Live_Q&A_2

From 11/17/06 09:47 AM To 11/17/06 12:14 PM Pacific
From 11/17/06 11:47 AM To 11/17/06 02:14 PM C Amer
From 11/17/06 12:47 PM To 11/17/06 03:14 PM Eastern
From 11/17/06 12:47 PM To 11/17/06 03:14 PM SA Pac
From 11/17/06 05:47 PM To 11/17/06 08:14 PM W Africa

---Begin Transcript---

/Pascal Kaplan has joined./

/Neha Suchak has joined./

/Ruth Berg is the facilitator./

(1) *Jeffrey Barnes*: Hi Ruth!

(2) *Ruth Berg*: Welcome Jeff!

(3) *Francoise Armand*: Hi all!

(4) *Angela Albright*: Hello

(5) *Ruth Berg*: Welcome Angela and Eric!

(6) *Eric Derks*: Hi Ruth and all.

(7) *Ruth Berg*: Glad you could join us Monte!

(8) *Barbara O'Hanlon*: Looks like we have a good number for today's session.

(9) *Ruth Berg*: Barbara and Meaghan - good to have you here.

(10) *Meaghan Smith*: Hi Ruth and everyone,

(11) *Ruth Berg*: OK - Let's get started

(12) *Ruth Berg*: Welcome to today's live chat! It's remarkable that this online technology has allowed us to meet so many new colleagues with rich ideas and experiences to share in the area of private sector health care in the developing world!

(13) *Ruth Berg*: I'm Ruth Berg, Director of the Private Sector Partnerships One Project. I'll serve as your facilitator today.

(14) *Ruth Berg*: We're going to start as an "open chat" - which means that anyone can post a comment or a question of anyone else and anyone can respond.

(15) *Ruth Berg*: Though we can discuss any topic you'd like today, we will start this session with an invitation for you to provide specific examples of private for profit providers who serve the poor.

(16) *Ruth Berg*: How did they do it? Why did they do it? What were the limitations, problems, or challenges you observed?

(17) *Alene Gelbard*: Hello everyone

(18) *Ruth Berg*: Hello Alene, Beatriz, Yinka and Duc - Welcome!

(19) *Francoise Armand*: My example is from Azerbaijan where PSP-One recently conducted a private sector assessment. We had the opportunity to meet with Dr. Malik Kerimov, who opened the first-ever private sector clinic in 1197, in Qusar, a rural, fairly low-income area two hours away from the capital city (Baku). This clinic is for-profit and actually profitable but serves everybody, including the poor. It manages to remain profitable by using a cross-subsidy scheme: Clients who can afford it (the majority) pay full price for services while indigent clients pay nothing.

(20) *Francoise Armand*: I meant 1997! Sorry

(21) *Ruth Berg*: Welcome Niranjan!

(22) *Monte Achenbach*: And this is left to an honor system? Meaning, client pays whatever he or she can, and doctor trusts that it's the truth, right?

(23) *Susan Mitchell*: Everyone always says private practitioners, in particular doctors don't go to rural areas because its not profitable, can you talk about why he chose this location, rather than an urban setting?

(24) *Meaghan Smith*: From what I have seen, many small-scale private health providers, such as midwives, in many parts of the world serve the people in their communities. These types of providers are often located in poor and even rural areas. They typically price their services so that they are affordable and will often extend services on credit to those that can't pay at the time of service. While this approach can improve access- it can also cause cashflow problems for providers. Many of them struggle to collect funds and often have to write-off outstanding accounts.

(25) *Ruth Berg*: Hello Denise - glad you could join!

(26) *Yinka Ayankogbe*: Hello Ruth. How did you know I have joined. Had some technical problems as I logged in. Did not understand what I should do at first. Yes this is s fantastic and rich experience! I have a contribution to make.

(27) *Duc Ha*: Hi all

(28) *Jeffrey Barnes*: I think informal cross subsidization is quite common, Francoise. Private providers often give credit to poorer clients which turns into free health care. Obviously, these providers don't advertise such practices, but they happen everyday. Private providers think of themselves as health care professionals first and businesspeople second.

(29) *Francoise Armand*: There is an official price list. If patients say they cannot pay, they get the service for free. Apparently, no one is abusing this.I think the lesson here is that cross-subsidy schemes can work, as long as the clinic also has a sizable proportion of paying clients. Also, the clinic clearly needs to have a sense of social mission, since they are in no way obligated to do this.

(30) *Ruth Berg*: Yinka, I would like to thank your for your extensive participation in the conference - I'm glad you've joined. The technology lets us know when people are on.

(31) *Ruth Berg*: Hello Shana - glad you could join us!

