# THE ROLE OF THE PRIVATE SECTOR IN HEALTH

PRE-CONGRESS SYMPOSIUM

THE WORLD CONGRESS OF THE INTERNATIONAL HEALTH ECONOMICS ASSOCIATION (iHEA)

BEIJING 11 JULY 2009

# SYMPOSIUM REPORT

# 为健康而一起工作

UCSF

Karolinska Institutet

Results for Development

Alliance for Health Policy and Systems Research

Leland Stanford Junior University

Shandong University

The Rockefeller Foundation

USAID from the American People

PSP-One private sector partnerships for better health

International Health Systems Program

# CONTENT

## BACKGROUND

The private sector is playing an increasingly important role in health. Currently, nearly 60% of the total expenditure on health in low- and middle-income countries is private, rising above 80% in countries such as India, Pakistan, Guinea, and the Democratic Republic of Congo. Historically, the private health sector has been neglected in policy making, but information regarding the scale and complexity of the private sector has grown the last decade. Today, it is generally acknowledged that there is a need to improve the research base in this field in order to promote evidence-informed policies.

A full-day symposium on the role of the private sector in health was held July 11th 2009 at the Beijing International Convention Centre bringing together health economists, public health experts, policy makers and health care managers specializing in improving health care in low- and middle-income countries. Convened one day before the World Congress of the International Health Economics Association (iHEA), this private sector symposium attracted over a hundred participants from nations around the world.

The program featured sessions with technical presentations covering the following themes: *Understanding growing private participation in changing health systems, Understanding the private sector role in service delivery, Models of mixed systems*, *Working with the private sector* and *Policy.* Further, the program included keynote speakers from the World Bank, **Mukesh Chawla**, and the Chinese Ministry of Health, **Dr. Haichao Lei**. A plenary panel session led by **Dominic Montagu**, the Global Health Group, University of California, San Francisco (UCSF), closed the full-day symposium. The panel discussed the most important aspects of private health care delivery for public health and what governments should do in order to address those issues.


**FIGURE 1 PRIVATE HEALTH CARE CLINIC IN INDIA**

## SYMPOSIUM GOAL

The goal of the symposium was to foster the increasingly important dialogue between researchers interested in the private sector and health policy makers. The symposium served as one event of a series[1] with the long-term goal of promoting greater research interest and knowledge generation around the private sector to benefit health systems development. Specifically, the symposium aimed to:

- Review issues regarding the private sector where the evidence base is strong and where there is some (emerging) consensus about what is known
- Identify pressing policy issues concerning the private sector where further evidence is required
- Present research on emerging trends and innovations that are in the process of changing the character of the private sector and its relations with government
- Identify and develop strategies to address the main challenges in further developing the knowledge base in this area

## ORGANIZERS

The symposium was supported financially by the PSP-One Partnership and the Rockefeller Foundation, and was organized by the following institutions:

*Center for Health Management and Policy, Shandong University, Jinan*
*Div of Global Health (IHCAR), Dept of Public Health Sciences, Karolinska Institutet, Stockholm*
*The Global Health Group, UCSF, San Francisco*
*The International Health Systems Program, Harvard School of Public Health, Boston*
*PSP-One, Abt Associates Inc., Washington, DC*
*Results for Development, Washington, DC*
*Shorenstein Asia-Pacific Research Center, Stanford University, Palo Alto*
*The Alliance for Health Policy and Systems Research, Geneva*
*The Rockefeller Foundation, New York*
*The International Health Economics Association*

An organizing committee carried out the preparatory work for the symposium and included: **Ruth Berg**, PSP-One, Abt Associates Inc; **Peter Berman**, Harvard School of Public Health; **Birger Forsberg**, Karolinska Institutet; **Karen Eggleston**, Stanford University; **Gina Lagomarsino**, Results for Development; **Qingyue Meng**, Shandong University; **Dominic Montagu**, the Global Health Group, UCSF; **Stefan Nachuk**, The Rockefeller Foundation.

[1] A session on "The Role of Private Sector in Health Care: Past Experiences, Current Situations, and Future Opportunities" was carried out at the iHEA conference in Copenhagen, Denmark, July 8-11, 2007, and a conference was organized in Jinan, China, on "The Private Sector in Health Care Delivery – Potentials and Challenges" in 2006. For more details visit www.psp.ki.se. Also, planning for a follow-up private sector symposium is underway for the 2011 iHEA conference in Toronto.

## SYMPOSIUM SUMMARY

### *FOCUS ON OUTCOMES RATHER THAN DEBATE*

**Birger Forsberg**, from the Division of Global Health/IHCAR at Karolinska Institutet in Stockholm and part of the organizing committee, opened the symposium with a welcome. Since 2002, Forsberg has been conducting a collaborative research initiative on the role of the private sector in health involving ten research institutions around the world (for more information visit www.psp.ki.se). Forsberg's work focuses on the individual patient experience in low- and middle-income countries, specifically the issues of access and quality of care. He said, "we need to look at all possible sources of care to ensure access, irrespective of owner systems or type of services. Above all, we are interested in ensuring the quality of that care." Forsberg expressed a desire for the symposium to be one of several steps building towards a good balance between public and private service provision and productive partnerships between the public and private sectors.

As the program of the symposium proceeded the first keynote speaker, **Mukesh Chawla** from the Health, Nutrition, and Population unit of the World Bank, emphasized the importance of shifting focus from a debate of pro-public or pro-private health care delivery to health outcomes, and asked how we can use both the private and public sectors to achieve desired results. He then emphasized that there is no universal strategy to achieve results to fit all contexts, as context varies across, as well as within, countries. He stated, "to work effectively with the private sector, and minimize the risks that could accompany a lack of direct government control, governments should choose partnerships that suit local needs and conditions, focus on outcomes, and gain more expertise in contracting, monitoring and evaluation, and regulation". Chawla ended his speech by listing important issues going forward. He addressed the fact that more research is needed on the role of the private sector in health, as well as evidence on what works when it comes to outcomes, efficiency, equity and cost. Moving forward there is a need to strengthen ways in which we can all work together to find the answers we all seek.

### *A GROWING PRIVATE SECTOR – HOW DO WE WORK WITH IT?*

The program featured parallel sessions with several scientific paper presentations. Results showed a growing private sector in low- and middle-income countries, all of which showed potential to increase access to health care, although with varying quality (**Ha Nguyen**, Title: *Private provision of health services in Vietnam: an assessment of accessibility and quality*; **Wei Zhang**, Title: *Privatization in Health Services Delivery- A Case Study from China*; **Krzysztof Krajewski-Siuda**, Title: *The process and perspectives of privatization of health care providers in Poland).*

Findings addressed in several presentations indicated that there is potential to further engage the private sector in combating communicable diseases, particularly in the fight against HIV/AIDS (**Nina Viberg/Jesper Sundewall**, Title: *STI management in Tanzanian private drugstores - practices and roles of drugsellers*; **Wenjuan Wang**, Title: *The role of the private sector in financing and utilization of HIV/AIDS services in developing countries)*.

**Onil Bhattacharyya**, St Michael's Hospital, University of Toronto, discussed innovative ways of delivering health care services in the private sector (Title: *Innovative Health Service*

*Delivery Models for Low and Middle Income Countries).* These innovations included marketing strategies to better target the poor, financial models to reduce costs and new delivery processes to make services more available. Further innovative health service delivery models in Andhra Pradesh, India, were described by **Sofi Bergkvist,** ACCESS Health, (Title: *The Health Sector Reforms in Andhra Pradesh, India*) in a session on policy issues. In Andhra Pradesh, novel approaches have been politically supported in the reform process since 2004. Services such as a toll-free telephone line for medical advice that receives more than 50,000 calls per day and mobile vans with fixed-day services in villages more than two miles from health care centers are available in Andhra Pradesh today.

**FIGURE 2 DAVID BISHAI PRESENTING IN THE SESSION WORKING WITH THE PRIVATE SECTOR**

With a growing private sector using innovative approaches that could benefit the public sector, it is crucial to find good ways of collaboration and linking the private and public sectors. Studies were presented on the use of vouchers (**Kara Hanson**, Title: *Linking the public and private sectors in delivery of health sector services and products*), contracting with NGOs for basic health care (**Birger Forsberg**, Title: *Predicting performance in contracting of basic health care to NGOs – experience from large-scale contracting in Uttar Pradesh, India*) and social franchising (**David Bishai**, Title: *Measuring Multiple Impacts of Social Franchised vs. Private Clinics in Pakistan and Ethiopia*) as ways of working with the private sector. Hanson's paper indicated that it is feasible to implement a voucher scheme at the national level in a large, low-income country. Vouchers as a means to distribute insecticide-treated mosquito nets (ITN) had effectively increased demand of ITNs in remote, rural areas. However, in this case, vouchers alone were insufficient to achieve and sustain equitable ITN use. Experience of large-scale contracting of basic health care to NGOs in India showed that proposal quality and training experience, rather than project experience or financial stability, could predict the performance of the contracted NGO. Bishai's presentation showed that when the impact of quality and the access for the poor was considered, private providers working under a franchising scheme could provide contraceptive protection at lower incremental cost than unfranchised.

### *NEW PUBLICATIONS INTRODUCED*

During a lunch session, **Stefan Nachuk** and **Gina Lagomarsino** introduced new publications by the Results for Development Institute and the Rockefeller Foundation: *Public Stewardship of Private Providers in Mixed Health Systems*, a Synthesis Report, and *Innovative Pro-Poor Healthcare Financing and Delivery Models,* describing 33 innovative financing and delivery programs ranging from donor-driven initiatives to large-scale government-subsidized efforts to engage for-profit businesses (available online at www.resultsfordevelopment.org).


