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Private health care in developing countries

If it is to work, it must start from what users need

Private healthcare provision is growing in low and middle income countries.[1,2] The poor, as well as the rich, often seek health care from private providers, including for conditions of public health importance such as malaria, tuberculosis, and sexually transmitted infections.[3,4,5] The reasons cited by users include better and more flexible access, shorter waiting, greater confidentiality, and greater sensitivity to user needs.[1,6] International policymakers are currently recommending greater use of private providers[7,8,9] on the grounds that they offer consumers greater choice; increase competition in the healthcare market; and remove state responsibility for service provision, thereby encouraging its role as regulator and guarantor. We should, however, be concerned.

When examined, the quality of care offered by many private providers is poor.[1,2,10] Furthermore, poor people spend a greater proportion of their income on health care (private or public) than do the rich, often using less qualified or totally untrained private providers.

We have recommended three objectives in relation to the private provision of care for conditions of public health importance: widening access, improving quality, and ensuring non-exploitative prices.[11] None of these will be simple to achieve; and multifaceted interventions, involving policymakers, providers, and users will be required.[12] Increasingly service users (or "consumers") are being highlighted as the key to driving improvements to achieve these goals. Their role has, however, been little evaluated in developing countries.[11]

Community education strategies

In the poorest countries most people who use private providers pay directly for services, drugs, and other health commodities. In theory, community education strategies could help people recognise, demand, and obtain higher quality care—and know what they might expect to pay for it. The influence of users is likely to be greater where popular political involvement, advocacy and consumer organisations, an active media, and higher levels of education are present. Working through representative community organisations is likely to be more effective than placing the onus on individuals to negotiate better quality care. Community education is a core element of social marketing strategies to stimulate demand and increase population coverage of products with public health benefits, such as oral rehydration therapy, contraceptives, and insecticide treated mosquito nets. This needs to be combined with measures to ensure access, affordability, and supply.

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Though users can identify what constitutes for them a good quality service, there is limited evidence that they can assess the technical quality of services. Users expect providers to act in their best interests, although this trust is often misplaced. Expectations that community advocates or increased user knowledge and confidence are enough to improve the quality of services are unrealistic, however, in relation to the appropriateness, quality, and availability of drugs and diagnostic tests, and even more so for more complex clinical services.

In the case of commodities with a public health benefit such as insecticide treated mosquito nets and contraceptives, information about product quality can be conveyed through a product brand, reinforced through use and experience. With more complex products such as correctly packaged doses of drugs for the syndromic management of malaria and sexually transmitted infections, users rely on some third party to guarantee technical quality.

Accreditation schemes

In relation to a package of services, accreditation schemes may monitor the services offered by providers against agreed quality standards, in exchange for which such services are promoted to potential service users. High levels of capability are required of accrediting bodies, however, and this strategy may not be feasible in many settings, especially when there are large numbers and different types of single providers and where resources are highly constrained. Such schemes are more practicable, and usually more politically acceptable, when working with qualified private providers organised into professional bodies.

With respect to the cost of health care, information on regulated prices for essential drugs has been communicated directly to users in several countries (Philippines, Colombia, Argentina, India, and Pakistan) with variable success. This strategy is hindered by currency fluctuations, uncontrolled drug markets, and weak state regulation. Price controls on a limited set of essential drugs and for generics are likely to be more feasible than price controls for branded products or for services.

A country's regulatory and legislative framework underpins the state's approach to working with private

providers. Too often, especially in the poorest countries, the framework is inadequate, dealing with only the most basic requirements, such as practice entry and facility registration. In particular, users' access to effective and affordable redress through administrative and judicial channels is often inadequate. The oversight role of health professional councils may also be limited. Conversely, in some circumstances lowering regulatory barriers may help: for example, the availability and use of contraceptives have improved through lowering regulatory and import barriers to product availability (Zimbabwe), relaxing advertising restrictions (Pakistan), and broadening the types of private providers who can administer injectable contraceptives (Egypt).

Free services for target groups

The way in which services are financed may offer mechanisms for limiting costs to service users and could be used to promote quality of care. Free services for specific target groups such as pregnant women, children, and commercial sex workers and for priority services such as tuberculosis, sexually transmitted infections, and family planning deserve consideration. Fee exemption schemes, especially if targeted to particular groups, are costly to administer and may be difficult to scale up to national level. The most powerful levers operate where medical aid schemes and insurers influence the prescribing habits and services provided by private providers by specifying what diagnostic tests and drug treatments must be offered if the provider is to be paid. However, insurance schemes usually cover a minority of the population in many poor countries.

The potential of these strategies will depend on the context and the capabilities of various stakeholders, especially the state. The poorest countries, with impoverished populations and many untrained and unregulated providers, face the biggest obstacles, especially given their weak public sectors. Principles that should govern state collaboration with private providers include recognising that access to quality and affordable health care is a right; that ensuring access for poor people is a policy priority; and that the mechanisms to enhance influence of users should be promoted.[11]

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Cardiovascular complications of recreational drugs

Are an important cause of morbidity and mortality

The consumption of recreational drugs has reached epidemic proportions. Forty five million European Union citizens have used cannabis at some time, with proportionately higher use among younger people.[1] The consumption of harder drugs such as cocaine and heroin is rising, with an estimated 1.5 million problem users in the European Union. Drug use is commonly associated with complications, including an increased risk of premature death.[1 2] In particular, recreational drugs have profound effects on cardiovascular function. Some studies suggest that adverse cardiac events are relatively uncommon,[1 3-5] though recent data from the United States indicate that one in four myocardial infarcts in people aged 18-45 years can be linked to cocaine use, suggesting that variation in definitions may contribute to under-reporting.[1 6]

Many physicians will encounter patients with cardiovascular problems related to recreational drug misuse. In addition to the problems posed by self administration, massive overdoses may occur in individuals who attempt to smuggle illegal drugs by ingesting packets which rupture in the gastrointestinal tract; and inadvertent ingestion of recreational drugs by children has been reported. Successful management can be difficult, since many patients will be unwilling or unable to provide an accurate history. An awareness of the pathophysiological effects of these compounds is therefore an important aid to diagnosis.

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