(32) *Susan Mitchell*: Alene, I know you work with companies and many are located in poor and sometimes rural communities...what role do they play?

(33) *Jeffrey Barnes*: Meaghan, I completely agree with your comment. It is why I call them reluctant entrepreneurs.

(34) *Duc Ha*: I do not know how the private sector can support the poor. In Vietnam, majority of private facilities concentrate in the urban areas where people have higher ability to pay

(35) *Denise Averbug*: I agree with Jeff's comments that most private providers think of themselves as healthcare providers first, then business people (if at all). I met a few providers in Honduras who went out of thier way to reach the neediest people and bring them in to their practices.

(36) *Alene Gelbard*: I've gathered information from several multinational companies that are partnering with local governments and NGOs to deliver women's health services. Some build hopitals and clinics and others support local government services to increase the sustainabililty of these services.

(37) *Francoise Armand*: Are there good public health facilities in rural areas in Vietnam? Could that be why?

(38) *Yinka Ayankogbe*: I once opened a private clinic in Ijebu-Ode about 28 years ago and atarted to servge the poor in surrounding villages from my city centre. I was young inexperienced and naive at that time I think. But I saw a lot of potentials in the arrangement. After I year, I had to fold up. and headed back to Lagos whwre I joined bigger for profit organisations. My entering into academia has helped a lot where we now run Primary Health Care Services to the poor in our model Primary Health Care Teaching facility in Pakoto, near Lagos

(39) *Monte Achenbach*: This is the case in Pakistan, as well. Rural areas are served more by government clinics or nurses or entrepreneurial Lady Health Visitors, who are trained by the government but often run private practices.

(40) *Jeffrey Barnes*: I think we also need to consider traditional providers who are particularly important in Africa. They are accessible and affordable to rural, poor groups. The challenge has been how to improve their quality and their outcomes. Perhaps donors and governments need to experiment with ways to license traditional providers to ensure quality.

(41) *Ruth Berg*: Thanks Yinka! It's great to hear from someone who has actually tried this. What were the lessons learned from your experience?

(42) *Susan Mitchell*: And we shouldn't forget all the pharmacies that serve both rich and poor, they are often the first line of treatment and tend to be located in all areas in some form or other.

(43) *Meaghan Smith*: Another strategy that I have seen providers use in lower income communities is prepaid plans. Providers ask their clients to pay for care in advance at a time when their clients have money, such as after a harvest. I have seen prepaid plans work in different ways but often the provider will give clients a discount on services, deducting from the prepaid amount. Pre paid plans have two positive benefits. They act as a kind of health savings account for clients and ensure that clients have put money aside to pay for health care when they need it so they don't have to resort to selling off assets in order to visit their provider. Prepaid plans also help providers manage their cashflow.

(44) *Susan Mitchell*: Most of us working in development and health are looking for ways to serve rural and low income communities by either encouraging government to shift focus from urban to rural or to partner with the private sector (for profit & NGO) but it hasn't been very easy.

(45) *Monte Achenbach*: Greenstar has been working on tailoring part of its franchise for traditional providers (homeopaths) and lady health visitors

(46) *Yinka Ayankogbe*: First, dont go to the vrural area alone without extensive organiusation back-up. Two thiunk like a bussinessman so you do not run at a loss. third use lower cadre health personell and train them by yourslf.Fourth, havre other income generating activities to suatain you and your family!!

(47) *Francoise Armand*: Monte, what is a Lady Health visitor and who pays their salaries?

(48) *Ruth Berg*: Yinka, how did you get the money to start up the practice? Did you see it as a risk at the time?

(49) *Monte Achenbach*: Lady Health Visitors receive two years of training in basic health from the government of Pakistan at one of their training facilities

(50) *Monte Achenbach*: They then go on to work either in government clinics, or can open up their own practices, mobile or fixed site

(51) *Monte Achenbach*: So they either receive a salary from the gov or charge their own fees, depending on what they choose to do

(52) *Angela Albright*: Does anyone have experience with providing mental health services in developing nations?

(53) *Ruth Berg*: Good question Angela - anyone have an answer?

(54) *Jeffrey Barnes*: I agree with Yinka's recommendations. I think part of the problem is that there is an underlying assumption that rural areas must use the same business models (e.g. stand-alone clinic with a set number of services) and there simply is not enough client flow to support such a delivery system. we should look at ways to encourage more doctor/farmers in rural areas or other health care providers who have one rural-based job and work part time as a health care provider.

(55) *Ruth Berg*: Angela, tell us more. Are you going to do this?

