Part Two: (C) The (In)Visible Hand of Government in the Medical Market

Frank Feeley

Frank (Rich) Feeley of Boston University Center for International Health and Development discusses the role of government in overseeing the private health sector. Mr. Feeley discuses quality of care in the private sector and examines specific strategies that have worked in developing countries to improve quality in the private sector.
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Susan Scribner
Nov 14 2006 10:19PM
I agree with your point that HIV/AIDS, especially the provision of ART, is an effective entry point for accreditation of private providers. Giving providers free or highly subsidized antiretroviral drugs is one incentive for accreditation and that is complemented by demand and willingness to pay for HIV/AIDS treatment by current and potential clients.
My question is, what is another entry point for private sector accreditation in countries that do not have high HIV/AIDS prevalence? For maternal health services for example, what drugs, equipment or training would provide an incentive for private practitioners to become accredited? Do you think it will be effective even if the frequency of demand for services and willingness to pay by clients are less than for HIV/AIDS treatment?

Frank Feeley
Nov 14 2006 10:26PM
In cities with multiple private hospitals, accreditation of emergency services would be another avenue. This might work in the large cities in India. Then private ambulances would be directed to the accredited hospitals. Effectively, this has been done in the US by setting standards for trauma centers, and the less competent hospitals have gotten out of the ER business in big cities.
It is harder with primary care services because a broad network is necessary, and full accreditation may be unrealistic. At the referral level, there is often only one hospital that is reasonably close by. Again in cities, where there is substantial private demand for maternity services, and too many low quality maternity homes, this might be another entry point. It is harder to think of a subsidy however, and the \"incentive\" for seeking accreditation of maternity services would have to be based on good publicity of the accredited list. One also must be careful that unrealistically high standards are not included in the accreditation----a good maternity service does not necessarily need an intensive care nursery, at least at lower levels of health spending.

Bruce Mackay
Nov 15 2006 3:02PM

Hitching accreditation to the wagon of highly-subsidised ARV drugs seems to me very short-sighted. These drugs are an extreme case - expensive, in short supply and life-saving, and thus highly prized by patients. Doctors in private practice will of course fall over themselves to sign up to any scheme which enables them to tap this currently lucrative market, but what happens when the scarcity is over and drug prices fall? There is already evidence from India of poor quality care by such doctors (see attached reference, incomplete I'm afraid but that is all I have to hand).

"Access to HIV in Pune, India" "MAAS-CHRD_reference_in_LSHTM_Target.pdf"

Luis Mauricio Pinet Peralta
Nov 15 2006 3:29PM
Regarding emergency services, especially prehospital care, my experience both on the field and in research has been that prehospital emergency services that are provided through the private sector are most efficient when contracted out and when the contracting is done for the market. If private ambulances are assigned to a hospital, who is then accountable for inefficient practices? The hospital? The ambulance service? 911? In the U.S., we have tried to limit the role of government in providing this type of service although it remains a core function through fire services, but only because of tradition, culture and a misled preconception that fire services are efficient. Some states have provided ambulance services (through bids) with performance-based contracts (e.g. Kansas City), where the government sets the standards and an independent board evaluates the job (leaving fire services out). Competing for the market instead of within the market gives a real incentive to be efficient and remain a profit-based organization. In Mexico, for example, I have done some research along with other colleagues in prehospital care performance. The single largest provider is a NFP organization, but there is no enforced regulation, no standards to be met and no control over how resources should be utilized. The government has its onw provider and is probably the least efficient of all. Moreover, there are more providers competing between themselves than the population needs (and ambulance services are not subject to the traditional market theory), so the economies of scale are so limited that services are inefficient, even though performance of some providers may be good. Contracting out on a performance-based strategy would be very benefitial.
The question then becomes, how to ensure that the contracting is done without favoring some organizations and not others? Who and through which standards it is decided who gets the contract and who evaluates performance?

Frank Feeley
Nov 15 2006 6:44PM
Your concern about the misuse of ARV's by private sector practitioners is appropriate. The risks of poor treatment and creating drug resistance are exactly the reasons to encourage accreditation in this highly sensitive area. Lower priced drugs provide an incentive for a provider to submit for accreditation, and give a benefit to his/her patients (compared to patients of a provider who is not accredited). Focusing on a particular critical service (like AIDS treatment) reduces the regulatory manpower required. With

national HIV treatment protocols, it is much easier to define \"quality\" in ARV treatment than attempting to do so for the full range of possible private sector services
The alternatives are unattractice. Ignoring the private sector means letting poor practices continue unabated. Restricting to public providers the critical treatments which must be done on a large scale (such as ARV's) puts an additional burden on the public sector, and means that those who can afford to contibute to their care will not do so, given the difficulty of means testing and the reluctance to charge user fees for this service. With general provider licensing, it is difficult to eliminate any but the most egregious conduct. Accreditation provides targeted quality control, and with controlled access to low cost drugs avaiable to the Government, an incentive that is not subject to all of the usual and lengthy procedural protections.

Frank Feeley
Nov 15 2006 6:54PM
Competitive contracting for pre hospital emergency services is an interesting concept. This only works, in general, if the agency that makes the contracting decision makes the payments. If payments are made by a number of agencies (insurers, individual, employers, etc), then this becomes more difficult. That is when you get to accreditation. An accredited agency is one that is entitled to advertise, and be paid, for the accredited services.
If you contract, how do you assure sound decision making. Transparency helps---publishing submissions, inspection reports, complaint investigations, maybe even response times. But few beyond the competitiors and the payers will read this material. If public money is involved, this probably has to be done bya public agency, although there are precedents for industry accreditation as a condition for payment. (Look at JCAHO and Medicare) It seems this may be more difficult for an industry like pre-hospital care, but it might be done-----for the same reason that accreditation works (when it does) elsewhere----that the more honorable and skilled members of the group want to prevent low cost, poor quality competition. You might consdier an accrediation agency with an outside, multinational reveiw board, rather in the manner of \"Visiting Committees\" used by Universities.

Monte Achenbach
Nov 15 2006 9:47PM
Mr. Feeley is right that continuing medical education can be a powerful tool to increase quality among private providers, and I believe that the inclusion of CME as a certification requirement would be an excellent way for governments to support its development. The government of Pakistan was considering such a requirement when I was working with Greenstar. This policy alone would spur the creation of broad new market for CME and provide a needed element of sustainability for professional development programs, which are quite limited in scale now. Although providers consider CME highly valuable and Greenstar has shown that they are willing to pay for it, the level of demand at prices that cover costs does not support broad accessibility and financial viability of the programs. If the government were to require CME and accredit non-government training programs, CME could become a growth area in the private sector with the likely outcome that volume would support self-sustainability.

Other incentives for better quality? Private providers respond strongly to recognition by peers, networking, and access to quality products (contraceptives in Pakistan are an example, and I think the ART suggestion, in particular settings, would follow that), and Greenstar has begun experimenting with rewards for performance and other network membership incentives. Accreditation of CME programs in combination with these network features would exercise a powerful influence on the quality of provider services.