

**P S P**

**PRIVATE SECTOR PROGRAMME  
IN HEALTH**

# PROGRAMME REPORT

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**REPORT TO Sida (Swedish International  
Development Cooperation Agency)**

**COVERING THE FUNDING PERIOD 2002-  
2007**

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## BACKGROUND

The Private Sector Programme in Health – PSP – is a collaborative research programme which started out with a Sida-funded project coordinated by the Division of International Health (IHCAR) at Karolinska Institutet, Stockholm, Sweden and the International Health Systems Program (IHSP), Harvard School of Public Health, Boston, USA. The programme seeks to strengthen health systems' performance and their outcome in terms of improved health by exploring the non-state (private) health sector and how it can be involved in providing adequate health care to the population, in particular those in most need. The programme has been supported by the Swedish International Development Cooperation Agency (Sida) from 2002-2008. The programme has so far engaged eight institutions in China, Vietnam, Laos, India, Uganda and Zambia in the research collaboration.

The rationale for the programme is that the private sector constitutes a large and important source of care for many people in low- and middle-income countries, not least the poor. Yet, the private sector has often been overlooked when trying to improve health systems in poor countries. Information on the scope of the private health care sector and the services it provides, including their quality, has been missing from most countries. The PSP has in the past five years sought to fill parts of that knowledge gap by implementing descriptive and analytical studies of the private sector in the low- and middle-income countries participating in the programme. In a first phase methodology and data collection tools were developed.

An important objective of the programme has been capacity building through decentralized planning and implementation. The emphasis in the core support has therefore been on technical tools development, technical support to project proposal development in countries and later implementation and overall management of the programme, including mobilization of financial support for the country studies. None of the country studies have been funded by core funds. Six out of eight institutions have been successful in mobilizing support for implementation of local PSP studies. The institutions participating in the programme 2002-2007 were located in Jinan and Guangzhou in China, Hanoi in Vietnam, Vientiane in Laos, Ujjain in India, Trivandrum and Chennai in India, Kampala in Uganda and Lusaka in Zambia. A list of the collaborating institutions and contact information for the principal investigators is found in Annex III of this report.

As part of programme preparations a workshop was held at Sida's headquarters in Stockholm in January 2002. The workshop was financed under a separate grant by Sida. At the workshop, researchers from the institutions in the six participating countries developed the details of the research programme together with a team from Karolinska Institutet, Harvard and Sida. Research teams were formed in eight programme sites in the six countries. Each team consisted of at least one person from either Karolinska Institutet or Harvard and a lead researcher and his collaborators in the institution that was to host the study. A program steering group consisting of researchers at KI and IHSP was also formed.

## OUTPUTS

The general outputs of the programme can be grouped under research, conferences organized, participation in other conferences, articles and book chapters produced, other academic outputs, website and database, capacity building including training and other outputs. Country specific outputs are given further down in the country summaries. Full country reports and references to country-level publications can be found on [www.psp.ki.se](http://www.psp.ki.se).

### *Research*

Common research protocols have been developed for studies and assessments of the private health care sector and its clients. The protocols have been made publicly available for download and use through the programme website.

Further, six country studies have been conducted in five countries: China, India, Uganda, Vietnam and Zambia with technical support from Karolinska Institutet and Harvard. The studies in Uganda, Vietnam and Zambia have received financial support from Sida country offices. The work in Shandong and Guangzhou, China was financially supported by the Japanese Jaikai Foundation. Danida supported the research in Ujjain.

### *Conferences and workshops organized*

The programme has organized two workshops and one conference. The first workshop was the preparatory workshop described earlier. The second workshop in 2004 was held to report preliminary findings from country-level work and discuss implementation issues in the programme. Experiences from other international work on the private sector were also shared by invited guest speakers at that workshop. A full report from the workshop is available at the programme website.

The programme held an international conference in Jinan, China in 2006 comprising 30 international participants, 51 Chinese scholars and policy makers and about 60 students from Shandong University. Findings from country-level work were shared from all PSP institutions. At the end of the conference the participants issued a “Shandong Statement” where they called for

- **Governments in low- and middle-income countries** to give greater recognition to the role that the private health sector plays and to develop clear policies that can guide national and local governments work with the private sector, as strategic partners in health care delivery, with the aim of strengthening public health and access for all to health services.
- **Governments in low- and middle-income countries, their development partners, and international collaborations** to invest in developing reliable, routine information on the private health sector, through, for example, the development, conduct and analysis of regular facility surveys, complemented by other routine data sources where feasible.
- **Research funders** to increase their investment in synthesizing existing studies and conducting new research, especially on well designed and rigorously evaluated intervention studies. This should increase knowledge on the effectiveness of tools and

mechanisms that governments can use to engage the private sector, to help reach the poor and promote good quality care; all for improved health outcomes.

The full statement from the Shandong Conference is given in Annex I.

### ***Conference participation***

At the last three iHEA (International Health Economics Association) World Congresses; 2003 in San Francisco, 2005 in Barcelona and 2007 in Copenhagen, the programme has arranged organized sessions where programme participants and invited guest speakers have presented research findings and policy issues related to the private health care sector. In addition, programme country researchers have submitted a large number of individual abstracts which have been presented through posters and oral presentations. In May 2008, a synthesis of the findings from PSP country level research was presented at the Global Health Forum in Geneva and at the Global Health Council Conference in Washington DC.

### ***Articles and book chapters***

The programme has rendered publications in both international and national peer-reviewed scientific journals. It has also resulted in one book chapter. For specifics on publications from each country, please consult the individual country summaries in the report. Manuscripts are also being finalised during 2008. A summary of the research findings was published in *Läkartidningen* (Journal of Swedish Medical Association) early 2008.

### ***Reports***

The programme has continuously reported and disseminated progress of the programme as well as research findings through annual and conference reports. Reports from the conferences organized in 2004 and 2006 were printed and distributed to a large group of stakeholders at research institutions and international organizations around the world. All reports are made publicly available through the programme website.

### ***Other Academic outputs - Master theses***

Faculty at Karolinska Institutet has provided guidance on master students during the course of the programme. One result is two master's theses, one by Anna-Klara Berglund on "*Action for HIV/AIDS control – Exploring the partnership between the government and NGOs in HIV/AIDS prevention among commercial sex workers in Tamil Nadu, India*" at Karolinska Institutet and one by Phan Thanh Thuy on "*Quality of Private Health services in Bac Giang City, Vietnam*" at Umeå University. The PSP supported both studies financially.

### ***Website and Database***

In 2006, the programme opened its website ([www.psp.ki.se](http://www.psp.ki.se)). The website has a threefold purpose: sharing information about the programme to a wider audience, making tools for research on the private sector publicly available and be a resource for finding publications related to the private health care sector in low- and middle-income countries.

During 2007, an extensive database was developed comprising over 500 publications on the private health care issues in low- and middle-income countries. The intention is to update the database regularly.



## *Capacity development and networking*

### *Training course*

The programme has developed and organized an international training course on “Private health care: developing successful policies and programmes”. Participants in the course were researchers from the programme, policy makers from low- and middle-income countries, researchers and task managers and programme officers from international organizations. The course has been held on two occasions; 2003 in Stowe, Vermont and in 2005 in New Delhi. The course has been led by faculty members at Karolinska Institutet and Harvard School of Public Health and has included lecturers from international organizations such as the World Health Organization and the World Bank.

In addition to the training course, faculty members from Karolinska Institutet and Harvard School of Public Health have supported capacity development at collaborating institutions through country missions and regular communication. Furthermore, the programme has provided networking opportunities by facilitating interaction between the researchers in the programme and national and international organizations. The extensive interaction with other stakeholders by the coordinating institutions has also led to the development of a strong international network comprising researchers, policy makers and international organizations around the world.

### *Other outputs*

The programme has generated additional spin offs, such as assignments for the World Bank in Washington, Bangladesh and India on public-private partnerships. Another is collaboration with the Alliance for Health Policy and Systems Research.

The programme has also supported two studies on private sector provision, one in Zambia on maternal care and one in Ujjain on HIV/AIDS. The studies are on-going.

## **CONCLUSIONS AND THE WAY FORWARD**

The PSP has shown that the private sector is of significant importance in five countries in Asia and Africa, countries of great diversity with different political and health care systems.

In China, health care has gone from a completely socialized system to a system in which large parts of the ambulatory care are operated by private clinics. Hospitals are operated on a for-profit basis in spite of being government owned.

In Vietnam, private health care has grown from non-existent in the early 1990s to an estimated number of private health facilities of more than 27 000 in 2001. The number without a license to practice is much greater. Individual practitioners without clinic and traditional practitioners providing services through home visits are very popular, especially in rural areas. In the Vietnam National Health Survey 2001-02, utilization of private outpatient health services accounted for 60% of general outpatient treatment. Like in China, hospital care is to a much lesser extent private, accounting for just 4% of inpatient treatment. Still, many small clinics registered for ambulatory care may keep patients for observation for more than 24 hours, in reality providing inpatient care.

In India, the share of government health spending in India is one of the lower in the world at 24% of total health expenditure. 74% of total health expenditure is private out-of-pocket expenditure. Private providers constitute a large share of total providers. In one of the studies in Ujjain they were found to form over 80% of all providers.