**FIGURE 3 STEFAN NACHUK, THE ROCKERFELLER FOUNDATION, PRESENTING NEW PUBLICATIONS**

**Henrik Axelson**, Partnership for Maternal, Newborn and Child Health (PMNCH), presented an upcoming publication by PMNCH in collaboration with the Center for Global Development on the topic engaging the private sector in public health strategies and programs (for more information contact Henrik Axelson at axelsonh@who.int).

## *PRIVATE SECTOR IN CHINA*

**Dr. Haichao Lei** from the Chinese Ministry of Health served as the second keynote speaker. He delivered a presentation entitled "Health System Reform Policies and Private Sector Development" in China. Dr. Lei gave a brief introduction to health system development in China, and described China's Health System Reform Plan of 2009 and the development of private practices in the country. He explained that the private sector developed rapidly in China, with the first private clinics opening in 1979. Today, private clinics provide mainly outpatient care while public hospitals provide more than 80% of inpatient services. Still, health care costs to patients are high because hospitals have to cover a large share of their operating costs by collecting patient fees. The health reform in China now aims at providing universal insurance coverage for rural and urban people by 2020 through strengthening the basic health system and lowering the private out-of-pocket expenditure for health care by increasing public financing. Dr. Lei concluded that the main challenge for the health system today is financing health care.

## *QUALITY OF CARE – A MAIN ISSUE IN PRIVATE HEALTH CARE DELIVERY*


**FIGURE 4 SECOND KEYNOTE SPEAKER DR. LEI HAICHAO, DIRECTOR HEALTH POLICY DIVISION, MINISTRY OF HEALTH**

A plenary session concluded the full-day symposium. Led by **Dominic Montagu**, the Global Health Group, University of California, San Francisco, the panel discussed the most important aspects of private health care delivery for public health and what governments should do to address those issues. Panel participants included: **Gina Lagomarsino**, Results for Development; **Qingyue Meng**, Shandong University; **Mursaleena Islam**, Abt Associates; and **Mukesh Chawla**, the World Bank.

Quality of care, which often is not addressed or guaranteed through private health care services in low- and middle-income countries, was discussed by the panel as one of the main issues of private health care delivery. Lagomarsino argued that out-of-pocket spending is another challenge, and is highly related to

the private sector. She said, “frequently these two things (out-of-pocket spending and quality of care) are considered separately, but I would say they are quite connected. When you have many private out-of-pocket transactions taking place, there is very little ability to control and influence the quality of the private providers that are providing care.”

Lagomarsino argued that one way for governments to handle problems of quality of care and out-of-pocket spending is to create systems where governments pool funding and then purchase services from private providers. According to Lagomarsino, this will create a mechanism for the government to control the quality of care because the government is in charge of all resources. “Governments paying for private services is one of the best ways we have to ultimately control quality”, she said.

Islam pointed out that governments and donors have to look for innovative finance options for contracting with the private sector in order to improve quality of care.

The question of how to work with the private sector, which is often fragmented, was raised by a member of the audience. One answer provided by the panel was that purchasing from that market should be more coordinated in order to get more control.

### *Towards Toronto*

More work is required to achieve a balance between public and private service provision and to ensure a good partnership between the public and private sectors. Inspired by a successful day with good discussions, **Birger Forsberg**, Karolinska Institutet, closed the symposium by thanking everybody for their input and presence. He challenged participants to “pick up the symposium baton” and organize another symposium at the iHEA congress in Toronto 2011 to again focus on the private sector in health.

## More material available online

PowerPoint presentations, symposium program, symposium presentation abstracts, and recordings of keynote speakers and plenary sessions are available online at www.ps4h.org/ihea. This report can also be downloaded at www.psp.ki.se, www.ps4h.org or www.psp-one.com.

# PROGRAM

**9.00-10.00** **Welcome note: Birger C Forsberg, Karolinska Institutet, Stockholm, Opening Keynote: Mukesh Chawla, HNP, The World Bank**

**10.00-10.30** **Coffee/Poster Presentations**

**10.30-12.00** **PARALLEL SESSIONS: Understanding the nature of mixed systems**

### *Session A: Understanding growing private participation in changing health systems*

**Wei Zhang**, *Privatization in Health Services Delivery- A Case Study from China*

**Ha Nguyen**, *Private provision of health services in Vietnam: an assessment of accessibility and quality.*

**Sachiko Ozawa**, *Trust in Private Providers in Rural Cambodia*

**Krzysztof Krajewski-Siuda**, *The process and perspectives of privatisation of health care providers in Poland*

### *Session B: Understanding the private sector role in service delivery*

***Nina Viberg/Jesper Sundewall**, STI management in Tanzanian private drugstores - practices and roles of drugsellers*

**Wenjuan Wang**, *The role of the private sector in financing and utilization of HIV/AIDS services in developing countries*

**Asirvatham Edwin Sam**, *Efficient HIV/AIDS management through fuller use of local non-government resources: Capacity and strength of first-contact providers vis-à-vis HIV/AIDS care in rural Tamil Nadu, India*

**Ann Levin,** *A Conceptual Framework on the Role of the Private Sector in Immunization Service Delivery in Developing Countries*

### *Session C: Models of mixed systems*

**Bruno Meessen**, *Composition of pluralistic health systems: Can we learn anything from household surveys? An exploration in rural Cambodia*

**Elvis Mpakati Gama**, *The evolving two-tier health system in Malawi*

**Edson C. Araujo**, *Two-tier health system in Brazil: implications for equity.*

**Onil Bhattacharyya**, *Innovative Health Service Delivery Models for Low and Middle Income Countries*

**12.00-13.00** **Lunch Presentation of new publications**

**13.00-15.00** **PARALLEL SESSIONS: Working with the private sector**

### *Session D: Working with the private sector*

**Kara Hanson**, *Linking the public and private sectors in delivery of health sector services and products*

**Birger Forsberg**, *Predicting performance in contracting of basic health care to NGOs – experience from large-scale contracting in Uttar Pradesh, India*

**Anna Vassall,** *How are private health markets treated in health sector plans?*

**David Bishai,** *Measuring Multiple Impacts of Social Franchised vs. Private Clinics in Pakistan and Ethiopia*

### *Session E: Policy*

**Ying Xiaohua**, *How to develop the private health sectors in China?----a case study in Shanghai.*

**Richard Lowe/Dominic Montagu**, *Legislation, Regulation, and Consolidation in the Retail Pharmacy Sector in Low-Income Countries*

**Sofi Bergkvist**, *The Health Sector Reforms in Andhra Pradesh, India*

**Barbara McPake**, *Two-tier issues in low income countries' health systems*

**15.00-15.30 Coffee/Poster Presentations**

**Faheem Ahmed**, *Role of Public Private Partnerships in Pakistan Health Care Scenario: A Qualitative Study.*

**Ann Levin,** *The Role of the Private Sector in Immunization Service Delivery in Developing Countries*

**Arun Bahuleyan Nair**, *Public private partnership for equitable and rationalized healthcare under National Rural Health Mission in India*

**Awad Mataria,***Public policies to enhance private sector investment and competitiveness in tertiary health care in the occupied Palestinian territory.*

**Christian Lorenz,** *Household expenditures on health – microdata analysis on out of pocket payments in Pakistan*

**Cunrui Huang,** *Private healthcare provision in China: a study of its role and potential*

**Dina Balabanova**, *Health Sector Governance: how can governments engage with the private sector and what are the capacities required?*

**Elizabeth Ekirapa-Kiracho**, *Disparities in Access To Quality Health Care*

**Folashade Laoye**, *Improving access to health care for the poor using donor subsidized risk pooling schemes*

**Gerald Bloom**, *Making health markets work better for poor people*

**Hanna Pernefeldt,** *Bringing innovations from the private sector to public sector - for improved health service delivery*

**Indrajit Hazarika**, *Potential Impact Of Medical Tourism On The Workforce And Health System In India*

**Keerti Bhusan Pradhan**, *Private-Private Partnership for High Quality, High Volume and Sustainable Eyecare Services-A model in Africa*

**Keerti Bhusan Pradhan,** *Doing Right Things vs Doing Things Right-An example of a National Plan for Prevention of Blindness in Rwanda.*

**Lan Yao**, *Study on developmental policy of non-state owned medical facilities*

**Lydia Esther Buzaalirwa**, *Efficient Delivery of HIV and AIDS services in Uganda: Lessons from the Uganda HIV Services Project (UHSP)*

**Maki Ueyama**, *Integrated Rural Health Care Solutions in Rural Tamil Nadu, India*

**Preethi John**, *Critical workforce motivation strategies-Healthcare*

**Subodh Kandamuthan**, *Managing Primary Health Care Centres Through Public Private Partnersip In Andhra Pradesh In South India*

**15.30-15.50 Afternoon Keynote: Dr. Lei Haichao, Director Health Policy Division, Ministry of Health**

**15.50-17.00 Plenary session: The role of International Organizations and National Government in Facilitating the Alignment of Private Health Providers with Public Health Goals**

**Chair: Dominic Montagu, Global Health Group, University of San Francisco, California. In the panel; Gina Lagomarsino, Results for Development, Mursaleena Islam, Abt Associates, Qingyune Meng, Shandong University, Mukesh Chawla, HNP, The World Bank**

# ABSTRACTS OF ORAL PRESENTATIONS

## PARALLEL SESSIONS: UNDERSTANDING THE NATURE OF MIXED SYSTEMS

### SESSION A: UNDERSTANDING GROWING PRIVATE PARTICIPATION IN CHANGING HEALTH SYSTEMS

Chair: Qingyue Meng

**Presenter's Name: Wei Zhang**

**Organization:** China Europe International Business School

**Title:** Privatization in Health Services Delivery- A Case Study from China

**Full Author List:** Wei Zhang, M.D., Ph.D, Assistant Professor of Management

Health services privatization has been of great policy controversy in China, yet little empirical research has been conducted. From 2001 on, one specific underdeveloped region (we call it Region A) in southern China has privatized all public hospitals and community clinics and become the only region in China where all health services provider institutions are private. Our study aims to empirically evaluate the impact of this privatization on the regional health system performance through a difference-in-difference approach. We started our study in 2007, and a neighboring region (we call it Region B) has been chosen as the study control group.