(56) *Yinka Ayankogbe*: In Nigeria, mits the missioneries who are really serving the poor. We can learn a lot from them. They are definitely a fantasic example of contractring health care to NGO's to

help the poor. However, their focus on religion limits full ngvernment support. However, in many states government pay salaries while the missionaries pay for everything else using user fees and grants from parent bodies abroad

(57) *Susan Mitchell*: It is very enlightened of the Gov. of Pakistan to let non-medical staff provide health services, what services can the lady health worker provider and how is the quality? Can they survive in private practice?

(58) *Ruth Berg*: Welcome Sara!

(59) *Alene Gelbard*: Yinka,
What kinds of services do the missionaries provide?

(60) *Angela Albright*: I am new to international work, have just begun to work with a School of Nursing in Africa and , having a mental healt background myself, noticed that this is a very minimally addressed area. The problems are large.

(61) *Sara Sulzbach*: Hi all

(62) *Denise Averbug*: Hello Angela, I can give you some contacts of people doing mental health work in developing countries.

(63) *Angela Albright*: Thank you, Denise.

(64) *Francoise Armand*: Angela, how do you think this should be addressed? Introduce low-cost drugs? Train more mental health doctors?

(65) *Ruth Berg*: Angela, I agree. When I was in Zambia this was identified by private providers as a huge need. Rich Feeley will be on at 2:00 and may be able to help answer this.

(66) *Jeffrey Barnes*: Perhaps we need a millenium development goal for mental health.

(67) *Angela Albright*: Francoise, quite frankly, it is hard to know where to begin. One goal would be to educate more nurses who seem to be the primary providers.

(68) *Ruth Berg*: Welcome Doug!

(69) *Yinka Ayankogbe*: Full clinic, medical surgical paediatric and O& G services via doctors operating as general practitioners and family Physicians in full fledge hospitals. In fact many of the hospitals are providing post-gradiuate traininig and experience for in-country doctors in collaboration with the post-graduate Colleges in Family Medicine and rural health .I was a beneficiary of that training.Hence my passion for rural health!!

(70) *Ruth Berg*: Welcome back Monte!

(71) *Yinka Ayankogbe*: we have been told that there is a problem with low cost ngeneric drugs in terms of quality and bioavalability. I just wonder how we are going to cope with millions of poor patients

(72) *Susan Mitchell*: Angela, don't forget the private providers (nurses or others) and don't just work with the public sector! Too often that happens and its not necessarily where people go, particularly if they want confidential services. We can certainly work with you to help give you ideas for how to best reach private providers

(73) *Jeffrey Barnes*: Perhaps an incentive scheme could be developed to encourage medical graduates to set up practices in rural areas. This would help rural health and reduce the brain drain which is a serious problem in countries like Nigeria, Malawi, Zambia, etc.

(74) *Alene Gelbard*: Yinka, wonderful range of services. Are there any restrictions on the services missionary groups will support? I'm thinking of women's reproductive health services in particular.

(75) *Francoise Armand*: You are right, Yinka. It is a problem. Some governments are trying to address this (Nigeria). About mental health drugs: There seems to be a big problem around (potentially addictive) antianxiety drugs being widely available without prescription in dev. countries. i.e. Cambodia. Not sure about Africa. I find that pretty scary.

(76) *Monte Achenbach*: Hi there....sorry, got cut off. In response to Susan's question about lady health visitors, they are distinct from lady health workers (I know...it's confusing). LHVs can charge fees and run their own practices. LHWs get less training and then become government employees, mostly serving rural areas. The goal is 1 LHW per 1,000 people

(77) *Angela Albright*: Anti-anxiety drugs are the least needed, from what I saw.

(78) *Sara Sulzbach*: In response to Jeff's last posting, creating a network of private providers could be one approach to encouraging new graduates to locate in rural areas. Such a network could incorporate a policy whereby after a certain period of time, doctors could then rotate into urban areas, to be replaced by newer graduates at the rural location.

(79) *Francoise Armand*: Interesting, Angela. So what do you think is needed?

(80) *Monte Achenbach*: LHVs do well in private practice, offering basic maternal and child health services and family planning, mostly.

(81) *Angela Albright*: Anti-psychotics, for example

(82) *Barbara O'Hanlon*: Monte, We too found that many midwives in the private sector survive financially and are able to serve their population groups who are traditionally poor. I have a paper on this topic.

(83) *Monte Achenbach*: Yes, and networking can help improve their skills and quality

(84) *Jeffrey Barnes*: Anyone have any ideas on my question about traditional providers? I understand traditional birth attendants have received a lot of training, but it hasn't improved outcomes in terms of reducing maternal morbidity and mortality.

