## Break-out Sessions: Advancing Quality in the Private Sector

**Barbara O'Hanlon**
Nov 9 2006 12:39AM
How To Participate In A "Break-Out" Session: Advancing Quality in Private Sector
Welcome to the break out session on advancing quality in the private sector. This is your opportunity to meet others interested in this area and to share your questions and experience on this topic. We hope to encourage a lively discussion on different approaches used to successfully ensure quality of care in private sector health services.
To start the discussion, the PSP-One project has some initial questions:
1. The poor pay a disproportionate amount of their income on health services in the private sector but are they receiving quality care for their money?
2. Is there any evidence that quality of care in the private sector is better or worse than in the public sector?
3. Do you have examples of policies and programs undertaken by either the public and/or private sectors that could offer lessons for other countries?
Please respond by clicking on the \"contribute\" button and writing your comments in the text box. When you are done, click the \"submit\" button.
We look forward to hearing from you."

**Luis Mauricio Pinet Peralta**
Nov 13 2006 2:50PM
Mexico has undergone siginficant changes in terms of financing healthcare, especially for those who have greater needs but are unable to access health services. Two of the strategies include Seguro Popular and Oportunidades, which focus on increasing coverage with minimum financial resources (mainly from taxes and other contributions) and to improve health promotion and preventive services to build human capital. I am attaching an article published recently that explains this in more detail.
National Insurance in Mexico Frenk_Lancet_2006.pdf

**Barbara O'Hanlon**
Nov 13 2006 7:39PM
Luis Thank you for you country example. Mexico is well known for its innovative health programs in reaching the poor. Sorry, I have not had time yet to glance through your attached article. I would like to know if the two strategies you mentioned involved the private health sector? Or were these strategies primarily public sector initiatives - funded by the public sector with services and programs delivered by the public sector?

**Bruce Mackay**
Nov 13 2006 9:29PM
I find it interesting that there have been so few direct comparisons of quality of care in the public and private sectors (though they are often the same providers, of course!). I would be intersted to hear of any. On quality, here is an analysis by my former colleague Lucy Palmer (now with Marie Stopes) which tested whether private providers trained to advise women on hormonal contraception actually did what they said they did. We first sent monitors to follow up the training, asking them directly 'what do you if X or Y'; and

then followed up with mystery clients expressing X and Y. The results were, frankly, pretty disappointing, but I suspect that only lavishly-funded follow-up and support can achieve really significant improvements in private provider quality. PS. I cannot recall the reference but am pretty sure there was an article about PPs in Nigeria which asked 'what are the main benefits of being in private practice?', and in the top 3 was 'No supervision'. "What do private providers do?" "PvtSecProvidersBrief.pdf"

**Susan Wright**
Nov 13 2006 10:00PM
I found the Lancet article contributed by Luis Pinet Peralta to be an excellent summary of how enlightened public policies can support national health reforms. in fact, I find myself envying the clear evidence-based process that was used to gain comprehensive health insurance in Mexico and wishing that it could be applied by its northern neighbor, but that is perhaps a different discussion.
What was not clear to me however from that article is whether, and in what way, private providers are part of the scheme. Does the Seguro Popular compensate private providers when they provide services to members? Is there a form of capitated payment, or by episode? I would appreciate any clarification you (Luis) can provide on these points. Thank you very much.

**Luis Mauricio Pinet Peralta**
Nov 14 2006 6:33AM
Susan and Barbara,
Thank you for your comments. This is not one great example of how the private sector took \"charge\", but how it can remain viable for those who can afford them and integrate with public insurance systems. The main strategy with the Seguro Popular does not involve the private sector, but the integrated efforts of this program along with two other public insurance systems (IMSS for private sector workers and ISSSTE for state workers) collaborate towards reducing out-of-pocket spending for the most vulnerable, which represent catastrophic expenses for them. Private sector involvement is small, but out-of-pocket expenses represented the majority of the total costs for them. Private insurance is part of the set of alternative financing mechanisms available for the public in general and some portions of the private sector are contributing by ensuring that their most vulnerable groups voluntarily participate in this program to recieve needed services. By promoting preventive services in the public sector, the private counterpart sees the need to provide fair enrollment and expanded services to a larger population and distribute risk pools in a more efficient way.

**Sohail Agha**
Nov 14 2006 8:19PM
My colleague, Dr. Mai Do, and I are conducting a study to compare quality of care offered by the public and private (primarily NGO) sectors. This is in response to absence of direct comparisons between public and private sector in terms of the quality of services provided. I have attached some of the initial findings we have for Kenya. This was presented at the recent American Public Health Association Meeting in Boston. The data

is from nationally representative Service Provision Assessment (SPA) surveys conducted by MACRO.
The data show that clients perceive quality of care to be higher in the private than in the public sectors. However, actually quality of care is not higher in the private sector. The public sector is better in terms of technical aspects of quality. The private sector is better in terms of readiness to provide services (including shorter waiting times). "
"quality in public and private" "QOC_APHA2006_final.ppt"

**Moises Rosas**
Nov 15 2006 1:53PM
Thanks Sohail for sharing your (very interesting) experience. I would like to ask if the patients form your study were from a paired sample, that is, if every patient surveyed attended to BOTH public and private facilities.

**Bruce Mackay**
Nov 15 2006 2:22PM
Thanks Sohail for those slides. I have a similar question to Moises - what defined 'private', what was the universe MACRO selected from and how did they sample from that universe? I also have an observation/question about the reference to 'commercial sources' for contraceptives. This is often proclaimed to be evidence of active private sctor engagement, but surely it is as much to do with method mix. If FP programmres promote the pill then women may have their first consultation with the public sector but mostly end up in surveys reporting that they buy their pills from private sector retailers. No?"