To compare the regional health system performance, our study focused on 4 dimensions: access/resources, cost, quality of care, and public perception. Each dimension has its own set of indicators, which are developed from literature review and are subject to the availability of data in this study. The study dada consist of the following:

government health statistics of region A and B from 2000 to 2006

25 field interviews with government officials, hospital executives, physicians in both region A and B, conducted in 2007;

hospital level performance data from 2 regions (4 comparable large hospitals in each region)

Inpatient satisfaction survey, 200 inpatients for each region, conducted in 2007

Household survey on public opinion on the regional health care system, conducted in 2007

Our preliminary results suggest that the initial stage of privatization facilitated the growth of health service capacity and enhanced patient access, but such privatization risked aggregation of medical arm race for the time being. On the cost perspective, we observed significant lower price for some well-defined medical procedures and more inpatient service efficiency improvement in the privatized region, but the comparison of overall health care cost remained unknown. On the quality perspective, service is significantly better in the privatized region, yet technical quality remains a challenge for both public and privatized providers. Finally, public perception of the regional system seems to favor the privatized region due to enhanced access and better services. Meanwhile, the evolvement of policy priorities in Region A's bureau of health since 2001 might also shed light on the effective regulation of private providers, which can be of valuable policy implications for Chin and the rest of the developing world.

**Presenter's Name: Ha Nguyen**

**Organization:** Health Services and Policy Analysis

**Title:** Private provision of health services in Vietnam: an assessment of accessibility and quality.

**Full Author List:** Ha Nguyen, Dao Lan Huong, Nguyen Thi Bich Ngoc and Le Anh Tuan

Similar to many middle and low income countries, Vietnam has experienced rapid development of the private health services over the last few decades. The magnitude of the private sector has been quantified in terms of household utilization and out-of-pocket expenditure. Qualitative studies often attribute the popular preference for private providers to their caring attitude toward patients and flexibility in terms of timing, location, and payment. However, little is known about the real number of private providers and their technical quality. This study assesses the physical accessibility and technical quality of the private health service providers in Vietnam. Its goal is to provide a better understanding of the real situation of service provision at the private sector, which guides interventions involving the private sector.

This study makes use of the unique combination of household, commune, and provider surveys from the Vietnam National Health Surveys (VNHS) 2001/2002 to describe the private sector from both the user and practitioner sides. VNHS covers 36,000 households residing in 1,200 communes in all 61 provinces of Vietnam. The household survey collected detailed information on the utilization of services. The provider survey interviewed private practitioners and tested their knowledge in five common health conditions: acute respiratory infection, diarrhea, child malnutrition, hypertension, and pregnancy related. Private providers were sampled from a list submitted by surveyed communes, which enables an estimation of their totality in the whole country.

Descirptive analysis provide a comprehensive picture of private providers in terms of number, distance to commune town, years in operation, whether also being public sector personnel, interaction with the public sector, conditions of drugs and equipments, knowledge of common health conditions, and prescribing patterns. In addition, multivariate analysis is performed to investigate the prescription patterns of the private providers.

Study findings confirm the common notion that the private sector is heavily concentrated in the urban and relatively wealthy regions. However, even in the rural area, the average number of private practitioner per commune was 1.7, or 21.8/100,000 population at the time of VNHS. Nationwide, the average distance from a commune health center to a private practitioner was 2.2 kilometers, whereas the corresponding distance to a district hospital was 9.2 kilometers. Although a significant number of government staff had private practice, there was little interaction between the two sectors.

Although most private practitioners stored essential drugs, less than 40% of them had sterilization equipment. Roughly 10% of surveyed practitioners scored 75% or above correctly on how to recognize and treat conditions relating to hypertension and pregnancy. Private practitioners who were also public sector staff were shown to have better knowledge on common health conditions. Those who attended periodical refresher training scored much higher than those who did not. However, only 20%-30% of exclusive private providers were invited to attend training on important national health programs such as HIV/AIDS and diarrhea. Controlling for the type and severity of health conditions, private providers were significantly more likely to prescribe injection compared to public facilities at all levels. This pattern was particularly strong in the rural area and among uneducated patients.

This study reveals that private providers have great potential in providing health services due to their large number and close distance to the users. Their technical quality leaves much room for improvement, and improvement is feasible with refresher training and closer interaction with the public sector. Findings from the current study call for a more active role of the mainstream public sector to involve the private sector in the overall planning of health services, with the ultimate goal of improving the quality and accessibility of services for the population.

**Presenter's Name: Sachiko Ozawa**

**Organization:** Johns Hopkins Bloomberg School of Public Health

**Title:** Trust in Private Providers in Rural Cambodia

**Full Author List:** Sachiko Ozawa, Damian G. Walker

To understand the motivation of villager's trust in private health care providers in Cambodia.

There is a sizable private health care market in Cambodia. According to the Cambodian Demographic and Health Survey of 2005, people are twice as likely to visit the private sector for all treatments compared to the public sector. While numerous comparisons have been made between public and private providers, people's trust for these providers has yet to be examined in Cambodia. This study hypothesized that villagers' trust for private providers differ greatly from that of public providers. Anecdotal evidence suggests that people are more likely to trust private providers rather than public providers.

Qualitative research was employed to explore the meaning and role of trust in northwest Cambodia in April-May, 2008. The study was conducted in Thmar Pouk, in the Banteay Meanchey province. Seven focus groups were conducted with seven to thirteen participants in each focus group. A snowball sample was used to find individuals who fit a screening criteria. Study participants were asked how individuals in the community perceive their relationships with public and private health care providers. Focus groups were transcribed, translated, coded and analyzed using grounded theory methodology.

Participants described their trust for public providers quite differently from private providers. Public providers were regarded as being "honest" and having "good skills". Private providers were commended for being friendly and treating patients with care, being "quick to see patients", giving intravenous "injections" (IVs) and allowing patients to "owe money". In general, private providers were considered to be more friendly and quick, but expensive compared to public providers. Participants who use private practices suggested that their interactions with private providers are personal, where the provider is often originally from the village, may know the patient already, and there is "one doctor for one patient." Some respondents noted that calling private providers is "comfortable and easy" where providers "come to our home to give injections." A large number of participants suggested that they trust private providers more than public providers, because the doctor comes to their homes immediately after patients make a call, they have good medicine, they will give IVs, the treatment lets patients recover quickly, and "private [providers] treat us carefully."

This study provides a new understanding of people's trust in private health care providers in a low-income, post-conflict setting. We identified several characteristics that people value in deciding to trust private providers such as being "quick," giving IVs and "owing money". A greater number of participants appeared to trust private providers over public providers given the convenience and effectiveness of treatment. Understanding how trust for private providers is fostered in these contexts will contribute to identifying potential interventions that aim to build trusting relationships. Building trust among villagers, private providers and public providers will likely be critical to improve access to health services and build effective health systems.

**Key Terms:** Private Provider, Trust, Health Systems

**Presenter's Name: Krzysztof Krajewski-Siuda**

**Organization:** Medical University of Silesia

**Title:** The process and perspectives of privatisation of health care providers in Poland

**Full Author List:** Krzysztof Krajewski-Siuda and Piotr Romaniuk

Privatisation in Poland's health care started in early 90's, when the pharmacies has been totally privatised. The dynamics of ambulatory health services sector privatisation significantly increased after the reform implemented in 1999. After the reform there were few projects of privatisation of the in-patient sector, although none of them has been aproved for realisation due to the unfavourable political environment. Currently we are facing another reform of hospital sector proposed by the government. Despite of the existing obstacles, also in this sector the number of non-public providers is increasing. Privatisation of facilities is seemed to be a crucial for stabilisation of the hospital system finances.

The aim of the presentation is to discuss the current processes of privatisation of health services providers in Poland, as well as the perspectives of the increase of share of private units in the hospital sector.

Research was made based on the statistical data concerning the structure of services provided by health system in Poland, the currently binding legal regulations regarding health care units and services contracting, as well as political declarations of succesive governments with reference to the desired design of health system.

Currently in Poland 99% of pharmacies are private, also 85% of dental services are provided by the private sector. Only 18% of practising dentists are working in public facilities (the basic work place). Within two years after the reform implemented in 1999 the number of primary health care services provided by private sector increased by 250%, number of specialist ambulatory services increased by 500%. Currently 68% of all ambulatory services are provided by non-public facilities, where in secondary ambulatory sector this indicator is equal to 56%. At the same time 69% of active physicians indicate public units as the basic place of their practice. In the in-patient sector private facilities constitute about 20% of all hospitals, but dispose with only 5% of beds. A new form of hospital has started to expand recently, called the "self-governmental non-public hospital" that means a commercial-law based (trade) company owned by a self-government unit.