(85) *Monte Achenbach*: I'm not sure how much it can influence their location, but it can certainly help forge links to rural areas where there may be a need for referrals

(86) *Jeffrey Barnes*: It would be interesting do develop a network which put as much effort into recruiting new providers as leveraging existing ones.

(87) *Monte Achenbach*: We faced the question of TBAs a lot in Pakistan, and our feeling was that interventions tended to focus on teaching skills and not on incentives to improve

(88) *Meaghan Smith*: Does anyone have experience, using technology to connect providers in rural areas, provide back-up support, ect.?

(89) *Monte Achenbach*: It's too early to say, but we were working on networking with TBA, as well, to see whether franchising techniques could strengthen quality in the absence of trained midwives

(90) *Francoise Armand*: S

(91) *Angela Albright*: I agree Jeffrey. And what is important is to address the level of education of the providers. TBA's just will not be able to more than what they do.

(92) *Francoise Armand*: Since rural populations are so dispersed, isn't the right approach then to have "mobile" providers? A la LHVs?

(93) *Angela Albright*: From what I have learned, the problem with rural deliveries is that they need to be referred sooner when things are not going well, and that transportation to higher level care needs to be more immediately available.

(94) *Jeffrey Barnes*: Meaghan, I know PSI tried to develop an internet based CME program for providers in its New Start network. I think it was an incomplete experiment, however. They underestimated how much work would be needed to provide content and how much training providers needed to access the web.

(95) *Alene Gelbard*: I recall an NGO working in rural Bolivia years ago that did just what Angela is suggesting, for pregnant women. They had a team in the village ready to help in any emergency including getting the woman to the nearest clinic or hospital when she needed care that went beyond the capabilities or resources of the village workers. Someone was in charge of the vehicle, making sure it was ready at all times, etc.

(96) *Susan Mitchell*: So what I'm hearing is lets work with those providers that are able to survive (and offer affordable services) in rural areas and provide them with the training , support and a referral structure to provide quality care? This gets back to Meaghan's point about whether technology can help us do that.

(97) *Angela Albright*: And, of course, the issues of proper pre-natal care, nutrition, etc. will have to be addressed if the mortality rates are to truly drop.

(98) *Jeffrey Barnes*: Angela, thanks for your response. In Nigeria, the COMPASS project is working with TBA almost exclusively to encourage refererrals for high risk pregnancies. It seems to me, however, part of the problem is cultural. The practice of referrals and the health pyramid is very much a western concept. As one of the TBA's I talked to admitted to me, even though she knows that she is supposed to refer when she encounters a breech presentation, for example, in her traditional practice she was trained to use incantation for breech births.

(99) *Barbara O'Hanlon*: Yes susan. But there is a role for the public sector to support them not only with training but also possibly contracting their services to serve this population group that the moh is ot reaching.

(100) *Susan Mitchell*: Barbara, I agree, the public sector defintely needs to be part of the system.

(101) *Yinka Ayankogbe*: Alene, I got caght of. To answer your question, missionary hospuitals provide women reproductiove health services. This icludes family planning, prenatal care, care of STI's and HIV. In factb they are the only ones that give extensive care and support to AIDS patient. The only thing is they frown at and do not support termination of pregnancies

(102) *Ruth Berg*: Welcome Rich - Alene had a question that we thought you might help answer regarding mental health services in developing countries (post 52). Can you help answer this?

(103) *Ruth Berg*: Sorry Rich, I meant Angela! (Not Alene)

(104) *Christine Prefontaine*: Meaghan, I just started working with an ICT (information and communications technology) project -- telecentre.org -- that supports people who run community technology centres. One of the things we are doing is to develop services and curricula, (based on their needs) which can then be offered to the community. I will look into this technology question for you. I am guessing that there is something out there already that can be improved or tailored.

(105) *Francoise Armand*: Transportation is a huge issue in rural areas. I accompanied a rural doctor to a remote village in Bolivia. He was asked to examine a sick woman who just had a baby. He said she had to go to the hospital urgently and offered her a ride. The entire family (over 10 people) piled up in his pickup truck! It was so hard to access the hospital the were afraid they would never be able to visit.

(106) *Sara Sulzbach*: I know of one example of a private health network that is encouraging young doctors to work in rural areas. The network is called Clinic Africa, and currently operates 5 full service clinics, but has plans to expand both within Uganda and into other countries. The network identifies recent graduates who are from underserved areas, and offers them work in one of the new clinics. The incentives include being close to their families, while also being able to earn a decent salary.