In Uganda, the PSP study of three districts showed that informal providers made up 77% of the providers in the mapped area. The informal providers, however, were usually one-person ventures, which offered a narrow range of services mostly based on traditional medicine and healing on an irregular basis. Private formal clinics and drug shops constituted 17% of all facilities. The public facilities represented 4% and the non-profit NGO sector only 2% of all mapped facilities in the study districts. (The non-profit sector accounts for 42% of the 108 hospitals and 28% of the 1617 officially registered lower level units in Uganda.) Around half of families interviewed sought care when someone fell ill and out of those 58% went to a private provider. Hence, the public sector still served many patients, in spite of the private providers being many more in number. For inpatient care the public sector was the dominant, reflecting the fact that there are still few private for-profit hospitals in Uganda outside Kampala.

In Zambia, the study of two districts showed that 95% of the providers were private for profit while 5% were either government or private not-for-profit. The prominence of the private providers was due to the many traditional health practitioners and drug vendors. Almost 60 % of all providers mapped were not registered with any regulatory authority or professional organization.

Quality of care was looked into in several of the studies suggesting that there is need for more attention to the matter. Private care, especially ambulatory care provided through small clinics, is often linked to overprescription of drugs and treatments.

These are just a few of the many results that have come out of the PSP research programme. Clearly, they point to the fact that the private sector is of essential importance in provision of care for people in low- and middle-income countries. There is also an increasing role of the private sector in research, technology development, and communication. As a result of all this, public-private partnerships emerge as one of the main areas of innovation in health. There is a wide menu of options available to governments choosing to work with the private sector:

- **subsidies** – providing real inputs or funding to non-government entities or providing access to care at private facilities through vouchers schemes or other subsidies to clients
- **training and technical strengthening** – increasing knowledge, skills and capacities to improve the quality of care
- **contracting out and in** – purchasing services from non-government entities
- **regulation** – using legal and administrative rules to affect non-government entities
- **other innovative mechanisms** – such a social franchising and public health competitive funding

The emerging scene of significant public-private sector mix in all stages of health care have given rise to a much broader scope for public-private partnerships than the government-NGO partnerships that were the early innovations. Some of the new potential areas for public-private partnerships are new dedicated taxes (e.g. air travel tax) or commercial arrangements

as now tried by the Global Fund and GAVI, advance purchase commitments (to stimulate drug development), import of management skills to public sector organizations from the growing sector of large private companies in health care, and letting the public sector learn from private organizations in marketing and advertising for improved health communications.

Public-private partnerships are not a natural or easy fit for most country health systems. There are both risks and benefits to working with the private sector. The interest in, and need for, public-private partnerships reflect longer term changes in the health sector and its supporting environment which are not likely to be easily implemented. These include the weaknesses of public sector institutions, changes in organization of producers of inputs (both human and technological) to health systems, and growth in important knowledge and skills in the non-government sector. Poorly developed partnerships with the private sector can make things worse so caution has to be taken when developing such collaborations. Partnerships imply joint participation in planning, decision-making and programme management. It also means sharing power, and often governments are reluctant to open up to that as they may feel it undermines their authority and control. The PSP has shown that such authority and control is missing in large segments of the health systems in the five countries studied. Hence, working towards public-private partnerships may rather strengthen than weaken the role of the government. Establishing confidence in the advantages of public-private partnerships is a challenge and skill in itself. This is as true for the public sector as for the private.

The changing scene for public-private partnerships also raises some questions for the future:

- ***Can public-private partnerships move beyond a marginal add-on to government health systems in many countries?*** There is a fundamental conflict with the commonly existing National Health Service model. Will governments seriously engage in a model in which they alone do not try to provide all services that people demand?
- ***How will public-private partnerships interface with trends towards decentralizing government systems?*** Knowledge must be generated to determine if these two strategies are alternatives or complements.
- ***Do governments have the capacity to manage large-scale public-private partnerships?*** Can governments develop and acquire the necessary skills to handle this task?
- ***Can governments find an optimal balance between collaborating with the private sector to reach more people without promoting the use of poor-quality services?*** Is it possible to change behaviour towards rational use of medicine and medical investigations when private providers often earn incomes from medical investigations and drugs.
- ***Can equitable service delivery be achieved in a system based on inequitable out-of-pocket payments?*** Can the private sector be engaged to work with the public sector to deliver services to those in most need and still be motivated to do so?
- ***Is “partnership” really possible?*** Can genuine trust and productive cooperation between the public and the private sector be built?

Currently, some evidence exist on what works and what does not work in public private sector collaboration in health, but much knowledge is still missing. Also, results from one country or specific setting can often not be generalized and the effects and impact of various models varies with context and system.

The knowledge gaps on how to work with the private sector for improved health need to be filled. High priority should be given to research and evaluation of interventions for public-private partnerships. Sound evaluations of outcomes as well as comparative assessments of processes and costs need to be carried out on a continuous basis.

The options for expanding the work on public-private partnerships are many. And so are the challenges. However, the present situation leaves no room for complacency. Every day, many people in low- and middle-income countries seek care from private providers, some of them offering good quality services, many of them not. These people spend significant amounts of their limited financial resources on private care, sometimes for good, sometimes just for nothing and at times even for bad. The call for protection of the poor and the improvement of their health and ultimately their quality of life is a call for engagement in broad health systems development, a development in which the private sector cannot be ignored.

## **PSP - CONTINUATION**

PSP will continue to be a network for researchers and policy makers interested in issues related to the private health care sector in low- and middle-income countries. Plans are also underway to host a pre-conference in connection to next year's International Health Economics Association's World Congress in Beijing in collaboration with several international organizations and research institutions. Furthermore the PSP network will strive to further disseminate and publish country level findings in international journals, reports and policy briefs.

## COUNTRY REPORTS

### *China – Shandong*

**Institution:** Center for Health Management and Policy, Shandong University

**Principal Investigator(s):** Qingyue Meng

**Other Investigators:** Jiangbin Qu, Yuanli Liu, Birger Forsberg, Xifan Zhang, Lingui Li.

### **Research activities**

The major activities in the program included

- 1) April 2004: Dr. Yuanli Liu from Harvard school, USA visited Beijing to assist in designing the project.
- 2) September 2004: the pilot study was conducted and the study instruments modified.
- 3) January 2005: Dr. Birger Forsberg visited Shandong to discuss the collaboration between the Center and Karolinska Institutet and Harvard School of Public Health and the study.
- 4) May 2005: Field work commenced with support from the Jiaikai Foundation, Japan. During the field survey, Dr. Yuanli Liu visited Shandong to participate in and guide the field work.
- 5) July 2006: A report on “*The role and scope of Non-government and private health sectors in China - the case of village private health practitioner in rural, Shandong*” was finalized.

### **Conference participation**

- 1) 2005: Professor Jiangbin Qu participated at the fifth iHEA World Congress in Barcelona presenting a paper on “*The case of village private health practitioner in rural, Shandong*”.
- 2) A conference on “*The private sector in health care delivery – Potentials and Challenges*” was held in Jinan, Shandong, China, September 26 – 28, 2006. The conference was organized by Shandong University in collaboration with Karolinska Institutet and Harvard School of Public Health.

### **Publications**

**Jiangbin Qu, Xifan Zhang, Qingyue Meng, Lingui Li, Xinfeng Pan, Yuanli Liu.**

*An Assessment on Current Situation of Village Clinics in Shandong Province, China – the general situation of village clinics. Chinese Health Economics, 2006,25(1):29-31*

**Jiangbin Qu, Qingyue Meng, Xifan Zhang, Lingui Li, Yuxia Li, Yuanli Liu.**

*An Assessment on Current Situation of Village Clinics in Shandong Province, China – An assessment of Standardization and Quality of Health Services Provided by Village clinics. Chinese Health Economics, 2006,25(2):29-31*

**Jiangbin Qu, Qingyue Meng, Xifan Zhang, Tang Ying, Yuanli Liu.**

*An Assessment on Current Situation of Village Clinics In Shandong Province, China – A Study on the Status Prevention and Health Care Provision of Village Clinics. Chinese Health Economics, 2006,25(3):34-35*

**Liu Y, Berman P, Yip W, Liang H, Meng Q, Qu J, Li Z.**

*Health care in China: the role of non-government providers. Health Policy 77(2006) 212-220*

## *China – Guangzhou*

**Institution:** Department of Health Management, School of Public Health, Sun Yat-sen University

**Principal Investigator(s):** Haocai Liang

**Other Investigators:** Cunrui Huang, Lu Han, Jinhua Chen, Shaoxian Chen

### **Research activities**

In 2002-2003, a pilot study was conducted in China to test the research protocols developed by the PSP. In 2004-2006, a larger study of private health care providers and their clients was conducted in Guangdong province, China. The main study was given technical support from Karolinska Institutet in Sweden and financial support from Jaikai Foundation in Japan.

### **Main findings and conclusions**

Non-governmental hospitals in Guangdong Province are still small in scale, weak in strength and limited in service quantity. They only hold 3% of the market share. Most of them are located in well-developed area.

Compared to public hospitals, non-governmental hospitals prioritize specialization; employ strict management and flexible allocation; emphasize patient-centered conception, the attitude and quality of medical services; focus their attention on those able to pay and finally they put much effort on marketing themselves.

The major difficulties encountered by non-governmental hospitals in their development process include; inadequate policy support from the government to develop the sector, heavy tax burden, scarcity and high staff turnover and poor social recognition.

One private hospital and one public hospital in Dongguan city of Guangdong Province was selected to compare patient satisfaction. In the outpatients and inpatients, significant difference between the private and public hospital existed in age, occupation, education level, household income, residence and sort of payment. For the outpatients, total satisfaction in the private hospital was higher than in the public hospital. For the inpatients, however, there was no statistically significant difference between these two hospitals.