1. The pharmaceutic and dental sectors in Poland are already privatised. 2. The process of privatisation of the ambulatory health sector is highly advanced, particularly in regard to the primary care. 3. In case of in-patient sector the process is progressing much slower, where the incoherent and unfavourable legal regulations are recognised as the basic obstacle.

**Key Terms:** privatisation of hospitals, Poland, health reform

SESSION B: UNDERSTANDING THE PRIVATE SECTOR ROLE IN SERVICE DELIVERY

Chair: Gina Lagomarsino

**Presenter's Name: Nina Viberg/Jesper Sundewall**

**Organization:** Division of Global Health (IHCAR), Karolinska Institutet, Stockholm

**Title:** STI management in Tanzanian private drugstores - practices and roles of drugsellers

**Full Author List:** Viberg Nina, Mujinja Phares, Kalala Willbrord, Kumaranayake Lilani, Vyas Seema, Tomson Göran, Stålsby Lundborg Cecilia

To describe the role and possible contribution of private drugstores in STI management in rural Tanzania.

A cross-sectional study that included drugsellers in private drugstores in eight districts of Tanzania. Data were collected through interviews with drugsellers. Further, simulated clients (SC) presented a male and a female STI case. Descriptive statistics were used. "QATI" scores (Questions, Advice, Treatment and drug Information) were developed to describe overall STI management.

Although 74% of the drugsellers stated there were no STI-related drugs in the store, a majority of the SC received drugs; 78% of male and 63% of female SC. Of these, 80% and 90% respectively were dispensed drugs recommended in the Tanzanian guideline for syndromic management of urethral and vaginal discharge syndromes. Antibiotics were dispensed to 76% of all male and 35% of female SC. Drug-use information was provided to almost all. Most drugsellers agreed that it is within their professional role to give information on STI treatment (89%) and prevention (95%). Comprehensive syndromic STI management was however rarely provided and dosage regimens were often wrong. Advice was seldom provided and questions only occasionally asked. Overall STI management was better for men than for women.

The drugsellers, although aware of the prescription-only status of antibiotics, saw themselves as having a role in STI management and were ready to provide drugs to simulated clients. Our results indicate that there is a need and a potential to empower Tanzanian drugsellers to provide effective and safe STI management especially to male patients.

**Presenter's Name: Wenjuan Wang**

**Organization:** Abt Associates Inc.

**Title:** The role of the private sector in financing and utilization of HIV/AIDS services in developing countries

**Full Author list:** Wenjuan Wang, Susna De, Sara Sulzbach

The continued increasing number of people infected by HIV generates tremendous and growing demands for HIV/AIDS related health services. While there has been an unprecedented increase in fiancing the HIV/AIDS response by donors such as the President's Emergency Program for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the World Bank Multi-country AIDS Program, a relatively less examined aspect of the global response to HIV/AIDS is the role of the private sector. There is little known about the extent to which the private sector is financing or delivering HIV/AIDS services, nor how this may be changing over time and be affected by the influx of donor funds. Understanding the role of the private sector at both financing and services delivery level is essential to strategically engage the private sector and accordingly to ensure sustainability of HIV/AIDS services in the long term. Focusing on the private-for-Profit segment of the private sector, the objective of this study is to document the current role of the private sector in financing and utilization of HIV/AIDS care and treatment, and to the extent possible assess the changes over time given the influx of donor funding for HIV/AIDS.

This study primarily draws data from existing internationally recognized data sources. National Health Account (NHA) HIV Subaccounts provides internationally and longitudinally comparable data of HIV/AIDS financing flows in terms of funding sources, funds managers and recipients. Five countries with multi-year data, Kenya, Malawi, Tanzania, Rwanda and Zambia were included in the study to allow for assessing trends.. Private HIV/AIDS services utilization data from the Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS) was also analyzed. Twelve countries were included where private services utilization data including HIV testing and STI counseling are available.

With the influx of donor HIV/AIDS funds, the private sector's relative and absolute contribution has decreased over the period. Private company contribution has decreased from 18% in Malawi to 85% in Rwanda. Private sector's role in controlling HIV/AIDS resources has decreased in four of five countries. Nonetheless people living with HIV (PLWHIV) are spending more out-of-pocket (OOP) on health care compared with the general population, although OOP by PLWHIV overall has decreased since donor influx. In Zambia, OOP of PLWHIV was $53.78 per capita in 2002, but $20.67 in 2006 after adjusting for inflation.

Private for-profit hospitals were largely financed by OOP payments, and are not receiving funds from donor or public sources. The expenditure on traditional healers has been largely reduced. On the utilization side, the private sector is a significant source for HIV services. Up to forty-four percent of women reported receiving HIV test from a private sector. Relatively high private sector utilization for HIV testing was reported in countries such as Haiti, Uganda, Ethiopia and Guyana. While private utilization is associated with wealth status, a significant portion of people from poorest group are utilizing private services.

The analysis of financing data in five countries implies that donor funds appear to be displacing private investment in HIV/AIDS. This is compounded by the finding that government contributions also dropped over the period. This raises concerns about sustainability, especially in light of the current global economic recession. While the current private utilization for HIV services varies by county, there is a great potential to engage the private sector in the fight against HIV/AIDS. The limited information on HIV private utilization highlights the need for collecting private utilization data in future international household surveys.

**Key Terms:** Private sector, HIV/AIDS services, Financing, Utilization

**Presenter's Name: Asirvatham Edwin Sam**

**Organization:** Health Economics Unit, Sree Chitral Tirunal Institute for Medical Sciences and Technology (SCTIMST), Trivandrum

**Title:** Efficient HIV/AIDS management through fuller use of local non-government resources: Capacity and strength of first-contact providers vis-à-vis HIV/AIDS care in rural Tamil Nadu, India

**Full Author List:** Edwin Sam and Durarai Varatharajan

A recent national health survey (NFHS-3) in India reveals that rural areas are under-served in terms of HIV testing, treatment, care, condom usage and knowledge. This is probably due to sub-optimal utilization of key resources such as non-government (often less than fully qualified or LTFQ) providers, who are the first contact/treatment points for the rural community. Widespread and knowledgeable about the local community, these providers are a key input in the provision of HIV/AIDS care.

This paper brings out the results of a study assessing the capacity and strength of non-government first-contact points (providers) vis-à-vis HIV/AIDS care in the Indian state of Tamil Nadu.

Combing, listing and interviewing of the potential HIV/AIDS care providers were used in this study carried out in three high-prevalent districts with a total population of 7.1 million. These three districts together had 23 sub-districts (known as Taluks) and 975 Health Sub-Centres. Each sub-district, on the average, had a population of about 300,000 and 42 health sub-centres (each covering 7,000 people). One sub-centre from each sub-district was chosen as the survey area for the study and the entire population covered by the chosen sub-centres was included. In other words, a total population of about 300,000 was actually covered in the combing operation. All types of first-contact points used by the local community were included. Identified first-contact points were then interviewed using a semi-structured interview schedule.

A total of 223 (9.7/sub-centre or 1.9/1,000 population) first-contact points were identified during the combing process - 28.7% qualified allopathic practitioners, 31.8% trained LTFQs and 39.5% untrained LTFQs. Majority (81.6 %) of them felt that STI and HIV/AIDS prevalence was significant in their surroundings. A series of focus group discussions among the local community in these districts also revealed that high-risk sexual practices were found among hitherto untargeted population groups. Over 81% of those fully qualified and 56% of the LTFQs (both trained and untrained) were confident of treating HIV cases; 62.5% of the fully qualified and 58.4% of the LTFQs already 'handled' HIV cases. However, only few of them were actually involved in the formal treatment process under the HIV/AIDS control programme.

Hitherto unutilized local health care providers or the first-contact points could be involved in the management of HIV/AIDS care. They prove to be additional cost-effective resources for HIV/AIDS care and could be part of a specific aspect of identification of suspects, HIV testing, treatment, or care. With appropriate training, provision of facilities, and incentives, 84.3% of the fully trained physicians could be involved in HIV/AIDS care including the administration of ART. LTFQs, on the other hand, could be involved in identification of HIV suspects, HIV prevention and counselling. Otherwise, numerous high-risk people may be missed or may continue to receive inappropriate treatment.

**Key Terms :**HIV/AIDS, Non-government providers, and resource utilization

**Presenter's Name: Ann Levin**

**Organization:** World Health Organization

**Title:** A Conceptual Framework on the Role of the Private Sector in Immunization Service Delivery in Developing Countries

**Full Author List:** Miloud Kaddar and Ann Levin

Although many governments would like to provide all preventive health services to their populations, not all are sufficiently well-equipped and financed to provide high quality services that are available and accessible to all. In many developing countries, the private sector (both private and not-for profit) are providing immunization services to certain segments of the population either to provide vaccines not provided through or to increase access to services also provided through the public sector. If the role of the private sector in providing these services can be better documented and analyzed, then it will be easier for the government to define appropriate incentives and regulation and for the two sectors to work together and to develop interventions to improve the quality of these services provided in the private sector.

The objective of the paper is to present the diverse practices of the private sector in delivering vaccination services based on existing data and to present a framework for analysis of this service delivery.

A literature review was conducted on Pubmed to obtain published articles on the role of the private sector in immunization service delivery and other health services in developing countries. The authors also solicited grey literature on the subject through various networks of persons working in immunization service delivery. After the articles and other data were collected, these were used to develop a conceptual framework for analysis of the private sector's role.