(107) *Yinka Ayankogbe*: Thats the point Christine. We can use technology to jump start Africa's health developmemt.I can participate in this discussion because of technology. If we can get this into the rural areas, like has been done in some other developing societies,(especially with agriculrural commodity trading at the US stock exchange) we can provide a lot of services(including transportation services) to rural commiuities

(108) *Alene Gelbard*: Meaghan, I can also give you a couple of vague leads. I know a doctor (US) now in Singapore, who was working on creating a computer network for doctors in Bali, Indonesia to access the latest medical updates via computers. And there is an effot in India to link clinics via computers so as people move around they can still access their medical records and clinics can exchange updates on medical issues. Don't know how far this has progressed, but I understand that Nicholas Negroponte who is at or affiliated with MIT and is running a project to provide $100 computers in the developing world is involved.

(109) *Rich Feeley*: In responses to Angela,Outside of high end psychiatric services in capital cities, there is not much mental health care in the prviate sector (unless you count traditional healers). Typically, the public sector may have an inpatient psychiatric facility, maybe a psych service in the national teaching hospital. Some interesting stuff has been done recently with group

therapy for depression among HIV positives. The work has been reported for Uganda. Botswana tried doing some pscyhiatric training for primary care workers, but I'm not sure if that was continued. You will find some NGO's that may be doing basic psychaitric work with specific target populations (refugees, orphans).

Of course, the data suggest that a lot of somatic complaints that present in public and private care are linked to substance abuse or depression, but that is another story.

(110) *Alene Gelbard*: Regarding efforts to get medical personnel to serve in rural areas such as Clinic Africa - do you know who pays for this?

(111) *Angela Albright*: Rich, of course, somatic complaints are socially acceptable symptoms and it takes a motivated primary care provider to understand the underlying emotional issues. In fact, primary care providers are often able to successfully intervene, if only they would.

(112) *Francoise Armand*: Does anyone know about any efforts anywhere to "map" private providers in a specific country (maybe with GPS technology?)

(113) *Jeffrey Barnes*: I wonder if some of the investment which has been made in care and support for people living with AIDS and their families cannot be leveraged to provide greater access to mental health counselling.

(114) *Yinka Ayankogbe*: Sara, can nyou give me more information on Clinc Africa. I will like to tap into theire ideas and experiences. I am alrady thjinking of that as an intervention research in our ppractice bsed research network.

(115) *Rich Feeley*: Jeff
That is clearly where the interest (and funding) for the group therpay intervention is coming from

(116) *Ruth Berg*: Hi Francoise, we are mapping private providers with the Pop Council in Pakistan.

(117) *Barbara O'Hanlon*: Mapping of private providers - what an interesting idea since one of the MOH primary issues with the private sector is they do not who they are, where they are and what they do!

(118) *Susan Mitchell*: My question is if Clinic Africa is highly subsidized is that the way we want to go? Wouldn't we be better off working with the privaters, even if not doctors, who are already there?

(119) *Yinka Ayankogbe*: No francoise. but we are doing manuall mapping of practitioners in Lagos state, Nigeria. That would be an intersting tsechnmolgy based intervention. for us.

(120) *Monte Achenbach*: Francoise, Greenstar was just getting started using GPS to map providers, but it's a new iniative. I'll find out how it's progressing.

(121) *Ruth Berg*: Yinka, how are you going to use the mapping information in Lagos?

(122) *Monte Achenbach*: We had set up a database with demographic

data, as well, so we could have visual data on whether Greenstar clinics were serving low-income areas

(123) *Ruth Berg*: Welcome Taara!

(124) *Jeffrey Barnes*: Yinka, I would be very interested in learning more about your mapping exercise of provider in Lagos. PSP-One will be working with private providers on managed care training and increased their access to credit and we could use this information to help our strategy for recruiting doctors into the training program.

(125) *Ruth Berg*: Welcome Maggie!

(126) *Meaghan Smith*: In response to Francoise's question about mapping, the Banking on Health Project often tries to get a sense of the size of the private health sector. We work with local financial institutions to stimulate lending to the health sector. Being able to give financial institutions information about the size of the market, where its located, etc. is important. We do a lot of market research to get this information. But it is imperfect. In many countries, providers are not registered or there is not a good central "database" of private providers. If anyone has thoughts on estimating market size and mapping private providers in a low cost way, I would be interested.

(127) *Francoise Armand*: PSI has a low-cost GIS-based approach. They use lot quality assurance sampling to go around the costliest aspect of this technology (mapping)

(128) *Yinka Ayankogbe*: Ruth, to build networks of private doctors working together, being in contact with each othert electronically either in research or in interventions. I believe the key to private participation is working as a block of practitioners.There is a lot we are already doing. The gps do not have the organisational strenth yet to intervene deeply and effectively. So government support is weak. We in academia are supplying evidence based ideas.

(129) *Susan Mitchell*: One issue with private sector is ensuring that the drugs people buy are quality drugs...has anyone had experience with this?