The results leads us to suggest that the government should fully realize the functions of non-governmental medical service and avoid unfair treatment of them and bring the development of non-governmental hospitals into national health development program, and thus break the monopolistic position of government hospitals.

### **Conference participation**

- International Health Economics Association's - 5th World Congress. Barcelona, Spain. July 10-13, 2005.
- *“The Private Sector in Health Care Delivery – Potentials and Challenges”* Jinan, Shandong, China, September 26-28, 2006.

## Publications

- **Huang Cunrui, Zhai Zutang, Sun Binggang, Chen Shaoxian, Liang Haocai.**  
*The Analysis of the Problems Exists in the Development of the Non-governmental Hospitals in Guangdong Province. Chinese Health Economics, 2006, 25(8):31-33*
- **Huang Cunrui, Chen Shaoxian, Han Lu, Zhai Zutang, Sun Binggang.**  
*Investigation and Analysis of Non-governmental Hospital in Guangdong Province. Chinese Journal of Hospital Administration, 2005,21(6):377-380*
- **Huang Cunrui, Liang Haocai, Chen Jinhua.**  
*The Survey and Analysis of Non-governmental Hospitals in China, Chinese Journal of Hospital Administration. 2004, 20(6):333-335*
- **Huang Cunrui, Liang Haocai, Chen Jinhua.**  
*The Current Status and Prospect of the Non-governmental Medical Institutions in China. Chinese Health Economics, 2004, 23(1):57-59*
- **Huang Cunrui, Liang Haocai.**  
*The Research on Non-governmental Medical Institutions in China. Chinese Health Service Management, 2003,19(7):388-389*



## *India – Ujjain*

**Institution:** R. D.Gardi Medical College, Ujjain, India

**Principal Investigator:** Dr. Vijay K Mahadik

### **Research activities**

**2002-2004:** Survey and GIS mapping of public and private health care providers of Ujjain District. The study highlights the need to consider private providers in health policy in India. The study identified additional providers other than those registered with health authorities and individuals with no formal training constituted the majority of these. Formally trained doctors were highly concentrated in urban areas while untrained providers dominated in the rural areas. The study also demonstrated how GIS can be used to create an improved basis for health service research.

**2004:** Under a DANIDA sponsored project a model of public-private partnership was developed at primary health centres in Narwar, Ujjain. Private and public health providers were evaluated and trained for management of ARI/diarrhea in children under five in 30 villages. The study has been disseminated to the government.

**2004-2005:** GIS mapping of all private and public health care providers in Madhya Pradesh province (60.4 million inhabitants). 3 papers have published on this so far.

**2004-2005:** Policy maker interviews on perceptions on the private health sector, reasons for expansion, quality of care, motives for existence. One paper has been published on this. Another is in manuscript form.

**2005-2006:** In a study on health care seeking behavior of cough patients (2004-2006) it was identified that the majority seeks care from private providers and patient holding is better in the private health sector.

**2006:** A study assessing the interaction between private providers in Ujjain (rural and urban) and the public sector TB program carrying the title: *.Private health providers in Ujjain and the revised national TB control program – public, private or private-public mix?* was conducted. This study is currently under consideration for publication.

**2007:** A study assessing knowledge of HIV among private providers was done in Ujjain district. Stigma among these providers was also assessed using specially developed social interaction and prejudicial scales, with case vignettes involving both genders as clients. The data collection phase of the study is completed. Data is now being entered and cleaned.

### **Conference participation**

**2003:** One person participated in the iHEA fourth World Congress in San Francisco and presented a paper on health insurance.

**2006:** PSP Conference- “Private Sector in Health Care Delivery- Potentials and challenges” at Jinan (Shandong) China.

## Publications

- Kirti Deshpande, RaviShankar, Vishal Diwan, Knut Lönnroth, Vijay Kumar Mahadik, and Ram Krishna Chandorkar “*Spatial pattern of private health care provision in Ujjain, India: a provider survey processed and analysed with a Geographical Information System*”. *Health Policy* 68 (2004) 211–222. 2004.
- Grethe Fochsen, Kirti Deshpande, Ashwani Mishra, Vishal Diwan, Vinod Diwan, Anna Thorson. “*Health care seeking among individuals with prolonged cough and Tuberculosis: a population based study from Ujjain district, India.*” *International Journal of Tuberculosis and Lung Disease*, Volume 10, Number 9, September 2006, pp- 995-1000(6).
- Grethe Fochsen, Kirti Deshpande, and Anna Thorson “*Power imbalance and consumerism in the doctor-patient relationship: health care providers’ experiences of patient encounters in a rural district in India*”. *Qualitative Health Research*, vol. 16 No. 9, November 2006, pp- 1236-1251.
- DeCosta A, Saraf V, Jhalani M, Mahadik VK, Diwan VK: **Managing with maps? The development and institutionalization of a map-based health management information system in Madhya Pradesh, India.** *Scand J Public Health* 2007 (Accepted)
- DeCosta A, Diwan V: **Where is the public health sector? Public and private sector healthcare provision in Madhya Pradesh, India.** *Health Policy* 2007, In press doi:10.1016/j.healthpol.2007.1004.1004.
- DeCosta A, Johannson E, Diwan V: **Barriers of mistrust – Public & private health sectors perceptions of each other in Madhya Pradesh, India.** *Qualitative Health Research* 2007 (Accepted)
- DeCosta A, Eriksson B, Diwan V: **Characteristics and distribution of private health care providers in Madhya Pradesh, India.** (*Submitted to Human Resources for Health*)

### ***India – Thiruvananthapuram***

**Institution:** Sree chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, India

**Principal Investigator:** Dr. D. Varatharajan

**Other Investigators:** Dr. V. R. Muraleedharan (for a brief period in 2003)

### **Research activities**

In 2003, a project was undertaken in collaboration with Indian Institute of Technology, Madras to review the published and unpublished literature on the private sector performance in India. The review was completed in September 2003.

### **Other activities**

Dr. D. Varatharajan, in 2006, served as a co-supervisor to Ms. Anna-Klara Berglund, Karolinska Institutet, Stockholm, Sweden for her Master of International Health thesis on *'The role of NGOs in commercial sex workers interventions in the management and control of HIV/AIDS in Tamil Nadu'*. Sam Edwin from the institute also collaborated actively in the implementation of the study.

### **Conference participation**

**2005:** Participated in the fifth World Congress of the International Health Economics Association (iHEA), Barcelona, Spain, 10-13<sup>th</sup> July 2005

**2006:** Participated in the International conference on “Private sector in health in Jinan, China from 26<sup>th</sup> to 28<sup>th</sup> September 2006 organized by PSP Programme, Karolinska Institutet, Sweden.

**2007:** Participated in the sixth World Congress of the iHEA, Copenhagen, 8-11<sup>th</sup> July 2007

### **Capacity building**

Two members from the research team, Dr. Edwin Sam and Dr. Prasad, participated in the PSP training course on “Private Health Care: Developing Successful Policies and Programs” in New Delhi in May 2005

## *Lao PDR – Vientiane*

### **Research activities**

Study yet to be funded.

### **Conference participation**

Members of the Ministry of Health PSP team have participated in the following conferences through PSP:

**2005:** One person from the Ministry of Health PSP team attended the iHEA 5th World Conference in Barcelona, Spain.

**2006:** Two persons attended and presented at the PSP conference in Shandong, China.

### **Capacity building**

Two persons from Ministry of Health participated in the PSP training course on “Private Health Care: Developing Successful Policies and Programs” in New Delhi in May 2005

## ***Uganda – Kampala***

**Institution:** Makerere University School of Public Health (Formerly Institute of Public Health)

**Principal Investigator(s):** Joseph Konde-Lule, Sam Okuonzi

**Other Investigators:** Charles Matsiko, David Mukanga, Virgil Onama, Sheba Nakacubo Gitta

### **Research activities**

#### **October 2004 – January 2005: preparation for the study**

During this period, investigators prepared for field work. Activities included: a pre-visit by investigators to the proposed study sites, recruitment and training of research assistants, pilot testing and finalizing the research protocols.

#### **January 2005 – July 2006: data collection and report writing**

- January – June 2005, data was collected in the three study districts. This involved conducting household and health facility surveys, health provider mapping exercise, focus groups discussions with community members as well as interviews with policy makers.
- Data entry and preliminary analysis were performed concurrently with data collection.
- The investigators made data validation field visits in September 2005 and February 2006.
- The final research report “*The potential of the private sector to improve health outcomes in Uganda*” was submitted to Sida, Kampala and Karolinska Institutet in July 2006.

### **Main research findings**

- Informal providers (mainly traditional healers [67.4%]) were the most numerous among mapped health providers.
- However, a majority of community members, who reported illness in 30 days prior to survey, visited a formal provider (56%) or self-treated (41.2%). The most frequently visited formal providers belonged to the private sector (58%).
- The range of services provided by formal health facilities addresses the common problems in the community. The public and private not for profit (PNFP) sectors provide more preventive services than the private for profit (PFP) sector.
- Quality of care in PFP facilities is compromised by employment of unqualified personnel and lack of/limited support supervision.
- PFP facilities lack a functional health management information system.
- Private health facilities have longer working hours and more often offer credit services than public facilities; thus being more accessible to patients.
- Referral is a common practice both within and between the private and public health sectors; however, it is often informal and undocumented.
- Laws to regulate the private health sector were introduced 10 years ago, with the main intention of promoting the formal private sector.

**Dissemination of Findings: July – November 2006**

Study findings have been shared at both district and national levels. Dissemination workshops were held in September 2006, in each of the study sites. Participants included community representatives, health care workers from both private and public facilities, traditional healers, the district health teams and local leaders.