The conceptual framework has two aspects. First it distinguishes between type of providers (for-profit and not-for-profit) and second, it presents the mechanisms through which the private sector's contributes to immunization coverage levels and mortality reduction in developing countries. The ability of a government to deliver immunization services is affected by its economic level and its governance capacity. Thus, countries with limited governance capacity or 'fragile' states are less able to provide and finance service delivery. . The not-for-profit sector includes organizations that provide immunization services and/or advocacy and is more likely to be dependent on governments or donations/external aid.

This conceptual framework will be used to map the diverse practices of the private sector in delivering vaccination services, identify strengths, weaknesses and best practices and indicate potential ways to better integrate the private sector into national immunization programs.

**Key Terms:** Private Sector, Immunization Services, child health

SESSION C: MODELS OF MIXED SYSTEMS

Chair: Peter Berman

**Presenter's Name: Bruno Meessen**

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| **Organization:** Institute of Tropical Medicine |
| **Title**: Composition of pluralistic health systems: Can we learn anything from household surveys? An exploration in rural Cambodia |
| **Full Author List:** Bruno Meessen, PorIr, Kannarath Chheng, Chean Rithy Men, Kristof Decoster and Wim Van Damme |
| In spite of all efforts to build well-functioning national health services, health systems of many low-income countries are today highly pluralistic. Households use a wide range of public and private health care providers, many of whom are not under the supervision of the national health authorities. Many experts have called upon ministries of health to re-orientate their missions in order to strenghten their role of steward of the entire health system. Good stewardship will require national and decentralised health authorities to have an accurate view on their pluralistic health systems, especially the components outside the NHS. Little guidance has been provided so far on how to develop such a view. In this paper, we explore the extent to which household surveys could be a source of information. We carry out our study in Cambodia, a country with a highly fragmented health system. The exploration is mainly conducted by using a representative household survey (5,975 households) carried out in three rural health districts in Cambodia. Despite data and methodological limitations, the comparative analysis suggests different 'maps' of health seeking behaviours. Projects and major public providers seem to leave a 'footprint' behind. In their absence, different components of the private sector take over. A few lessons in terms of health system organization and further needed research on health system composition - including empirical challenges - are drawn |
| **Key Terms:** public/private sector, health systems, low-income countries |

**Presenter'sName: Elvis Mpakati Gama**

**Organization:** Malawi Polytechnic and Institute for International Health and Development, Queen Margaret University

**Title:** The evolving two-tier health system in Malawi

**Full Author List:** Elvis Mpakati Gama and Barbara McPake

Malawi is one of a few countries experiencing extreme crises of both human resources and HIV/AIDS, all of them in sub-Saharan Africa. Overall expenditure on the health system has been rising, supported by a growing public sector in turn supported by growing external assistance.

This has implications for the nature and shape of the public health system. It is highly stressed, in particular in relation to human resource availability. In principle it is focused on the provision of an essential health package (EHP), focused on mainly infectious diseases that account for the greatest burden of disease which is the priority of external funding channelled through the national sector wide approach process. Although only recently included in the EHP, much external assistance has been channelled to an antiretroviral treatment programme which has been considered an 'island of excellence' in an otherwise very basic public health system. For relatively wealthy Malawians who are not HIV positive or currently eligible for antiretroviral treatment, the public health system is likely to offer little.

WHOSIS data also indicate stagnation of private expenditure on health in international (purchasing power parity) dollar terms while other data indicate a growing private health care sector in Malawi. The number of private health services providers as recorded by the business registrar has increased from 40 in 1995 to 78 by the end of 2007. Similarly, a physical count of private health providers shows that the number of private providers has increased from 65 in 1995 to 138 by end of 2007. His combination of observations is likely to imply a struggling private sector with providers moving in and out of the sector as they initially invest and often then fail to remain solvent, such as has been described in Tanzania

The implications of this category of private sector for the nature of two-tier provision are likely to differ from the implications of a more thriving and stable private sector.

This paper will present evidence of the characteristics of private sector development and their consequences for the nature of two tier provision using available data concerned with:

•Human resource distribution across the health system and implications for retention and motivation

•Factor prices

•Distribution of users of the tiers of the system in relation to income or wealth quintiles and disease profile

•Distribution of benefit incidence across user groups

comparing these, where internationally comparable data are available, with data from countries in which there appears a more thriving and stable private sector. The paper will inform the development of a research proposal focused on the implications of two tier provision for equitable access to health care in different types of settings.

**Presenter's Name: Edson C. Araujo**

**Organization:** Programa Economia da Saude, Universidade Federal, Queen Margaret University, Edinburgh, United Kingdom

**Title:** Two-tier health system in Brazil: implications for equity.

**Full Author List:** Edson C. Araujo

The coexistence of public and private health insurance has become a central point of analysis in the majority of Latin American health systems. Some argue that a greater role for private health insurance (PHI) and private providers will 'crowd out' the public health services and alleviate financial pressures on the public system; also it is claimed that the PHI would be more responsive to consumers' preferences than the public health services and can result in cross-subsidy between privately insured and public users. Others point out the negative consequences of a 'two-tier' style of health care, such as the limited fiscal relief for public system and equity issues arising from the reduction of political pressure to improve the quality of public services when removing the higher demand individuals to PHI. Since the mid-1980s the public health system in Brazil has undergone expansion, decentralization and economic reorganization. As a result, the private sector has emerged as a major payer of health care in Brazil in the last decade, creating a two-tier health system. There is evidence that such features result in a regressive system of financing (where the burden of payment for health care is proportionally greater on the poorest) and a higher level of catastrophic health care expenditures.

This proposal aims to explore the determinants of demand for PHI in health systems with two-tier features. This paper provides new evidences of the effects of perceived quality differentials between public and private health services on households' choice for health coverage and how these effects vary across different households (in terms of income, education, risks of illness and other socioeconomic characteristics).

Initial analysis was undertaken using a national household survey (Pesquisa Nacional por Amostra de Domicilios – PNAD ) and a series of regression models were estimated to observe how the levels of satisfaction among public and private services users influence the decision to purchase PHI. Subsequently, a discrete choice analysis will be conducted to explore the importance of different elements of quality in households' insurance purchase decisions.

The regression results show a negative association between the decision to purchase PHI and being satisfied with public health services. This analysis helps to understand the level of demand for PHI in the context of a mixed public and private health system (two-tier health system). The discrete choice analysis will reveal further detail about the elements of quality that are most important in motivating purchase of PHI. Where there is policy influence over these elements, there is an entry point for influence over how many and which households purchase PHI, the extent of cross subsidy between the tiers of the system and the implications for clinical qualities of the distribution of uptake that results. The paper will consider the extent of leverage achievable and the definition of optimal distributions of demand, quality and subsidy.

**Presenter's Name: Onil Bhattacharyya**

**Organization:** St Michael's Hospital, University of Toronto

**Disclosure:** This research was funded by and carried out on behalf of the Rockefeller Foundation. The authors have no conflict of interest with regard to this project.

**Title:** Innovative Health Service Delivery Models for Low and Middle Income Countries

**Full Author List:** Onil Bhattacharyya, Sara Khor, Anita McGahan, David Dunne, Abdallah Daar and Peter A. Singer

Low- and middle- income countries have mixed health systems, often with large private sectors which are widely used by both rich and poor. However, lack of availability, high out of pocket expenses, and poor quality of care in these systems result in low utilization and suboptimal health outcomes. Private sector organizations with innovative service delivery models targeting the poor have emerged in many countries. This paper reviewed a series of private sector organizations with a reputation for innovation in health service delivery and improving availability, affordability or quality of care for the poor.

We reviewed print and online sources to identify private sector organizations in low- and middle- income countries that have a reputation for innovative business models, and improvements in availability, affordability or quality of care for the poor and have scaled up from initial pilots. We then developed a series of case studies based on a health care delivery value chain, selecting exemplars from different geographic regions, addressing different disease areas and with a variety of innovations. Using comparative case studies, we characterized business process innovations, which fell into the broad categories of marketing, finance and operations.

Based on the qualitative analyses of ten organizations, we found that the organizations innovate across marketing strategies to better target the poor; financial models to dramatically reduce costs; and novel delivery processes to make services more available. Innovations in marketing strategies were mostly in mass communication, customer orientation and franchising. Financial strategies focused on reducing capital and operating costs, high-volume, low-cost models and cross subsidy from rich to poor. Operating strategies included extensive use of paramedical staff and novel delivery mechanisms to reach patients more effectively. All but one of these organizations innovated across all three business processes mentioned above, suggesting that there is no single effective strategy, and a range of strategies are needed to address the barriers in knowledge, financing and geography access to health care faced by the poor.

Most organizations had a narrow disease focus (e.g. eye care or heart surgery) with a range of innovative business processes. The predictability of the health problems and treatment strategies make it easier to simplify processes, delegate tasks to lower trained personnel and measure quality, all of which can reduce costs while increasing reach and quality. Some organizations had innovations which could be translated from private sector organizations to public health systems. None of the organizations we studied attempted more horizontal approaches, addressing the spectrum of population health needs rather than a particular disease. Though vertical approaches have limitations, they may lead to innovations whose benefits could be captured by replication or by linking them to broad-based health services. These cases show that entrepreneurial organizations with innovative business models could make a distinct contribution to designing better health services for the poor.