(130) *Rich Feeley*: Oneof the problems in mapping private providers is that, even if the registration and licensing system works (and people apply for re-registration) it is rarely computerized in a useful way. I know the Medical Council in Zambia was seeking support to computerize its files. It''s not rocket sciene. A good take for a computer literate volunteer who would be willing to work for 6-10 months.

(131) *Ruth Berg*: Yinka, do the GPs have an association? if yes, is it effective?

(132) *Ruth Berg*: Welcome Moises! I was hoping to "see" you here.

(133) *Jeffrey Barnes*: Yinka, I think what you say is right. We recommend strengthening professional association to promote more provider to provider dialogue. We are testing a self-directed quality improvement tool in Uganda with midwives and one of the things we expect to see is more discussion between the midwives on how to adopt the quality practices.

(134) *Francoise Armand*: Unfortunately I have to leave. I have really enjoyed this discussion. Thanks everybody! Monte, I'll be following up on the LHV story...

(135) *Moises Rosas*: Tkanks Ruth, congratulations for this excellent effort!!

(136) *Ruth Berg*: Welcome back Yinka!

(137) *Monte Achenbach*: OK, take care Francoise.

(138) *Ruth Berg*: Taara, could you please tell us more about Clinic Africa? Does it look like a model to help increase access to rural services?

(139) *Ruth Berg*: Welcome Karen!

(140) *Karen Eggleston*: Hello, nice to join you.

(141) *Sara Sulzbach*: Sorry for my delayed response...with regards to Clinic Africa, anyone who would like more information can send me an email. They are working on a web site, but I don't think its public yet. As for who pays, approximately $10,000 goes into clinic start-up (including construction). This is provided by a UK non-profit. However, their experience to date indicates that most clinics are self-sustaining in three months. So the non-profit is providing seed funding and some ongoing TA, but for the most part the clinics are recovering costs fairly quickly. Not all their clinics are rural - they are targeting both rura/underserved areas and urban slums.

(142) *Ruth Berg*: Moises, do you have any expamples from Peru of the private sector actively serving the poor?

(143) *Meaghan Smith*: Hi Rich,

We worked with the Medical Council in Zambia to develop an excel file for all their registered private providers. This was just finished in October.

(144) *Sara Sulzbach*: I also have to leave now. I've enjoyed the discussion.

(145) *Taara Chandani*: For now, it seems CA is actually focusing in peri-urban areas of Uganda - because of the high cost distribution and little consumer ability to pay in rural areas. The model itself gives doctors (who may already live in rural areas) a great start for a new business. Since the model is based on cross-subsidies, once CA has sufficient clinics running they could give take more risks to start clinics in rural areas.

(146) *Niranjan Konduri*: Susan, The Rational Pharmaceutical Management Plus (RPM Plus) project of Management Sciences for Health (MSH) has an ongoing project with the Tanzanian Foods and Drugs Authority (TFDA) to strengthen their technical capacity to monitor drug quality

(147) *Yinka Ayankogbe*: Thanks Ruth. you are monitoring me. I was responding to Jeffery question when I was caught off. Like I was saying before I was rudely interrupted(by technology), there are 4000, ,private health facilities in Lagos State.There are aboput 2000 doctor run private clinics/hospitals. We chose a ssample of 400 practices. We are mapping out the diseases that present in these practices using the ICPC classification. We are also recording practitioner profiles for the400

practices . We are doing 100 practices at a time, in four phases. If we get m,ore fuinds we can do the practitioner profiles of all of doctor run practices in Lagos State. we are being funded by the Cenrral resaerch committee of the University of Lagos and our team consits of 54 professors of Medicine. I am The Lead Investigator

(148) *Yinka Ayankogbe*: 4 professors not 54

(149) *Susan Mitchell*:
Niranjan...how is it going...do they involve the private sector? In what ways?

(150) *Jeffrey Barnes*: Niranjan, I'm curious to know what approaches have been used. In Nigeria this has been a huge problem. Their drug quality agency NAFDAC has made considerable progress, but so far their approach has focused on approving manufacturing facilities and they don't have the capacity to do the massive amount of lot testing which is needed to ensure a reduction in substandard drugs.

(151) *Jeffrey Barnes*: Yinka, this sounds very interesting. We should be in touch. I am also interested in your system for classifying diseases among private providers. We are working with the HMO's and they have a need to standardize their recording the diseases they see and the services they provide.