A national dissemination workshop was conducted in November 2006 in Kampala, the capital city of Uganda. Participants included Ministry of Health officials, district representatives, traditional healers, private health care providers, as well as representatives from academia and development partners.

**Publications**

Study findings were compiled into a report on “The potential of the private sector to improve health outcomes in Uganda” which was published in July 2006. Copies of this report have been distributed at the local dissemination workshops, university libraries and copies availed to Ministry of Health.

Plans are underway to submit manuscripts to both local and international journals. The team also plans to write policy briefs which will be presented to the Ministry of Health.

**Conference participation**

- In 2003, two researchers attended the iHEA fourth World Congress in San Francisco.
- During July 2005 two researchers from the Uganda PSP team attended the iHEA 5th World Conference in Barcelona, Spain. Preliminary findings from the Uganda study were presented during the conference.
- Two representatives from the Uganda PSP team attended and presented at the PSP conference in Shandong, China in September 2006.
- In 2007, two researchers presented findings from the main study during the sixth IHEA World Congress in Copenhagen.

**Capacity building**

During April 2005, two members of the Uganda PSP team attended the PSP training course “Private Health Care: Developing Successful Policies and Programs” in New Delhi, India.

## *Vietnam – Hanoi*

**Institution:** Health Policy Unit, Ministry of Health

**Principal Investigator(s):** Nguyen Hoang LONG

**Other Investigators:** Duong Duc THIEN, Phan Thanh THUY, Pham Duc MINH

### **Research activities**

From 2004-2006, a study was conducted by the Health Policy Unit in the Ministry of Health aiming to describe the situation of private health sector in Vietnam and investigate their role and potential in health service delivery. The study include two sub-studies; sub-study 1 reviewed current status of the private health sector in terms of size, operational types, distribution, development trend as well as policies/regulations affecting their performance. Sub-study 2 explored the nature of private health sector, its roles and expectations to government in Bac Giang province. The study was supported by Sida through the Vietnam-Sweden Health Cooperation in Hanoi.

### **Main findings and conclusions**

In short, the study concluded that private health sector has taken an increasingly important role in health service provision. With the increased presence of private providers, people's access to health services will be improved. Many private health facilities are located close to people and it is very convenient for patients to early detect disease and take regular and timely action.

Private health sector also helps in reducing overloading of public facilities and generate more options for patients to choose health facilities appropriate with their diseases and economic conditions. Private health sector development has had a strong impact on public health facilities, creating competition and forcing public facilities to improve quality of services and concentrate on complicated and specialized techniques to promote the decisive role of public health sector. The size and scale of private facilities is quite small. There is a limitation in technical and professional quality of private health sector, especially facilities in rural areas. There is overuse of diagnostic services in some private health facilities; not following regulations regarding prescription, mainly prescribing unnecessary imported and expensive products.

### **Recommendations**

Given the importance of private health sector, the government should consider the private sector as an indispensable part of Vietnam's health system. Government must encourage private health sector to develop larger scale facilities in urban areas and support training activities to improve private providers' capacity to provide better primary health care. Further the government can improve quality of private health services by tightening regulations of safe medication. Supervising and checking the conformation of guidelines to avoid drug abuse is of great importance. Data collection from private health sector needs to be strengthened and integrated into national health information systems.

### **Conference participation**

Researchers from the Health Policy Unit have participated in the last two iHEA congresses. In 2005, findings from work on the roles of the private health sector in providing primary health

care from the Vietnam National Health Survey 2002 were presented at the iHEA congress in Barcelona. Representatives from the team also attended the PSP conference in Jinan, China in 2006. Finally findings from the study on current situation and potentials of private health sector at basic level, a case study in Bac Giang province, Vietnam was disseminated at the Copenhagen congress in 2007.

### **Capacity building:**

- One staff member from the Health Policy Unit participated in the PSP training course “*Private Health Care: Developing Successful Policies and Programs*” in New Delhi in May 2005.
- One staff member obtained a Master of Public Health degree through a training programme at Umeå University in Sweden with the support of PSP funding.

### **Publications**

- **Long NH, Thien DD, Thuy PT, Minh PD**  
“*Current situation and potentials of private health sector at basic level, a case study in Bac Giang province*”, Medical Publication House”, Hanoi 2006



## ***Zambia – Lusaka***

**Institution:** Department of Economics, University of Zambia

**Principal Investigator(s):** Webby Wake

**Other Investigators:** Dale Mudenda, Pamela Nakamba Kabaso, Chrispin Mphuka, Jesper Sundewall, Margaret Maimbolwa

### **Research activities**

In 2002/2003, a pilot study was conducted in Lusaka district to test the research protocols developed by the PSP. The pilot study was followed up in 2005/2006 when a larger study of private health care providers and their clients were conducted in two districts (Chingola and Lundazi). The main study was supported by the Sida, Lusaka.

### **Main findings and conclusions**

In short, the study concluded that the size of Zambia's private health care system extends beyond what is currently documented. Considering the difficulties associated with the study of informal providers (traditional healers, drug vendors etc) in general, this finding could be an underestimation of the size of the private sector in the two studied areas, especially the informal sector. Quality of care in the informal sector tends to be lower than in the formal sector and their practices are unregulated. Also, the traditional practitioners seem to cater for a population with lower income, but charge higher prices. Given the size and importance of the private sector in Zambia, especially the informal sector, the government should take a stronger role in regulating the sector and also find ways of better utilizing the private sector to meet national health objectives. Utilizing the private sector should be possible as most providers expressed willingness and interest in collaborating with the government.

### **Conference participation**

Researchers from Zambia have participated in the last three iHEA congresses. In 2003, findings from the pilot study was presented at the iHEA Congress in San Francisco and in 2007, findings from the main study was disseminated at the Copenhagen congress.

Two researchers from the Department of Economics also attended the PSP conference in Jinan, China in 2006.

### **Capacity building**

Two staff members from the Department of Economics participated in the PSP training course "Private Health Care: Developing Successful Policies and Programs" in New Delhi in May 2005.

### **Publications**

- Wake, W., Mwikisa, C., Sundewall, J. and Forsberg, B.C. "A Pilot Survey of Private Health Care Providers in Lusaka District", in Policy Lessons and Emerging Challenges in the Zambian Health Sector 2000-2005, Cheelo, C., Ndulo, M., and Ödegaard, K. (Editors). 2006, The Swedish Institute for Health Economics. Department of Economics, University of Zambia: Lund. p. 225-45.

- Wake W, Sundewall J, Mudenda D, Mphuka C, Maimbolwa M and Forsberg B C.. **“Private health care in Zambia: findings from provider and client surveys in two districts”**. Lusaka: Dept of Economics, 2008.

## Annex I

### STATEMENT

#### **by Participants in the Shandong Research Conference on the Private Sector in Health Care Delivery**

Researchers from a collaborative international programme on the role of the Private Sector (PSP) in health and policy makers and international scholars met in Jinan, Shandong Province, China, September 26-28 September 2006 for a conference on “The Private Sector in Health Care Delivery – Potentials and Challenges”.

The conference heard findings from six countries involved in the PSP programme: China, India, Laos, Vietnam, Uganda and Zambia. Researchers and policy makers from China also shared experiences regarding private sector involvement in health in China. Presentations were also given by scholars from the World Health Organization, The Alliance for Health Policy and Systems Research, the Bangladesh Rural Advancement Committee (BRAC), the World Bank, UCLA, Harvard School of Public Health, and Karolinska Institutet, Sweden.

- Findings from two districts in Zambia indicate that informal providers constitute more than 75% of health care providers.
- District level studies in Uganda show that people’s positive assessment of the skills of informal providers contributed to their decision to use these providers. Yet, very little is still known about quality of care among informal health care providers. More information is needed on how less than fully qualified providers can be better utilised by governments to deliver services, especially in under-served areas.
- Research conducted in Guangdong, China, indicated that health services offered by private qualified providers are growing rapidly and that patient satisfaction is generally higher among clients of private health care providers than among those of government health providers.
- In Shandong, China, study results showed that over 60% of ambulatory services are provided through private providers in rural China. No significant differences among rural government and private primary care providers were detected in their “appropriate” prescribing behaviour.
- Studies conducted in India showed that pharmacists, village health nurses, qualified doctors and less than fully qualified providers are all potential partners to the government in HIV/AIDS control.

Based on this, and a wealth of other data presented at the conference, participants concluded that private health care providers are a significant part of national health systems in most low- and middle-income countries (LMC) today. Private sector providers already account for a large share of access to basic health care services and they contribute significantly to public health outcomes. Public-Private Partnerships (PPP) have emerged as one of the main areas of innovation in health development; such partnerships can be created around health care provision, research, technology and communication and other relevant fields of work. There are many mechanisms through which the public sector can work with non-governmental providers, including the provision of subsidies, training and technical strengthening,

contracting out and in, and regulation. More information is needed on how these mechanisms can be optimized for improved health outcomes.

Meeting participants noted that inadequate attention, at both global and country levels, is paid to critical issues around the growth and role of the private health sector in health care delivery. Too often, governments do not have clear policy frameworks to guide their engagement with the private sector. The lack of basic, routine data on the size, form and behaviour of the private sector is an impediment to sound strategic policy development. Furthermore there is limited global knowledge on the effectiveness of different mechanisms to engage private sector providers.