**Key Terms:** Private Sector, Develping Countries, Innovation

PARALLEL SESSIONS: WORKING WITH THE PRIVATE SECTOR

SESSION D: WORKING WITH THE PRIVATE SECTOR

Chair: Mursaleena Islam

**Presenter's Name: Kara Hanson**

**Organization:** London School of Hygiene and Tropical Medicine

**Title:** Linking the public and private sectors in delivery of health sector services and products

**Full Author List:** Kara Hanson, Tanya Marchant, Hadji Mponda, Caroline Jones, Yovitha Sedekia, Rose Nathan

Vouchers are one mechanism for channelling public financing for health services or products to private providers. A recent systematic review of the equity impact of interventions working with for-profit health providers in low- and middle-income settings identified only 4 voucher programmes which had been "rigorously" evaluated (Patouillard et al. 2007). All of these programmes operated in a limited geographic area (one or two districts, or one urban centre), leaving open the question of whether it is feasible and cost-effective to administer a voucher system at a national scale. The Tanzania National Voucher Scheme (TNVS) for insecticide-treated nets has been delivering vouchers for bednets throughout Tanzania (population 38 million) to prevent malaria among pregnant women and children for the past 4 years. This presentation analyses the cost, impact and operational issues associated with the use of vouchers to link the public and private sectors.

The presentation will draw on the results of an ongoing, multidisciplinary evaluation of the TNVS. It uses data from nationally representative household and facility surveys, a survey of shops, a cost- and cost-effectiveness analysis, and a series of in-depth discussions with stakeholders involved in different aspects of the programme.

By June 2008, a total of 6.6 million vouchers had been distributed, and 2.8 million vouchers had been used to buy a net. Between 2005 and 2007, use of a net by infants increased from 33% to 56% (ITN from 16% to 34%), and by pregnant women from 25% to 39% (ITN from 11% to 23%). Sharp socioeconomic gradients in coverage have persisted, however, with infants in the lowest socioeconomic quintile only 41% as likely to sleep under a net as those in the highest quintile in 2007. Data on the distribution process in 2007 allow it to be disaggregated into its constituent parts in order to understand the elements responsible for these inequities. The effect of the voucher scheme in drawing ITN supply into more remote areas is described, and the views of different actors in the process are presented.

Vouchers have both advantages and disadvantages as a means to distribute ITNs. It is feasible to implement a voucher scheme at the national level in a large, low income country, and vouchers have effectively increased demand in remote, rural areas. However, in this context, vouchers alone are not sufficient to achieve and sustain equitable ITN use: a mixed delivery strategy is necessary to achieve public health impact.

**Presenter's Name: Birger Forsberg**

**Organization:** Karolinska Institutet

**Disclosure:** Authors were consultants of the World Bank that supported the project.

**Title:** Predicting performance in contracting of basic health care to NGOs – experience from large-scale contracting in Uttar Pradesh, India

**Full Author List:** Birger C Forsberg and Anna Heard

Escalating costs and increasing pressure to improve health services have driven a trend toward contracting with the private sector to provide traditionally state-run services. Such contracting is seen as an opportunity to combine theorized advantages of contracting with the efficiency of the private sector. There is still a limited understanding of the preconditions for successful use of contracting and the resources needed for their appropriate use and sustainability. This study assesses large-scale contracting of non-governmental organizations (NGOs) for delivery of basic health services in Uttar Pradesh, a state with almost 170 million in India. A total of 294 NGOs were contracted for such services.

Data on characteristics of the NGOs (intake data) from proposals and reports submitted by NGOs selected were related to information on performance indicators from reports and from third party monitoring. The data were combined to identify correlations between intake data and health service monitoring outcomes.

NGOs selected were generally small but well-established, had implemented at least 2 large projects, and had more non-health experience than health experience. Bivariate regressions of outcome score on each input variable showed that training, proposal quality, and having "health" contained in the objectives of the organization, were statistically significant predictors of good performance. Factors relating to financial capacity, staff qualification, previous experience with health or non-health projects, and age of establishment were not. A combined training plus proposal score was highly predictive of outcome score (â = 1.37, p<.001). The combined score was found to be a much better predictor of outcome scores than a total score used to select NGOs (â = 0.073, p = 0.539).

Results indicated that experience in training field staff and the quality of the project proposal were significant predictors of performance. The organization's assets, financial turnover, and number and volume of previous projects, were not. Smaller organizations, where this contract would make up a larger portion of their paycheck, and who may be more easily dissolved, might have a greater incentive to take the initial disbursement and then fail to deliver. However, that concern was not supported by this study since financial stability measures did not remain in the regression. It is, however, surprising that the experience indicators were not more predictive. It appears that NGOs were able to hire the necessary expertise to implement their tasks or that health project experience was not necessary for being able to improve basic health services. This may in part be due to the relatively low level of sophistication needed to address basic health care. It is reassuring to see that the rating of the project proposal was significant in predicting outcome scores. This indicates that demonstrated understanding of the tasks was predictive of outcome score.

The study provides valuable experience from large-scale contracting. Findings show proposal quality and training experience, but not project experience or financial stability, are predictive of performance. Conclusions on criteria for selecting NGOs for providing basic health care could guide other governments choosing to contract for such services.

**Key Terms :**Contracting, Basic Health Services, India

**Presenter's Name: Anna Vassall**

**Organization:** HLSP

**Title:** How are private health markets treated in health sector plans?

**Full Author List:** Bruce Mackay, Yasmin Hadi, Anna Halen and Yvonne Shonemann

Many health sector plans in developing countries ignore the reality of private health markets, i.e. consumers putting their hands in their pockets and buying medicines and services directly from shops and providers.

The malaria section of a plan may acknowledge that mothers buy medicines for their children from a local shop, and may even propose to do something about it, but this seems to be the exception rather than the rule.

Using a framework similar to that used in a WHO report by Janovsky and Peters*, we are reviewing the plans of 6 countries (and 2 states in one federal country), looking at how each plan deals with three broad issues – demand, supply, and stewardship.

Under these we have identified 16 specific topics (see below) which cover the main issues which we think an 'ideal' health sector plan should include if it is to reflect the reality of private healthcare markets, and do anything about them.

Each time a plan refers (or fails to refer) to these topics, we have asked ourselves three questions, and scored our own answer 'Yes', 'Somewhat' or 'No'.

1. Are the for-profit market aspects of the topic addressed in the document? 2. Is data about for-profit markets presented and/or analysed? 3. Do strategies proposed in the plan include for-profit markets?

**A. Demand**

A1. Health-seeking behaviour; A2. Out-of-pocket expenditure; A3. Consumers' experience

**B. Supply**

B1. Unlicensed peddlers or shops selling drugs; B2. Licensed pharmacies, drug shops or peddlers; B3. Licensed service providers working 100% privately; B4. Licensed service providers working in both sectors (dual practice); B5. Unlicensed 'modern' providers´; B6. Traditional providers; B7. Not-for-profit service providers (missions, NGOs etc)

**C. Stewardship**

C1. Quality of drugs; C2. Quality of care; C3. Regulation and licensing of shops; C4. Regulation and licensing of providers; C5. Professional or trade organisations; C6. Data collection and analysis

* Improving health services and strengthening health systems: adopting and implementing innovative strategies', Working Paper 5, Making Health Systems Work, WHO 2006. Janovsky and Peters

**Key Terms :**Health sector plans; health sector planning; private markets; demand; supply, stewardship

**Presenter's Name: David Bishai**

**Organization:** Johns Hopkins Bloomberg School of Public Health

**Title:** Measuring Multiple Impacts of Social Franchised vs. Private Clinics in Pakistan and Ethiopia

**Full Author List:** David Bishai, Wenjuan Wang and Nirali Shah

The key social goals in health service provision are quality and accessibility to the poor. Social franchises are one mechanism to achieve both goals, but little is known about their performance. The objective of this paper is to compare the cost per each percentage point increase in the proportion of poor clients for social franchises as compared to government providers. The study uses data from the Carolina Population Center Alternative Business Models (CPC-ABM) Surveys conducted in Pakistan, Ethiopia and the Indian states of Bihar and Jharkhand. There were two rounds of data collection and three survey modules directed towards establishments, providers and clients of family planning facilities. Baseline interviews occurred in 2001 prior to phasing in social franchised systems. Follow up interviews occurred in 2004. Exit interviews and facility inspections provided measures of service quality. Client interviews provided measures of socioeconomic position of clients at each facility. In Ethiopia, India, and Pakistan the respective numbers of facilities enrolled in the study were: 369, 1297, and 993. We model costs as a function of the price of inputs and the quantity of outputs, focusing on 3 specific outputs: numbers of visits, quality of facilities, and percent of clinic attendances by patients in the lowest socioeconomic quintile. A decision weighting exercise helped to determine the relative weights of these 3 outputs for decision makers.

Comparing weighted vs. unweighted cost per couple year of projection shows that when the impact of quality and the access for the poor is considered the incremental cost per CYP is more attractive for franchised private providers than unfranchised. Sensitivity analyses are used to show how robust these conclusions are to alternate assumptions.

SESSION E: POLICY

Chair: Stefan Nachuk

**Presenter's Name: Ying Xiaohua**

**Organization:** School of Public Health, Fudan University, Shanghai, China

**Title:** How to develop the private health sectors in China?----a case study in Shanghai.

**Full Author List:** Ying Xiaohua and Huang Jiayan

Over a period of rapid economic growth, China set up a health system through increased the investment in health. A mixed public-private health system provided 2.3 billion outpatients services and 71.8 million inpatients services in 2005. However, China's private health sectors play a minor role in health system. Private hospitals had less than 5% of beds and health personnel respectively. They provided only 2.7% of outpatients services, and 2.5 percentage of inpatients services in 2005. The less development of private health sectors was considered as one of key factors for the less competition to public health sectors. It is also one of determinates of mismatch between increasing demand for and inadequate supply of safe and effective health care. Shanghai, the largest city of China, had the similar status of private health sectors to others.