(152) *Monte Achenbach*: It also sounds like a great source of information for focusing CME and networking programs to provider needs

(153) *Monte Achenbach*: (and ultimately, patients, or course)

(154) *Yinka Ayankogbe*: Thats thempoint , Jeffery. I agree. we need to get togrther. It was the finding that capitation fees for NHIS was not properly applied, especially to Primary Care Providers that prompted our study. We wanted to provide evidence that the HMO's were wrong in the ammount fixed for captation fees. They also do not know what primary care illnesses they should apply the capiutaion fees for. What is your e-mail please. Mine is yinayanks@yahoo.com

(155) *Jeffrey Barnes*: On the HMO side, the key advantage is that this is a part of the reimbursement mechanism under their private and public insurance schemes, so it is necessarily a sustainable way of data collection.

(156) *Susan Mitchell*: I'm interested in vouchers, and other financing schemes that might help minimize the burden of out-of-pocket payments by individuals going to private providers...does anyone have any experiene in this area?

(157) *Jeffrey Barnes*: Yinka this is excellent. My email and profile is on the participant list. We have been looking for some solid evidence base to revisit the capitation fee. All the providers we have spoken to complain about the low level, but they have been unable to provide evidence on the frequency of conditions and their costs which we can use to advocate for a higher capitation fee.

(158) *Yinka Ayankogbe*: Yes. HMO's in Nigeria do not know of our work yet. We want to gather the data first before publicity. we wiil be done in about 6 months

(159) *Karen Eggleston*: Hello all. I was curious if people have experience to share regarding dual practice -- providers working both in public facilities and private practice.

(160) *Yinka Ayankogbe*: Jeffery, we must meet!! We are thinking the same way. If vwe can provide the data for a better operation of the NHIS in developing countries of Africa,, both the patients and the service providers will be ecstatic!

(161) *Meaghan Smith*: Hi Karen,
A number of countries that we work in providers have dual practices. We did some market research of midwives in the Philippines last year and found that of those surveyed only about 40% worked exclusively in private practice. The rest were either dual practice or in the public sector. Interestingly, we found that those working exclusively in private practice earned more than two times as much as their dual practice colleagues.

(162) *Jeffrey Barnes*: Karen, in my mostly African experience, this phenomenon occurs a lot, mostly in urban areas. In some cases, it seems to be a beneficial practice (making more of provider skills) in others it seems to be pushing people to pay more.

(163) *Yinka Ayankogbe*: Karen, plenty!! We just finished a study that documented the fact that a large proportion of all the doctors in private practice also work part-time or full time in government hospitals in Lagos.Also, they run their own private hospitals. Oh the stress that the Lagos doctor go through to make ends meet!

(164) *Monte Achenbach*: In Pakistan it's quite common for public-sector providers to have private clinic hours in the evening to supplement their incomes.

(165) *Karen Eggleston*: Thanks Meaghan. Is there a publication available on that study? I'm curious whether there is a pattern, generally, of providers building a clientele while in dual practice before venturing out on their own, and is so, whether this greater experience partly explains the public-private difference in earnings, in some cases.

(166) *Rich Feeley*: Dual practice is certainly common, perhaps the dominant mode of private practice in many countires, particulalry in rural areas. However, the health expenditure surveys usualyl do not distriguish if the payment is to a full or part time private practitioner, so it is hard to quantify. But I would bet that most of the "private practice" among doctors in rural areas in many countries (Sri Lanka, Vietnam, for example) are probably "dual practice."

(167) *Ruth Berg*: Welcome Noamesi!

(168) *Karen Eggleston*: Do you think policymakers are interested in more systematic data on dual practice, and experience with regulating it? Any studies that you know of that try to study the causal impact of dual practice, or policies that regulate it? For example, I believe Vietnam is planning to ban dual practice from 2010. Do we have an evidence base to think about the impact of such a change? Do you know of any settings where data might be available to study this issue?

(169) *Meaghan Smith*: Hi Karen,

I will look to see if we have a draft ready to share. When we do I will get your email contacts from the conference and send them to you.

There maybe some financial security in holding on to a public position but I have heard many providers say that there is also an element of prestige in being employed by the public sector. Public sector

connections can also be a source of referals.

(170) *Yinka Ayankogbe*: Dual practice vwill be common where the private providers do not organise themselves well . Like has been noted,it is better a bhealth worker makes a carrier out bof private practice rather thatn dual parctice. The stress is more, the ghains are few.Usually the dual practitioner does not haveb time to plan for mulitple straems of income

(171) *Ruth Berg*: Yinka, could you please post your study at some point in the "introduce yourself" section of the conference hall? There is a botton on the bottom of the contribution page where you can upload. let us know if you have any trouble.

(172) *Karen Eggleston*: Thanks Meaghan. I can send you a recent article on the theory of dual practice, if you or others might be interested. I am interested in working with others to gather more systematic data about the prevalence of dual practice and its effects, positive and negative. It seems to be a critically important way in which public and private sector interacts in healthcare, especially in low and middle-income economies.