In light of this, participants at the meeting jointly called for:-

- **Governments in low- and middle-income countries** to give greater recognition to the role that the private health sector plays and to develop clear policies that can guide national and local governments work with the private sector, as strategic partners in health care delivery, with the aim of strengthening public health and access for all to health services.
- **Governments in low- and middle-income countries, their development partners, and international collaborators** to invest in developing reliable, routine information on the private health sector, through, for example, the development, conduct and analysis of regular facility surveys, complemented by other routine data sources where feasible.
- **Research funders** to increase their investment in synthesizing existing studies and conducting new research, especially on well designed and rigorously evaluated intervention studies. This should increase knowledge on the effectiveness of tools and mechanisms that governments can use to engage the private sector, to help reach the poor and promote good quality care; all for improved health outcomes.

Meeting participants acknowledged that the time is ripe for a broader, more open network to be created for scholars and policy makers interested in issues related to the role of the private sector in health care delivery and public health. Such a network should be centred around the need to generate more evidence and knowledge on the way private actors operate and how they can be engaged in improving health care and health outcomes. Meeting participants undertook to investigate how the existing PSP collaboration could be transformed into such a platform for the exchange of policy-oriented evidence and debate.

## Annex II

### Abstracts of selected findings from the country studies

(Excerpts from the Shandong Conference Report)

*The role and scope of non-government and private health sectors in China: - the case of village private health practitioner in rural areas, Shandong.*

**Professor Jiangbin Qu**

**Center for Health Management and Policy, Shandong University**

#### **Introduction**

The development of the private health care sector in China is closely related with China's overall political, social, and economic systems. Since private medical practice was allowed in 1982, the scope of the private sector in health care has been steadily increasing. In China, the majority of private practitioners are located in rural areas due to the disorganization of village collective economy and the collapse of the Cooperative Medical System (CMS). At present, the private sector is a major provider of ambulatory health services in the rural areas. In order to understand the roles and scope of private practitioners in rural health care system, a survey was conducted of 83 village clinics and 146 health providers in rural in Shandong, China.

#### **Objectives**

- To understand the current development of private village clinics.
- To gather evidence on type and quality of services and compare performance between public and private health care providers.
- To identify the potential and bottleneck issues for involving the private sector in public health activities.
- To develop policy recommendations and intervention proposals for the government on how to improve the private health sector in order to build an appropriate rural health system.

#### **Methodology**

*Data collection methods:*

- Review of documents and literature;
- Field survey with questionnaires for information on clinics, health practitioners and out-patients;
- Key informant interviews at provincial, county and township level.

#### *Study sample*

Three counties were selected according to geographical locations and level of economic development (high, middle and low). In each county, three townships were selected according to level of economic development (high, middle and low). In total, 9 townships were selected. In each township, 6-8 village clinic were selected at random, and all health providers from the selected clinics were investigated (83 clinics and 146 health providers in total). In each clinic,

5 out-patients who utilized health care within 10 days prior to the survey were interviewed. In total, 420 out-patients were interviewed.

## Results

Of the studied clinics, 30 percent were owned or operated by township health centres or by the village collective (defined as public by the research team). The remaining 70% were owned by individuals or jointly by village doctors (defined as private by the research team).

Buildings and equipment in some private clinics were more basic compared to the public clinics. Also, compared with public clinics a “three low phenomena” was observed in terms of low general educational level of village doctors, low professional training level and low quality of services of private providers. Furthermore, only two types of revenues existed in the clinics. The main source of revenue was from drugs sale (90%), the other was from user fees (10%) in the two kinds of clinics. It was also noted that health care procedures are not according to standards, especially in private clinics. These include:

- Record-keeping (case history): 65% of the public clinics and 22% of the private clinics kept proper records of their patients.
- Use of out-patient prescription slips: 95% of the public clinics and 17% of the private clinics used prescription slips.

### *Comparison of standard of health services in public and private clinics*

Item	Public clinics	Private clinics
Use prescription slips	95%	17%
Use out-patient medical record (case history)	65%	22%
Use out-patient registration	95%	60%
Use report card for infectious diseases	95%	69%

Finally, quality of health services is low in both public and private clinic, but especially in private clinics.

Two cases were presented to the providers; common cold in adult and a 5 year old child with diarrhoea. The village doctors were asked to give diagnosis and prescriptions. A panel of paediatricians and physicians were then organized to assess the quality of prescriptions according to the scoring system presented below.

*The contents of prescription evaluated according to (full mark = 100);*

- Clearly written (score: 7)
- Correct drug name (score: 10)
- Correct dosage, standard and utilization (score: 30)
- Total dosage is rational (score: 30)
- No dispensation taboo, no overlap (score: 15)
- Correct diagnosis (score: 8)

For common cold there was no significant difference between the scores given to public and private providers. For childhood diarrhoea public providers performed better than private providers in rational choice of drugs and drug dosage.

The survey also found that village clinics were not involved in public health care provision due to lack of financing from the government. Compared to public providers, there was lack of equality in the policies of private clinics in rural areas.

### **Discussion and policy implications**

The private sector plays a major role in ambulatory health service (60%) in rural areas. Hence the important complementary role of the private sector should be recognized. Furthermore, the private village clinics break the monopolistic situation of public health care facilities which existed under the planned economy period and have introduced consciousness of competition in rural health care. Private health care has also promoted the development of a rural health care system and increased access to basic health care for rural residents. Finally, development of private health care can increase the health resources for rural health and counteract the shortage of government health financing in rural areas.

### **Recommendations**

- The government should take measures for professional retraining of both public and private health practitioners, to improve professional quality.
- Supervision and regulations are needed for proper management of private village clinics.
- Supervisors should treat the public and private clinic equally and encourage fair competition (equality in policies).
- The government should increase the budget to village clinics, including the private sector and encourage private sector involvement in public health service provision.
- Further intervention studies are needed on how to build public-private partnerships in health.

## *Non-governmental medical services in Guangdong province, China*

**Professor Haocai Liang**

**School of Public Health, Sun Yat-sen University, Guangzhou, China**

### **Introduction**

Traditionally, governmental hospitals have been the main provider of medical services in the cities of China. In recent years, however, non-governmental hospitals have come up since the policy of reform and opening-up came into being, but growth has been slow and difficult. Currently, information concerning the non-governmental hospitals is still lacking. We do not know the amount, sorts, quality and fee of the services provided by the non-governmental hospitals. Neither do we know what problems exist in their development or what policies should be developed by the government to administer the non-governmental hospitals.

### **Objective**

To provide evidence to the government about the development of non-governmental medical service in Guangdong province, China.

### **Methodology**

A combination of quantitative and qualitative methods, including questionnaires, observations and interviews was used.

### **Results**

#### *The status quo of non-governmental hospitals*

There are 138 non-governmental hospitals in Guangdong Province. They represent 5.7% of all 2410 hospitals in the province. Furthermore, the non-governmental hospitals are weak and have a market share of merely 3% of all service provided. The distribution of non-governmental hospital is imbalanced and most of them are located in the more developed areas of the Pearl River Delta.

#### *The ways and characteristics of non-governmental hospitals' management*

a. Emphasize specialty feature; b. Strict management and flexible allocation; c. Emphasize patient-centred conception, the attitude and quality of medical services; d. attach much attention to person with ability; e. Focus on marketing themselves and presenting a social image.

#### *Major difficulties for non-governmental hospitals in their development process*

a. Governmental policy is not adequate to support the development of non-governmental hospitals; b. the heavy tax; c. no standard of consumption and difficult operation of price; d. scarcity and frequent staff turnover; e. poor social approval; f. management

#### Comparative research on patient satisfaction between the private and public hospitals

Two hospitals in Dongguan city, Guangdong Province were selected (one public and one private) to compare patient satisfaction between the two sectors. The selected hospitals are the two largest hospitals in Dongguan city and are already competing for customers. Questionnaires were returned from 2,138 patients, including 1,199 in-patients and 939 out-patients. 1,192 of in-patients and 927 of out-patients responses were valid (600 in-patients in private hospitals, 592 in-patients in public hospitals, 446 out-patients in private hospitals and 481 out-patients in public hospitals).



### *Demographic characteristics*

Among out-patients there were significant differences ( $P < 0.05$ ) in age, marital status, occupation, education level, household income, residence and sort of payment between the private and public hospital. In the in-patients group, significant differences ( $P < 0.05$ ) were found in gender, age, marital status, occupation, education level and residence between the private and public hospital. Among both out-patients and in-patients more than 60 years old, the group going to private hospitals was smaller than that going to public hospitals. Also, the patients in private hospitals had a higher level of education and household income.

### *Outpatient satisfaction*

The average score for out-patient satisfaction in private hospital was 70.16, ranging from high to low with regard to “medical environment and facilities” (80.29), “doctor and nurse service” (75.45), “checking and assistant section office’s checking” (75.37), “treatment outcome” (70.06), “waiting time” (67.77), “informed choice” (64.75) and “medical expenses” (60.50). The average score for out-patient satisfaction in public hospital was 69.37. Scoring ranged from above average for “doctor and nurse service” (76.24), “checking and assistant section office’s checking” (72.58), “treatment outcome” (72.57), “medical environment and facilities” (72.21) to below average for “informed choice” (68.62) and “medical expenses” (61.61).

The results were compared using multiple regression analysis. The total mark for out-patient satisfaction in the private hospital was significantly higher than that of the public hospital ( $P < 0.05$ ). There was, however, no significant difference in “medical expense” and “doctor and nurse service” ( $P > 0.05$ ). Satisfaction in the private hospital is significantly higher than that of public hospitals with regard to “waiting time”, “checking and assistant section office’s checking”, “treatment outcome”, “medical environment and facilities” ( $P < 0.05$ ). Finally, satisfaction of “informed choice” is lower in the private than in the public hospital ( $P < 0.05$ ).