This research aim to present the status and issues of China's private sectors, find the evidence on policy issues regarding private sectors, and develop strategies to address the main challenges in China. The study was based on data from 93 private hospitals and 259 private clinics. About 80 manages of privates sectors were surveyed. We also conducted 3 group discussions and analyzed 7 typical cases.

Compared to public hospital, private hospitals were smaller scale. The average registration investment capital was less than RMB 10 million, and with less 50 beds. The rate of licensed doctors to nurses is about 1 in private hospitals, and about 2 in public hospitals. Health care quality in private hospital was also worse than that in public hospital. The diagnosis concordance ratio between pre-surgery and post-surgery, inpatients admission and inpatients discharge were 74% and 85% in private hospital, compared to the ratios of 99.9% and 99.8% in public hospitals. Private hospitals also operated with lower bed occupational rate and higher health care prices. The bed occupational ratio was 60% in private hospitals, but 96% in average level in Shanghai. People should pay higher 55 percent cost for one visit to physician in private hospital than that in public hospital, and pay higher 13 percent cost for inpatients services. With regarding to low quality and efficiency, private hospital were difficult to contract to public health insurance plans. Non-for-profit private hospitals' quality was better than that of for-profit hospitals. The status of private hospital in China may be highly related with four policy issues: low entry standard for private health sectors, less regulation on quality of health care provided by private sectors, high tax rate for for-profit private sectors, and low percentage of private sectors contracting to public health insurance.

Government should identify the private hospitals' ownership aligned with hospital's characters. Donor's quality, more investment plan, and category of health care provision should be considered in private hospitals' entry. Punishment regarding with low quality health care and unnecessary care with highly cost should be strengthened. Government should also develop private hospitals, especially non-for-profit private hospitals through financial aid, donor's reimbursement, and bringing private hospital into regional health planning.

**Presenter's Name: Richard Lowe/Dominic Montagu**

**Organization:** UCSF Global Health Sciences

**Title:** Legislation, Regulation, and Consolidation in the Retail Pharmacy Sector in Low-Income Countries

**Full Author List:** Richard Lowe and Dominic Montagu

Formal pharmaceutical retailing in most countries in the world is governed by regulations concerning ownership, staffing, medicines, prescriptions and sometimes prices. However, in most low and middle-income countries regulatory enforcement is difficult or impossible: constrained by limited government capacity, and complicated by the fragmented nature of pharmaceutical retail markets.

This paper documents the current status of private-sector retail pharmacy legislation and regulation in the developing countries where private financing, mostly out-of-pocket, is most important. We look at regulatory frameworks in 25 countries, what legislative and market forces are causing changes in the practice of retail pharmacies, and what the effects of these changes have been in recent years.

Information on countries' retail pharmacy legislation, regulation and practice was collected using a number of strategies. Articles were sought through searches of the academic databases PubMed, ISI web of knowledge and the International Pharmaceutical Abstracts and through general web searches. Very few peer-reviewed articles that related to individual country legislation, regulation or pharmacy practice were found. Much of this information was obtained from Pharmacy Councils or Associations. A complete set of information on three areas of retail pharmacy - legislation, regulation and practice was only found for 13 countries.

Our findings show that in most countries surveyed, pharmacy legislation and regulation is fragmented and there is sporadic and limited enforcement of regulations. Market consolidation is usually restricted by ownership laws. Consolidation in South Africa has resulted from a legislative change, while in India it has been driven by existing legislation and market forces. In these two countries changes in the past five years have permitted rapid expansion of pharmacy chains. The early effects of these chains appear to be lowered prices, greater competition, and an initial balance between newly opened stores in shopping centers and the closure of independent pharmacies.

Four main factors determine the extent to which consolidation is possible in the private pharmacy sector: 1. Legislation on ownership, 2. Regulation, licensing and registration of pharmacies, 3. Availability of qualified pharmacists, and 4. Access to finance to set up a pharmacy.

**Presenter's Name: Sofi Bergkvist**

**Organization:** ACCESS Health initiative

**Title:** The Health Sector Reforms in Andhra Pradesh, India

**Full Author List:** Sofi Bergkvist and Hanna Pernefeldt

It is evident that innovative steps have been taken to shape the future health status of the population in Andhra Pradesh. The State Government has the last couple of years taken several new approaches to improve the access to quality health care. International organizations like the World Bank, European Commission and the Department for International Development (DFID) have a history of supporting reform initiatives within the health sector in Andhra Pradesh. But the political support for health care reform was anchored when the Chief Minister took a strong interest in initiatives for high impact and encouraged innovative approaches in the health sector reform process, back in 2004. This change of mindset resulted in significant budget allocations, providing the grow ground for the new initiatives and to spur improved services in a short period of time for the many underserved people in the State.

New technologies, approaches to service delivery and financial mechanisms have evolved and the aim is to present these, to provide important inputs to discussions on the potential of health sector reforms and role of different stakeholders. The focus is harnessing innovation and improving the access to health care.

The presentation will bring light to the main reform initiatives and describe underlying motives, challenges and opportunities associated with the reform process.

The engagement has resulted in contract arrangements where the government has harnessed the private sector for more effective health care delivery e.g. Health Management and Research Institute's (HMRI) services including training of unorganized individual rural health practitioners, calling center for medical advice, medical vans and electronic health records. Financial protection of the poor, e.g. the Rajiv Aarogyasri community health insurance scheme, covering more than 50 million people and catered to by more than 100 private health care providers, has been another motive of the reform given that health care costs have been the main reason for indebtedness, and the outcome is one of the world's largest health insurance schemes. The Andhra Pradesh Health Sector Reform Programme (APHSRP), with managerial focus for improved efficiency in the work of the government, is yet another initiative which falls under the reform efforts.

The ACCESS Health Initiative documentation, supported by the Rockefeller Foundation, brings forward the health sector reforms in Andhra Pradesh to spur the discussion of health sector reforms as a phenomenon. Through highlighting the change of mindset in Andhra Pradesh, the aim is to nourish the discussion around this at the symposium and to further inspire the spread of its rationale. Other governments can, and should, learn from the extensive and innovative approaches, while the government of Andhra Pradesh would benefit from improved access to information regarding related policy reforms and their affects in other countries.

**Presenter's Name: Barbara McPake**

**Organization:** Queen Margaret University, Edinburgh

**Title:** Two-tier issues in low income countries' health systems

**Full Author List:** Barbara McPake

This paper considers of those instances of two tier provision where a single provider offers both services, for example, where a 'private' or 'high-cost' service co-exists with a standard one or where a provider in the public, for-profit or not-for-profit sector seeks to tailor services to particular client groups to maximise producer surplus or to achieve specific cross-subsidies. These are interesting because the services are not substitutes in competition with each other, but part of the strategy of a single provider who will consider the implications for profit from one service when developing strategy for the other.

A model of two-tier strategies operating within a public hospital environment suggested that the implications for allocation of resources between the two tiers could be regressive given levels of cross quality and price elasticity between the two services of unknown plausibility.

This paper explores the broader implications of the model for the wider range of scenarios crossing public and private sectors, reviewing relevant literature for instances of analytically similar market situations, evidence of cross-price and quality elasticity and analyses of impact in terms of resource allocation.

Analytically similar market situations arise in insurance, where alternative packages are offered in competition with each other by the same and competing insurance agencies. Choices made by consumers between alternative insurance packages reveal risk information. They also reveal consumer preference information in ways that allow insurers to maximise producer (insurer) surplus through price discrimination. Insurers' reactions to the information revealed in both respects have implications for resource allocation and the equity of outcomes.

Other analytically similar situations arise in the pricing strategies of not-for-profit providers seeking to manage exemption systems in a manner that aims to cross-subsidise from richer to poorer users and in the 'Ramsay pricing' strategy argued to be operated by the pharmaceutical industry in pricing pharmaceuticals for different national markets.

Cross-price elasticities can be inferred from some studies of demand for health services and pharmaceuticals, hence can be identified at some points in relation to level of health service demanded (pharmacy shop, primary, secondary etc.); market structure (more and less competitive), and shares of public and private in total expenditure.

However, implications of the pricing strategies of market players, including public sector ones for resource allocation and equity are rarely evaluated except for in the cases of a few public policy areas such as changing basic fee levels in the public sector and to a limited extent with respect to the pharmaceutical pricing debate.

This paper argues that there is significant scope to gain better understanding of the scope and strategies for cross-subsidy of poorer health system users by developing better models with wider applicability of inter-dependent demand functions and focusing empirical research on the testing of these models.

**Key Terms :**Two-tier health systems; low-income countries; cross-subsidy; inter-dependent demand; equity; public-private mix

# ABSTRACTS OF POSTER PRESENTATIONS

**Presenter's Name: Faheem Ahmed**

**Organization:** Baqai Medical University Karachi, Pakistan.

**Title:** Role of Public Private Partnerships in Pakistan Health Care Scenario: A Qualitative Study.

**Full Author List:** Faheem Ahmed

To review the situation of public private partnership in health services of Pakistan.