(173) *Rich Feeley*: Karen, I think dual practice is a subject that deserves much more study. One key fact is that the public job provides a pension and security if the private market does not materialize. So it is understandable that folks do not want to let go of the public post.

(174) *Ruth Berg*: Noamesi, do you have an example from Ghana of private providers actively serving the poor?

(175) *Christine Prefontaine*: I have to leave in a few minutes. But I wanted to let you know that you've given me some great ideas about some specific types of services that community technology centres could provide in the health sector. Also I want to congratulate the PSP-One team for this wonderful e-Conference -- it is very impressive. How I wish we had had this at CMS! It is a wonderful way to document what's going on in the project, and a way for others to learn from and build on your work -- and so many leads for profiles and stories!!! :)

(176) *Meaghan Smith*: Hi Karen,

Yes I would be interested in the article. Is this something you could post?

(177) *Meaghan Smith*: Thank you for the stimulating private sector conversation everyone! I am signing off.

(178) *Karen Eggleston*: Sure, I'll post it. It summarizes theories, and I would like to follow up with more empirical evidence.

(179) *Rich Feeley*: In urban areas, the exclusively private practice makes sense. I am not so sure about rural areas. There, the "paying population" mahy be small, but welcome the opportunity to be seen without queuing all day in the public clinic. In addition, the possibility of a supplementary practice may make a small public salary tolerable. Until you pay doctors enough to make the exclusive public post in a rural area attractive, I would be hesitant to cut out dual practice.

(180) *Niranjan Konduri*: Jeffrey, sorry for getting back late. I was caught with a phone call. There are papers describing the work that was done in Tanzania for drug quality. This involves visual and basic lab tests at port of entries. I can send you those papers if you are interested

(181) *Yinka Ayankogbe*: We are stiil gathering data. We are training doctors to fill forms. the training workshop is taking place on the 2nd of december 2006.We do not have any thing yet that would show a trend. Do you think I should share our methodology? That is the only wothwhile information at this stage

(182) *Karen Eggleston*: Here is the article on dual practice, if anyone if interested.
/Attached: Physician Dual Practice/

(183) *Alene Gelbard*: Thank you PSP-One staff and everyone else. This is a terrific mechanism for shariing information. I look forward to more such discussions.

(184) *Jeffrey Barnes*: Rich, in my experience in Mali and Ivory Coast, this dual practice seemed more of an urban phenomenon. Providers typically referred public sector patients (with more income) to their better-equiped private clinics where they could provide better service. as you say, a lot more research is needed on this topic.

(185) *Ruth Berg*: Yinka, I would be interested in reviewing it if it is something you can share. My email is ruth_berg@abtassoc.com.

(186) *Niranjan Konduri*: Susan, yes the Tanzania program had a 5 year project in the past which involved accrediting private drug sellers and this is still ongoing. This showed demonstrable results and my project is hoping to extend this experience to other countries

(187) *Ruth Berg*: Great to have had you here Alene! Thanks for joining.

(188) *Susan Mitchell*:
I'm going to sign off, its been really interesting, I look forward to staying in touch!

(189) *Monte Achenbach*: Thank you for a stimulating discussion! Have to go, but thanks for the amazing access to so many resources you've gathered throughout this conference..

(190) *Karen Eggleston*: Does anyone know of a case where the rules governing dual practice changes, so that we could study the impact? Or if there is any other exogenous variation in the practice? In your experience, are providers willing to share honestly there dual affiliations, so that provider surveys give a clear picture, or not?

(191) *Jeffrey Barnes*: This has been great, Yinka, I will send you an email to follow up. have a great weekend.

(192) *Karen Eggleston*: Please contact me if you do, thanks!

(193) *Niranjan Konduri*: Thank you to Ruth and all participants for this lively discussion. May all ideas and knowledge exchanged here, eventually benefit the citizens of the developing world

(194) *Ruth Berg*: Dear all, thank you for participating. We are coming to the end of the two hour session. I have been highly impressed with your contributions and look forward to hearing more from you in the future. Just wanted to let you know that we will be officially closing the session in about 5 minutes. Please note that you can go to the

Participant List and access people's emails and profiles by clicking on their name if you would like to continue to engage one another.

(195) *Ruth Berg*: Also, please note that a transcript of this discussion will be available in about 15 minutes under "Live Q&A".

(196) *Ruth Berg*: Once again, I'd like to thank you all for such a rich discussion! Hope to see you all in person one day. This session is now officially closed.

/This meeting is now closed./

---End Transcript---