### *Inpatient satisfaction*

Average score for in-patient satisfaction in the private hospital was 76.59, ranging from “process to be in hospital” (85.53), “medical environment and facilities” (85.43), “nurse service” (83.26), “doctor service” (80.96), “assistant section office’s service” (79.97), “treatment outcome” (75.53), “informed choice” (64.40), “medical expenses” (61.50) and “meals supply” (60.07). Average in-patient satisfaction scores in the public hospital was 76.55. The scores ranged from high to low with “process to be in hospital” (85.39), “nurse service” (82.54), “doctor service” (81.80), “medical environment and facilities” (78.75), “assistant section office’s service” (78.22) and “treatment outcome” (77.67) scoring above average. On “informed choice” (68.25), “meals supply” (64.94) and “medical expenses” (61.94), however, scores were below average.

Multiple regression analysis was used to compare the scores between the public and the private hospital. The analysis showed that there was no significant difference between in-patient satisfaction in the private and public hospital ( $P > 0.05$ ). Neither was there any significant difference in the satisfaction of “process to be hospitalized”, “doctor service”, “nurse service”, “medical expenses”. Satisfaction of clients was significantly higher in the private hospital than in the public hospital with regard to “assistant section office’s checking”, “medical environment and facilities” ( $P < 0.05$ ); Finally, satisfaction with “treatment outcome”, “meals supply” and “informed choice” was significantly higher in the public hospital.

**Policy implications**

1. The government should fully realize the functions of non-governmental medical service and avoid treating them unfairly.
2. The government should bring the development of non-governmental hospitals into national health development programs, and break the government hospitals' monopolistic position.

## *Dual practice among public health providers in Vietnam*

**Ms. Phan Thanh Thuy**  
**Health Policy Unit, Ministry of Health, Vietnam**

In Vietnam, private health practitioners are divided into two groups; purely private practitioner and government staff engaging in practice off-hours. The Vietnam National Health Survey 2001-02 (VNHS) results indicate that 51.2% of government staff working in public facilities engage in private practice off-hours (dual practice – DP). Among government staff with private practice, 43% are working at the grassroot level and 44% practice without license. Doctor and doctor’s assistant account for 41.2% and 42.3%, respectively. Midwife, traditional medicine practitioner and nurse account for less than 10%.

Main reason for dual practice is to get additional income due to low salaries of public practitioners. Another reason is that the public practitioners are motivated to use or improve their skill but their job in public facilities is either mainly routine low-level services or administrative and managerial. But why do they then still stay in public facilities? The reason is that the two jobs complement each other, private practice being primary source of income but public practice providing stability, prestige, higher training opportunities and better working conditions.

Positive outcomes of dual practice are reducing budgetary burden to recruit and retain skilled staff in public health sector, increasing access (distance, service time) to qualified health providers (e.g., well-trained and experienced), reducing burden (patient load) on public health facilities. However, there are a lot of negative outcomes of dual practice including (1) competition for time; physicians replace hours they should work at the government facilities with hours in their private clinics. (2) Conflicts of interest for their own benefit; dual practitioners may send patients in the public facilities for care and treatment at their own private clinics. (3) Outflow of resources; misuse of the public sector’s means of transportation, office infrastructure, stationeries, consumables, medicines and personnel for private practice. (4) Abusive behaviour; dual practitioners use their authority to prescribe treatment for their patients to generate additional demands for their own services leading to financial burden on patients. (5) Cream skinning; dual practitioners taking easy-for-profit patients, and easy-for-profit services from patient, leaving difficult cases to the public sector. (6) Labour reproducing; in addition to official working hours in public sector, dual practitioners may work for 4-6 off-hours which is likely to reduce quality of working hours in the public sector. (7) Brain drain; public-to-private migration compounds the rural-to-urban migration because cities also offer more opportunities to diversify income generation.

Therefore, the issuance of clear regulations on private practice for in-service government medical staff is needed. In the “Ordinance on private medical and pharmaceutical practice” issued in 2003, the Government prescribes conditions and measures to restrict and proceed to ban state employees from private medical and pharmaceutical practice as from December 31, 2010. This has led to much feedback, positive and negative, from health workers as well as from society.

All policy options on dual practice should take into careful considerations the comprehensive socio-economic and cultural impacts (on whole society, patients, public and private, DP, Govt authorities etc). Paying doctors enough to match total public and private income is unlikely to

be feasible or sustainable in a poor resource context. Prohibition is generally unlikely to be effective, it only drives dual practice underground and makes it difficult to avoid and correct negative effects. When regulatory capacity is weak and the resources are poor, dual practice may be seen as part of a solution rather than a problem.

The recommendations are minimizing negative outcomes of dual practice and try to increase the public service motivation of providers by

- (1) paying salaries and wages according to outputs' quality and efficiency (Decree 10/2002, Decree 43/2006);
- (2) self-regulation related to an individual's reputation as a doctor in public practice, which influences income generating capacity in private practice;
- (3) defining the professional value systems to differentiate good services from bad;
- (4) establishing professional associations to create peer pressure, support members to maintain their personnel, inform the public of their rights;
- (5) creating opportunities for users to voice their discontent effectively;
- (6) improving working conditions: equipment, training, etc.;
- (7) regulating private practice' conditions, rights and obligations and monitoring and supervision.

## *The quality of health care services in private clinics in Laos*

**Mr. Phisith Phoutsavath**  
**Ministry of Health, Laos**

### **Background and objectives**

According to the private clinic regulation of 1991, private clinics are categorized into two types; Type 1 (private clinics open 24 hrs/day) and Type 2 (private clinics open after hours). Furthermore, they are classified according to characteristics namely if they are (i) General clinics, (ii) Traditional medicine clinics or (iii) Specialist clinics. There are in total 401 general clinics, 61 traditional clinics and 119 specialist clinics in Laos. Finally, private clinics are divided into three different levels as per:

- Level 1: Clinic using medical equipment with high technology
- Level 2: Clinic using medical equipment with general or middle technology
- Level 3: Clinic using basic medical equipment

It is recognized that the public health services cannot cover all areas of the country, especially the remote and rural areas. The development of the private health sector in Laos has had both positive and negative impact on improving health care treatment of people. Government policies aim at reducing poverty and improve quality of life. The private sector has been recognized as part of a comprehensive approach to improve health care services. No detailed studies regarding the role and quality of private health care in Laos has, however, been conducted.

Thus, the objective of the proposed research is to provide evidence on non-governmental health care providers in Laos to allow for the design of interventions contributing to improved health of the population.

More specifically, the objectives of the research are:

- To explore facility factors and quality of service among private health care providers.
- To assess knowledge and practice of private providers in private clinics.
- To assess drug prescription patterns using standard treatment guidelines (ARI and diarrhoea).

### **Methodology**

The study is a descriptive, cross-sectional study focusing on all general private clinics at all levels in the target areas (Luang-Prabang, Champasack, Savannakhet and Vientiane). Methods for data collection will include structured interviews, document review, checklist for evaluation of clinical facilities and case scenarios for communicable diseases.

### **Expected results and outcome**

The research is expected to generate evidence on private facilities, equipment and services provided, but also on the knowledge of the practitioners and their adherence to standard treatment guidelines. In a longer-term perspective, the study seeks to contribute to improving the quality of non-governmental health care services in Laos and ensure that private medical practitioners are using standard treatment guidelines in the practice.

***Attitudes of health care providers towards developing public-private partnership addressing acute respiratory infection and diarrhoeal diseases in children in Ujjain, India.***

**Dr. D A Dev**

**R.D. Gardi Medical College, Ujjain, India**

**Aims and Objectives**

1. To create a database of the public and private health care providers and facilities for diagnosis and management of ARI and diarrhoea in the study area.
2. To study knowledge, skills and practices related to the management of ARI and diarrhoea.
3. To study attitudes of the health care providers towards developing a model of public private partnership.

**Methodology**

Trained surveyors carried out a census of all health care providers in the study area using a structured questionnaire. They also inquired about their background information, qualification, experience, medical system of practice and types of morbidities diagnosed and treated. The questionnaire also included questions to assess provider's knowledge, skills and practices regarding diagnosis and treatment of ARI and diarrhoea. Health care providers were then separately interviewed with the help of a semi-structured questionnaire which covered the provider's willingness to collaborate with the government in the management of the tracer conditions and the reasons for the same. It also explored the expectations that would need to be considered for public-private collaboration to succeed.

**Results**

A total of 90 health care providers were identified in the area. The majority (80%) were private providers and the rest (20%) public providers. Private providers consisted of Jan Swasthya Rakshak (31%) who were practitioners trained in management of minor ailments, identification of danger signs and timely referral. Female health care providers were trained birth attendants in the villages who conduct home deliveries. More than half (57%) practiced allopathic system of medicine and the rest practiced combination of systems. Most (80%) run a clinic, though without admission facilities. Providers observe almost all kinds of morbidities but mostly fever cases, respiratory infections and diarrhoea cases. Providers were not qualified enough to prescribe antibiotics, injectables, intravenous fluids and steroids but still practiced prescription of the same. Allopathic medicines were prescribed in combination with ayurvedic medicines.

All the providers accepted that some form of linkage is required between private and public health care providers which can be in the form of training (80%), recognition of unqualified providers (34%) and/or incentives for their services by the government. Private providers had the opinion that linkage with public health care providers will improve their practice (54%), benefit the patients (51%), and decrease the patient load on the government facilities. Conditions for partnership with the public sector were monetary incentives (77%), supply of drugs (74%) and training (67%).