**Luis Mauricio Pinet Peralta**
Nov 15 2006 6:18PM
1. The poor pay a disproportionate amount of their income on health services in the private sector but are they receiving quality care for their money?\"
Even if the quality is good, the question must pass the test of asking \"so what?\". Does it matter whether you recieved good care if you are forced to decide between healthcare and basic goods (food, clothing, rent, utilities)? The problems that we face with healthcare in terms of access, quality and cost are related to whether you can afford the healthcare you need (if you are faced with such choices in the first place). This is about equity, not inequality. People should be able to get the right care, at the right time, by the right person regardless of whether they can afford it, and for the right reasons. Countries that provide universal healthcare coverage fare better than those who do not. Some of them involve the private sector (e.g. Germany) as the provider of some services, and ensure access to quality services for the entire population. There is always a comparison in terms of how much quality there is (waiting times for example), but in population terms, it makes little difference whether you are poor or not related to receiving needed health services.
The poor suffer catastrophic expenses for conditions that could have been prevented if proper care would have been provided, because they seek care later, do not have access to quality food, housing, work, insurance, education, etc. So whether they receive quality care matters little if they are not receiving care that includes primary prevention.

**Leah Levin**
Nov 15 2006 8:36PM
In March of 2005, PSP-One conducted a Quality Assurance Panel , which brought together a variety of experts to discuss current QA practices employed in the public health sector and how they can be applied to the private health sector. A major recommendation from this Panel was that current approaches and tools that improve the quality of public sector service provision be adapted for and tested in the private sector. PSP-One subsequently developed a QI package that has been developed for both the provider and his/her supervisor when one is available. It has been our experience that this package is most effectively introduced through a formal structure such as a professional association.
This QI package for the private sector is aimed at practitioners in private practice. They are likely to be the only or one of few staff in a privately owned clinic. The facility may be officially licensed by the government, but the government provides little or no supportive supervision, continuing education, practice guidelines, subsidies for supplies or other inputs that affect the quality of services. This QI package is a series of steps that a provider in independent, private practice can use to improve the quality of his/her services without relying on outside monitoring.
This package's content and ease of use was tested in Uganda with the Uganda Private Midwives Association in the spring of 2006. Currently, PSP-One is conducting a study to evaluate the QI package that will examine its acceptability and effectiveness of the tool. If participants are interested in the tool or would like to know more about the study, I'd be happy to post some documents.

**Sohail Agha**
Nov 15 2006 9:05PM
Dear Moses,
The clients were not from a paired sample. The study consisted both of observations of client provider interactions in independent public and private clinics/hospitals and exit interviews with clients who visited the clinics/hospitals.

**Sohail Agha**
Nov 15 2006 9:10PM
Bruce,
I'll have to look again at the sample frame that MACRO developed prior to sampling clinics/hospitals but I believe their universe consisted of public/commercial hospitals in the country and NGO clinics. I believe they could not find information that would enable them to develop a sampling frame for commercial clinics. Further details of the Kenya SPA can also be obtained from MACRO website.

**April Harding**
Nov 16 2006 11:44PM
I saw an interesting presentation at the Center for Global Development by Ken Leonard (U of Md) - presenting evidence of better care quality in private PHC facilities than in public in Tanzania.

Dr. Leonard and a colleague tried to assess the degree to which the organization of a facility affected the motivation of medical staff. They assessed both knowledge and practice by using vignettes and observation of key clinical practices in public and private facilities in Arusha (Tanzania). By measuring the ability and actual practice of this sample of clinicians in Tanzania and examining the terms of employment for these clinicians, they showed that both ability and motivation are important to quality. Even after controlling for their ability, they found that clinicians who work for organizations that use high-powered incentives are much more likely to properly diagnose and treat patients. It is almost exclusively the private organizations that use the high-powered incentives (mostly related to the labor contractual arrangements). So, they found that private organizations got their clinicians to practice closer to their ability than the public organizations - and therefore to provide better care
I'm attaching the working paper.
Happy reading!
The URL link is for the presentation at the Center for Global Development
http://www.cgdev.org/content/calendar/detail/5119" "Motivating Clinicians/ Leonard"
"Leonard_-_Getting_Phys_to_do_their_best_Africa.pdf"

**April Harding**
Nov 17 2006 1:14AM
I found another paper in my files. In 2000, Qingyue Meng and colleagues assessed the quality of primary care in public and private facilities in China - and found no discernible differences. I'm attaching the Health Policy and Planning paper. "Comparing pub & private China" "Meng_Liu_et_al_Quality_pub_vs_private_in_china.pdf"

**Jeffrey Barnes**
Nov 17 2006 4:32PM
I have a reaction to Luis, #10. This is more about beliefs than evidence, but much of the discussion around equity does seem to me to be based on beliefs. I question whether it is wise for government to guarantee the \"right\" to free health care. It is interesting that he mentions choices the poor face in having to choose between rent and food. As Philip Musgrove once pointed out to me, one can survive much longer without a visit to a doctor than one can survive without food. And yet, no one advocates that the government should guarantee the right to food or that the public sector should ensure subsidized provision of food. Like others, I dream of a more equitable world, but I recognize that whether it is food or health care, costs have to be paid and one should be practical and flexible (as opposed to ideological) in figuring out how to pay for the provision of quality health care.