the highest socioeconomic quintile obtaining family planning from the public sector. (DHS/IRHS analyses)

% current LAPM FP users (MWRA) obtaining LAPM from the private sector The percentage of current long-acting and permanent contraceptive methods (LAPM) family planning users (MWRA) obtaining the method from the private sector. LAPM include the IUD, female and male sterilization, and implants. (DHS/IRHS analyses)

% current SAM FP users (MWRA) obtaining SAM from the private sector The percentage of current short-acting contraceptive methods (SAM) family planning users (MWRA) obtaining the method from the private sector. SAM comprises oral contraceptives; injectables; female and male condoms; the diaphragm; and foams, jellies, and other vaginal methods. For the purposes of our analyses, we have excluded non-purchased SAM, such as fertility awareness-based methods. (DHS/IRHS analyses)

% non-contracepting MWRA citing the private sector as a source to obtain FP The percentage of MWRA not using contraception who can cite at least one private sector source for family planning. (DHS/IRHS analyses)

Unmet need for FP The percentage of MWRA who do not want to become pregnant or want to postpone the next birth at least 2 years and are not using contraception. (DHS)

Number of physicians The number of registered physicians practicing in a given country, per 100,000 people. (WHO-2)

Number of midwives and nurses The number of registered midwives and nurses practicing in a given country, per 100,000 people. (WHO-2)

Number of total units sold in the OC market The total number of oral contraceptive (OC) units (1 unit per menstrual cycle) sold in 2004. (IMS Health, IMS MIDASTM, 2004.)

Total value of pharmaceutical market The total sales of all pharmaceuticals in 2004, listed in US dollars. (IMS Health, IMS MIDASTM, 2004.)

% women who sought care at private source for child with diarrhea The percentage of women, ages 15 to 49, who sought care at any private sector source for a child who had diarrhea in the past 2 weeks. (DHS analyses)

% women who sought care at private source for child with fever/cough The percentage of women, ages 15 to 49, who sought care at any private sector source for a child who had a fever or cough in the past 2 weeks. (DHS analyses)

% women who delivered a child in the past 5 years, citing a private sector health source The percentage of women, ages 15 to 49, who sought care at any private sector source for childbirth delivery in the past 5 years. (DHS analyses)

Policy

Corruption Perceptions Index A poll of polls, reflecting the perceptions of businesspeople and country analysts, both resident and non-resident. The 2004 Corruption Perceptions Index draws on 18 surveys provided to Transparency International between 2002 and 2004, conducted by 12 independent institutions, and ranked on a scale from 0 to 10. Countries were given a score of 10 if there was little corruption. Conversely, a score of 0 indicated widespread corruption. (TI)

General financing constraints A judgment by businesspeople, rated on a four-point scale, as to how problematic financing was for the operation and growth of their business. Percentages reflect businesspeople's rating of financing as a "moderate" or "major" obstacle. (WB)

Obstacles to firm financing A judgment by businesspeople, on a four-point scale, as to how problematic such financing issues as collateral and access to credit were for the operation and growth of their business. Percentages reflect businesspeople's separate ratings of collateral and access to credit, respectively, as a "moderate" or "major" obstacle. (WB)

Tax and regulatory constraints A judgment by businesspeople, on a four-point scale, as to how problematic such regulatory areas as business registration, customs, and high taxes were for the operation and growth of their business. Percentages reflect businesspeople's separate ratings of business registration, customs, and high taxes, respectively, as a "moderate" or "major" obstacle. (WB)

Price controls Ranked on a scale from 0 to 10. The more widespread the use of price controls, the lower the score. Countries were given a score of 10 if no price controls or marketing boards were present. A score of 0 was given when there was widespread use of price controls throughout various sectors of the economy. (The Cato Institute)

† For the purposes of all DHS analyses involving MWRA, "reproductive age" is defined as ages 15 to 49, except for analyses from Albania, Honduras, and Paraguay, which only include MWRA ages 15 to 44.

NOTES

Countries were chosen for the *State of the Private Health Sector Wall Chart* based on the following criteria: (1) The country has conducted a *Demographic and Health Survey* (DHS) since 1999 and either has publicly released the data or has granted PSP-*One* permission to use its data; (2) the country has conducted a CDC *International Reproductive Health Survey* (IRHS) since 1999, and the data were sufficient for the desired analyses; or (3) the country has been graduated by USAID. Surveys within these parameters but for which only raw data were available were omitted.

The sum of general government (public) and private expenditures on health may exceed 100 percent because of rounding.

Health indicators marked "0" may range from 0 to 0.49 because of rounding.

The two bottom DHS socioeconomic quintiles (lowest and second) have been combined due to small sample size and labeled poorer/poorest. Likewise the DHS quintiles middle and fourth have been combined and labeled richer/middle.

Indicator definitions are taken directly from the data source when applicable.

* Data have been suppressed because they are based on fewer than 25 respondents.

— Indicates that data are not available.

All data in this chart are from the most recently available sources, as of July 2005.

Created July 2005

ACKNOWLEDGMENTS

Sara Zellner, Barbara O'Hanlon, and Taara Chandani developed the PSP-*One State of the Private Sector Wall Chart*.

The authors are most grateful to the staff of PSP-*One* and Marguerite Farrell, Shyami de Silva, and Jeff Spieler of USAID for their helpful feedback in the development of concepts included in this chart. A special thanks is also extended to staffs at the Population Reference Bureau, the Division of Reproductive Health of the U.S. Centers for Disease Control and Prevention (CDC), IMS Health, the United Nations Population Fund (UNFPA), the World Bank, and ORC Macro for their data assistance and insight. The project was funded by the U.S. Agency for International Development (Contract No. GPO-I-00-04-00007-00 Task Order 1).

SOURCES

Data were obtained from the Population Reference Bureau's *2005 World Population Data Sheet* (PRB); the World Bank's *2005 World Development Indicators* (WDI) and 2003 publication *Investment Climate Around the World: Voices of the Firms from the World Business Environment Survey* (WB); the UNAIDS' *2004 Report on the Global AIDS Epidemic* (UNAIDS); the World Health Organization's *World Health Report 2005—Make Every Mother and Child Count* (WHO-1) and WHO online database of Human Resources for Health (WHO-2); IMS Health's 2004 data (IMS Health); Transparency International's *2004 Corruption Perceptions Index* (TI); and the Cato Institute's 2004 annual report, *Economic Freedom of the World* (The Cato Institute); and through analyses of ORC Macro's *Demographic and Health Surveys* (DHS) and CDC's *International Reproductive Health Surveys* (IRHS). Questions concerning data sources may be directed to info@psp-one.com.

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Private Sector Partnerships-*One* (PSP-*One*) is a USAID-funded project that provides technical leadership to encourage greater private sector delivery of high-quality and affordable health products and services in the developing world.

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PSP-*One* is funded by the U.S. Agency for International Development and led by Abt Associates, Inc. in collaboration with
Data Management Services, Inc.
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Global Microenterprise Initiatives, LLC
IntraHealth International
O'Hanlon Health Consulting, LLC
Population Services International
The London School of Hygiene and Tropical Medicine
Tulane University of Public Health and Tropical Medicine