All the public providers agreed to the partnership for decreasing the patient load (38%), patient benefit (69%) and decreasing expenditure on illness. Ways to involve the private

providers suggested by public providers were training (46%), giving them recognition (7%) and incentives (23%) for collaboration, including referrals of patients.

Public providers also indicated the possible risk of partnership with private health care providers. Most public providers (92%) think that there are risks associated with public-private partnership if unqualified providers are included without proper training and regulations.

### **Discussion**

As revealed by the present study all the health care providers recognized a need for public private partnership in public as well as private health care systems. The attitude of the providers towards developing this partnership was favourable but there were some mutual suspicion and demands for participation in the partnership. The study indicated that the private providers intend to safeguard their personal interests in order to collaborate with public providers and public providers expressed concern over the risks of partnerships.

The private health sector in India consists of diverse groups of health care providers practicing different systems of medicine. A considerably large number of private providers are unqualified and it is a challenge to regulate and mainstream these providers. Their existence cannot be neglected when designing models of public-private partnership as most of the poor living in rural areas; urban slums and remote parts of India are served by private providers. The public health system often fails to serve the poor population or is less popular and those private providers who are qualified are concentrated to urban areas.

There are possibilities for developing models of public-private partnerships but they require first a situational analysis to understand factors facilitating and hindering such partnerships.

## ***Potential non-government partners for public-private partnerships in HIV/AIDS control: A survey of a Tamil Nadu district in India***

**Mr. Edwin Sam**

**Achutha Menon Centre for Health Science Studies, Trivandrum, India**

### **Introduction**

In India, 5.7 million people are HIV positive. Tamil Nadu is one of the high HIV prevalence Indian states accounting for 7 of 49 high-prevalence districts in the country. The state faces fresh challenges as infections have moved from 'high-risk' to general population through 'bridge' populations. The state has to think about fresh strategies to effectively deal with the emerging scenario as the conventional strategy of focusing on 'high-risk' cases will no longer yield results. Since sources of infections are increasingly unknown, there is a need to test hitherto unknown means of detecting new cases. This paper aims at enlisting new potential actors for Public-Private Partnership to successfully control HIV/AIDS. The focus of the paper will be on identifying new sources of infection, and the providers of care.

### **Objective**

The main objective of the paper is to identify the hitherto unknown 'risk' groups, map the actors who are in a position to identify new cases, and to provide a typology of providers 'treating' HIV/AIDS cases

### **Methodology**

The study is being carried out in one of the 7 high-endemic districts of Tamil Nadu state in India. It includes 24 focus group discussions (FGD) with various community groups and stakeholders (health care staff, teachers, barbers, washer men/women, lay community, youth club, cine fan clubs, traders, and others). In total 220 people participated in the discussions. The objective of the FGDs is to identify hitherto unknown 'risk' groups in the general population, to spot various 'actors' who are likely to identify a case first, and to enlist 'providers' of all forms. Second stage would elicit data from 'provider' groups using a checklist and an interview schedule. In total, 42 providers were interviewed (16, qualified, 9 trained but less than fully qualified (LTFQ) and 16 untrained LTFQ).

The results from the focus-group discussions were divided into groups covering the following themes:

- Perceptions about (high-risk) sexual practice (for example use of condoms)
- Known targeted risk groups (for example sex workers, drug users, truck drivers)
- Unknown, non-targeted, risk groups (for example construction workers, industrial workers, daily wages, college students, village dancers, police)
- Health seeking behaviour (with regard to HIV/AIDS)
- First contact point; 1. Pharmacy, 2. Doctors/hospitals, 3. Less than fully qualified providers (untrained), 4. Lodge based practitioners, 5. Kaimarunthu, 6. Less than fully qualified providers (trained).
- Reasons for the choice of provider (Nearer, Cheaper, No other alternatives, Fear, Confidence, Relationship with the patients, Respect for people)



**Results/Policy Implications**

- High risk sexual practices appear to be widely prevalent in general as well as high-risk populations.
- Many seek health care based on TV, paper and other media advertisements who claim that they have treatment for curing HIV/AIDS.
- Significant numbers of less than fully qualified providers are treating STD/HIV cases.
- Pharmacists, village health nurses, qualified doctors who are not treating at present and less than fully qualified providers could be potential partners in HIV control and therapy.

This is an ongoing study and the first stage is in progress now. The results will be classified into three types – new risk groups, potential actors to identify the cases, and the providers who may be used to refer the cases. A sketch of these three groups will provide valuable data and information to the policy makers to draw up policy so as to catch the cases early.

## ***Streamlining private out-of-pocket spending through Medisave: rural women's willingness and ability to pay for Medisave in the Karnataka, India***

**Dr. Varatharajan Durairaj**

**Achutha Menon Centre for Health Science Studies, Trivandrum, India**

### **Introduction**

The share of government health spending in India is one of the lowest in the world (23.9% of total health expenditure). Given that health insurance (social/private) is also under-developed, there is an excess reliance (73.5% of total health expenditure) on private out-of-pocket expenditure as a financing option for health care. Household spending on health has increased at a rate of 13.9% per annum during the last decade. Studies have shown that the burden is proportionately high for the resource poor. It is also inequitable as women receive less allocation from it due to unfavourable intra-household power relations. Even government expenditure targeting women do not reach them due to various reasons. As a result, women's health care needs are under-serviced. Streamlining private out-of-pocket expenditure is a major challenge and is the need of the hour for India. This paper proposes medical savings account as an option for streamlining it.

### **Objective**

The objective of the paper is to present estimates of rural women's willingness and ability to pay for Medisave (medical savings) accounts in Karnataka.

### **Methodology**

The study covered a population of about 32,000 from 27 backward villages, underserved by banks, in three districts of Karnataka state in India. The survey covered all households in these villages and all women present were interviewed, among other things, about their willingness to participate and pay for medical savings account. Out of 8,668 women interviewed, 600 women without prior banking experience were chosen for opening Medisave account in their names. Accounts were already opened in January 2006 and preliminary results about their ability to save are now known. The analysis is being carried out across various socioeconomic groups (based on literacy, caste, income, poverty, etc.).

### **Results**

About two-third of the surveyed women were socially backward and 58.8% were economically backward. An average of 55.0% women expressed their willingness to participate in Medisave. The rate was high among Scheduled Caste/Tribes (68.6%), most backward (63.3%), and landless (64.9%) women. It was around average for literate, married, and widowed/divorced women. Finally, the willingness to participate was low among never married (34.1%), forward (43.3%), unemployed (44.7%), regular readers/viewers of news (52.0%), and women lacking access to TV (51.4%).

Women were on average willing to pay US\$ 1.47 per month. Never married, widowed/divorced and forward women are willing to pay 13.3% less, while backward and literate women and those who enjoyed autonomy to spend money and to seek care were willing to pay 13.3% more. On the other hand, news viewers/readers were willing to pay 33.3% more than the average. Actual contribution to Medisave fell short of the willingness to pay by 53.7%.

### **Discussion**

Results showed that the willingness to participate in Medisave was quite high among rural backward women. The highest willingness was expressed by women hailing from households earning an income below the poverty line (about a dollar per day) indicating that even the poorest women were deprived of free government health care. Average savings by the women went up from less than US\$ 0.10 to 1.20 per month in six months indicating that women were increasingly convinced that savings was one secure form of pre-payment for health care.

## *Effect of policy on the growth of the private health sector in Uganda*

**Dr. Sam Okuonzi**

**Makerere University Institute of Public Health, Kampala, Uganda**

### **Background**

During the early 1990's the government of Uganda recognized the potential of the private health sector in providing health care, especially curative services. Conscious efforts have been undertaken by the Uganda government to remove barriers of entry for private providers. This led to that in 1995, three laws were enacted to stimulate growth of the private health sector. The laws made private practice legal for a wide range of medical professionals including nurses, clinical officers, laboratory technicians, dental assistants and others given that they followed four prerequisites. The prerequisites included that the provider must be trained, registered (with a professional association), supervised and, if needed, disciplined. Ten years later, the effects of these regulations have not been fully assessed.

### **Objective**

To establish a typology of private health providers in Ugandan rural areas and assess the effects of policy on the private health sector.

### **Methods**

As part of a health facility survey, different types of private health care providers were identified and interviewed to generate information on the particulars of health providers and various aspects of health services they provide to the community. Mapping of health care providers in one sub-county in each of the study districts was also carried out to assess typical distribution of public and private health providers in a rural district in Uganda. Sixty key informant interviews were conducted among policy makers and stakeholders from district and national levels to establish the effects of policy on the private provider mix.

### **Results**

The health facility survey manifested two broad types of private health providers: formal and informal. The formal type comprises Private not for Profit (PNFP) and Private for Profit (PFP) health providers that altogether make up 37.6% of the entire private health facilities surveyed, while the informal type constitutes 62.4%. The formal private for-profit providers consist of private clinics, maternity homes, nursing homes and drug shops. On the other hand, the informal type of private health providers consist of traditional healers, mobile health care providers and shop keepers.

Mapping of health facilities showed a similar ratio in the three rural study districts. The most common private providers were traditional healers with a concentration of 16 facilities per parish of 5,000 people, which sharply contrasts with the concentration of 4 PFP providers per parish, 0.5 PNFP per parish and 1 public facility per parish. Policy makers and public leaders agreed that laws and policy initiatives have not sufficiently stimulated the growth of the formal private health sector. They recommended that the government should provide financial support and tax exemptions as incentives to stimulate the growth of the formal private health sector.

**Conclusions**

The private health providers, in various forms, command a substantial stake in health service delivery to communities in Uganda. However, government policy is yet to significantly stimulate the growth of the formal private health sector and the greater fraction of private providers are still informal.

## *Reasons for choosing a health care provider in rural Uganda*

**Mr. Joseph Konde-Lule**

**Makerere University Institute of Public Health, Kampala, Uganda**

### **Background**

In Uganda there are many kinds of health care providers. At one end of the spectrum is a large informal sector, comprising traditional healers, faith healers and unqualified personnel that meet people's health needs. On the other extreme are the qualified allopathic providers that work in government or the private sector; constituting the formal sector. The decision to choose a particular health care provider often involves evaluating several different factors.

### **Objective**

To document reasons why patients choose to visit a particular type of health care provider.

### **Methods**

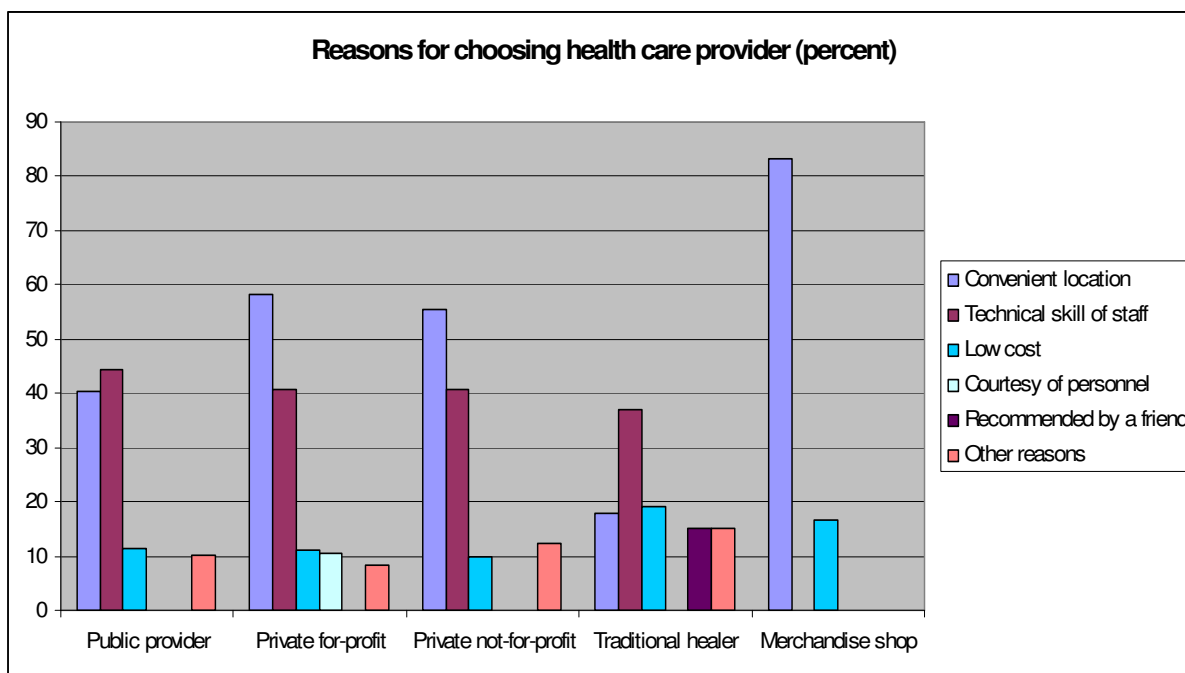
A household survey was conducted in three rural Ugandan districts (Iganga, Mpigi and Masaka) between January and April 2005 using an interviewer administered questionnaire. A total of 636 subjects that had experienced illness in the month preceding the survey and reported visiting a healthcare provider were studied. The results are based on quantitative analysis of the answers to the question "Why did you choose to go to this particular provider?" A comparison of reasons given across different provider categories is given.

### **Results**

In the formal sector, the major reasons for choosing to visit a public provider were: technical skills of personnel 44.5%, convenient location 40.5%, low cost 11.4% and "other reasons" 10.2%. Reasons for visiting a private for profit (PFP) provider included: convenient location 58.2%, good technical skills of personnel 26.0%, relatively low cost 11.0%, courtesy of personnel 10.6% and "other reasons" 8.2%.

The most important reasons for choosing Private not for Profit (PNFP) were: convenient location 55.6%, technical skills of personnel 40.7%, relatively low cost 9.9% and "other reasons" 12.3%

The informal sector consisted of traditional healers and general merchandise shopkeepers. Major reasons stated for visiting a traditional healer were: technical skills of personnel 37.0%, low cost 19.2%, convenient location 17.8%, recommended by friend 15.1% and "other reasons" 15.1%. The main reasons for visiting general merchandise shops were convenient location (83.3%), and low cost (16.7%). The above numbers are summarized in the table below.



The level of education influenced the decision of a sick person to visit a health care provider. Adults (individuals above the age of 18) with secondary education (67/104, 64%) were more likely to have visited a health care provider than those with primary or no education (198/382, 52.8%) [OR=1.68, 1.05-2.70].

### Conclusions

Overall, a convenient location was the main reason why persons chose to visit a particular provider, especially for providers in the private sector. Perceived good technical skills of health personnel was the most important consideration for patients choosing public facilities and traditional healers. Cost of treatment was not a major consideration when choosing a provider.

## *Reasons for visiting non-governmental health care providers – results from exit interviews in two districts in Zambia*

**Mr Dale Mudenda**

**Department of Economics, University of Zambia, Lusaka, Zambia**

### **Background**

Several studies have shown that non-governmental health care constitutes a large and important source of health care - not least for the poor and those in hard to reach areas. Yet, the private health care sector in low-income countries remains largely unexplored. This study reports the findings of exit interviews conducted with consumers of non-governmental health care providers in Lundazi and Chingola districts Zambia

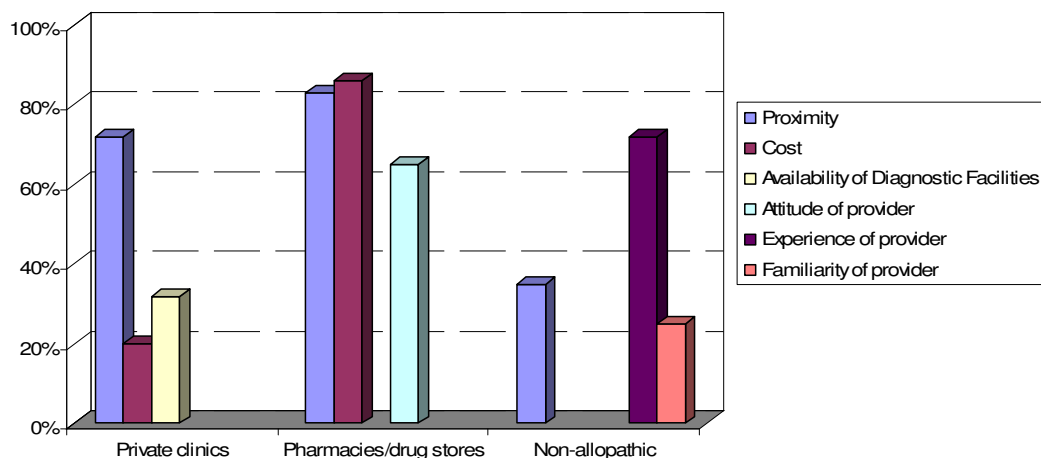
### **Methods**

The study was conducted using structured questionnaires, administered by trained research assistants. The questionnaires used were the generic Health Care Assessment Tools developed by the Private Sector Programme in Health (PSP). Adjustments were, however, made to make the questionnaires applicable to the Zambian context. Consumers of private clinics (25), pharmacists and drug vendors (63) and traditional healers and traditional birth attendants (214) were interviewed. In total, 302 clients were interviewed.

### **Results**

The study revealed that consumers in private clinics visited that particular clinic because of “proximity” (72%) followed by “availability of diagnostic facilities” (32%) and “cost” (20%). Clients of pharmacies/drug vendors rated “cost” (86%) and “proximity” together with “availability of drugs” as the most important factor (82.5%) for visiting that particular drug store/pharmacy followed by “attitude” (70%) and “attitude of provider” (65%) Finally, the main reason for clients of traditional healers to go to that particular provider was “experience of the provider” (72%) followed by “proximity” (35%) and “familiarity with provider” (25%). The results are shown in the table below.

**Three most common reasons for choosing health care provider**





**Conclusions**

The findings indicate that proximity is a very important factors for clients of private clinics and drug stores/pharmacies while for clients of traditional healers, the experience of the provider is more important. Cost is important for customers of private drug stores/pharmacies, but does not seem important for clients of private clinics and traditional healers. The low consideration given to cost in private clinics can probably be explained by the fact that many of the clients of private clinics were under the mining corporations' health insurance schemes.

## ANNEX III

### Collaborating institutions in the research programme

Country	Institution	Principal investigator(s)	Full address of institution	Phone/Fax	E-mail
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<b>Laos</b>	Ministry of Health Dept of Curative Medicine Food and Drug Department	Dr. Viengsavanh Phanmanivong  Dr. Chanphommah	Department of Curative Medicine Ministry of Health Simuang Road Vientiane Lao PDR	Ph/Fax: +856 21 21 78 48	<a href="mailto:viengsavanh2000@yahoo.com">viengsavanh2000@yahoo.com</a>  <a href="mailto:curativedept@laopdr.com">curativedept@laopdr.com</a>

Country	Institution	Principal investigator(s)	Full address of institution	Phone/Fax	E-mail
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