In most countries of world, financing as well as provision of health services has historically involved both public & private sector actors. The nature of interaction is variable but mostly lies within parallel, collaborative, competitive and complementary activities. In parallel, the two sectors coexist with little contact between each other due to different objectives among them in compare to collaborative where both sectors work together on the basis of agreed objectives, strategies as a joint venture. While competitive activities have similar objectives, cater to the same clientele which may have a capability of situation in control and compete with each other whereas complementary collaboration between the sectors is independent & complement to situation.

Public Private Partnership as a health sector reform in Pakistan had instituted to national health policy in 1960 and started in corporate social responsibility to serve nation till to date. The government is unable to fulfill its constitutional promise that the state shall provide basic necessities of life including provision of health care and bringing reform in health sector of Pakistan. National priority of government is to spend money on national security over human development. Pakistan is facing double burden of diseases and fail to overcome the infectious diseases i.e. polio etc and facing challenges to combat chronic diseases. The partnership is considered to be a successful health reform in health sector, but the policies in Pakistan remain largely unexamined and insensitive to the concerns of accessible, available, affordable, acceptable quality basic health services e.g. District Rahim Yar Khan. It could be due to disparity in power, lacking trust, downsizing of social capital and others like financial resources between the public and private sector. As a result, health sector in Pakistan is far from developing a consistent form of interaction between public and private sector and suffers from a persisting political polarization along three major, intersecting fault lines, are civilians and the military, different ethnic and provincial groups and religious and secularists reflecting burden of diseases and the gaps between the openness for collaboration at the policy and operational level in health care services since the partition of the subcontinent in 1947. As far as health indicators are concerned the infant and maternal mortality rates for Pakistan are 80/1000 live births and 340/100,000 live births very high as compared to other developing countries.

Public Private Partnership is a multidisciplinary and multi-sectoral approach in health services requires highly significant institutional development, socialisation, monitoring and evaluations systems. Therefore it is suggested to promote and practice standardized public private partnerships in health care services, when health care is inelastic and leading to greater benefit and improvement in health status of our society to meet the challenges of globalization and finally prosperous Pakistan for the 21st century.

**Key Terms :**Health policy, Burden of Diseases, Pakistan

**Presenter's Name: Ann Levin**

**Organization:** Consultant, World Health Organization

**Title:** The Role of the Private Sector in Immunization Service Delivery in Developing Countries

**Full Author List:** Ann Levin and Miloud Kaddar

While the private sector may play a relatively important role in delivering immunization services in developing countries, few articles have tried to summarize the extent of this role. If the real dynamic of the private sector in providing these services can be documented, then it will be easier for the public sector to develop policies so that it can work more effectively with the private sector.

The objective of the paper is to summarize what is known about the private sector's role in delivering vaccination services based on existing data.

A literature review was conducted on PubMed to obtain published articles on the role of the private sector in immunization service delivery and other health services in developing countries. The authors also solicited grey literature on the subject through various networks of persons working in immunization service delivery. The articles and other documentation were then summarized to assess what is know about the private sector's role in immunization service delivery as well as gaps in the literature.

Consumer surveys in selected Asian countries suggest that more than ten per cent of vaccination services are obtained through the for-profit sector. These consumers use these services for a variety of reasons: 1) to obtain vaccines that are not available through national immunization, 2) to reduce waiting times, 3) for perceived higher service quality, or 4) for the better reception received. In other regions of the world, a mixture of NGOs and for-profit private health facilities are providing some vaccination services. NGOs play an important role in countries with limited access to public services and those designated 'fragile.' Gaps were found in the literature on the extent to which consumers obtain these services through these outlets.

The literature review indicated that consumers are using the private sector to obtain vaccination services under certain circumstances for a variety of reasons, particularly in Asian countries. Many gaps in the literature remain on the extent to which consumers obtain vaccination services through the private sector.

**Key Terms**: Private Sector, Immunization Services, child health

**Presenter's Name: Arun Bahuleyan Nair**

**Organization:** National Health Systems Resource Center, New Delhi, India

**Title:** Public private partnership for equitable and rationalized healthcare under National Rural Health Mission in India

**Full Author List:** Gautam Chakraborty, Arun Bahuleyan Nair and Riya Dhawan

Health financing in India is characterized by very low public expenditure and heavy reliance on out-of-pocket expenditure to meet treatment costs. Due to shrinking budgetary support and fiscal problems, most state/provincial governments in India are finding it difficult to expand their public facilities to cater to the growing health care needs of their populations. Hence private provision of health care is one important constituent of health care delivery system in India and its role has increased considerably over the time. But, the increased dependence on private health sector leading to high cost private healthcare has increased the inequities in accessing affordable health care in India. Under the National Rural Health Mission (NRHM) launched by the Government of India in 2005 to bring about "architectural correction" in the basic health care delivery system, has adopted partnerships with the private sector as a strategy for expanding and rationalizing affordable health services for the poor in rural areas.

The objective of this paper is to evaluate public private partnership initiatives under National Rural Health Mission (NRHM) and to understand the importance of these initiatives in context of health sector reforms in India. The paper also looks into the different forms of partnerships arrangements and their role in improving health equity and system performance.

National Rural Health Mission (NRHM) envisages pro-people partnerships with non governmental providers for meeting public health goals and making the public health system to deliver quality health services. Under NRHM a wide range partnership initiatives have been taken up ranging from contracting services, social franchising, voucher schemes, risk pooling mechanisms and capacity building initiatives undertaken for realizing the above mentioned goals. Initial results suggest that these initiatives have been successful in providing quality primary care to poor people in rural areas, increased competition and choice of providers, and creation of synergy between the public and private systems thereby reducing the duplication of efforts and wastage of funds. But in the absence of effective regulation of private providers and lack of management capacity in public health system, many programmes contributed to inefficiencies in the system and duplication of efforts at some places and non-availability of services at others.

**Presenter's Name: Awad Mataria**

**Organization:** Birzeit University& Palestine Economic Policy Research Institute

**Title:** Public policies to enhance private sector investment and competitiveness in tertiary health care in the occupied Palestinian territory.

**Full Author List:** Awad Mataria and Philip Khoury

In its current arrangement, the Palestinian health care system does not guarantee full access to all patients. Tertiary health care provision continues to be sub-optimal, with high demand geared towards treatment abroad, that is, in Egypt, Jordan or Israel. Since its establishment, the Palestinian National Authority strived to support an open market economy, with active involvement from the private sector in all economic spheres. There are many negative views against some forms of competition; and policymakers aspire to identify the most efficient form particular to each market. It is believed that the private sector has potential to take up a leading role in tertiary health care provision in the occupied Palestinian territory, should effective competition structures set up in a manner that can enhance private sector's competitiveness. The nature of competition that is seen plausible for the occupied Palestinian territory is what is known as the "value-based competition". Under the particular conditions of value-based competition, health care providers benefit from incentives to compete on the goal to deliver value to patients, rather than on: reducing costs and/or increasing patients' volume.

This paper aims to inform the process of enabling private sector development in the area of tertiary health care provision in the occupied Palestinian territory by setting the basis for a structure of value-based competition.

The paper employs the "Diamond Model" proposed by Porter (1998) to assess the competitive status of the Palestinian health care system. The Model incorporates four determinants: demand conditions, factor conditions, status of related and supporting industries, and nature of firm strategy, which are influenced by the government and the external circumstances. A series of unstructured interviews conducted with a group of stakeholders involved in health care planning and provision was conducted to assess: the opportunities and challenges facing the health sector, the perspectives for future development, and the appropriateness of a value-based competition structure in the local Palestinian context.

The main factors that hinder private sector investment in tertiary health care are related to two groups of variables that compromise all four determinants of the Diamond Model. These are: financial hindrances (e.g., high running and capital costs, fragmented health care financing system, extreme uncertainty and risky investments, weak purchasing power of Palestinians, and movement restrictions); and features related to supporting health care provision (e.g., political and macroeconomic instability, unsupportive and variant Ministry of Health policies and strategies, limited and constrained demand, inadequate Palestinian stock of technical and scientific knowledge, weak private hospital administration and management, no effective representative body for the private sector, and the absence of cluster industries). Both groups of variables are influenced by the unstable political situation and the lack of an effective incentive structure in the local context.

Employing the right competition is instrumental for enhancing competitiveness. Should value-based competition be employed within the occupied Palestinian territory, it would increase the overall efficiency and sustainability of the health care system, ultimately lowering the costs of treatment and increasing the quality of care. For this to be materialized, policies should be constantly rooted in making 'value to the patient' the central focus for competition. This can be only ascertained under strong and effective stewardship conditions from the side of the Ministry of Health, something which necessitates public sovereignty and control over available resources. **Key Terms :**Value-based competition, Private sector, Tertiary health care, occupied Palestinian territory

**Presenter's Name: Christian Lorenz**

**Organization:** Federal Bureau of Statistics, Pakistan and Centre for International Migration and Development, Germany

**Title:** Household expenditures on health – microdata analysis on out of pocket payments in Pakistan

**Full Author List:** Christian Lorenz

Private households Out-Of-Pocket expenditures (OOP) are one of the most problematic components of expenditures for measurement. Besides that OOP are typically the first or second largest source of health care financing in developing countries. Estimations of private expenditures continue to present countries with the greatest difficulties and can even undermine the credibility of health accounts estimates, and could have a significant negative impact on policy-makers' views as to the credibility of NHA statistics. In most countries, private expenditures account for the largest source of error in estimates of national health spending, and represent the most substantial barrier to reliable international comparisons. Differences in the methodological approaches by health accountants in different countries explain a large part of the differences in levels of private expenditure being reported. Therefore, this paper focuses on the calculation of health OOP for NHA and describes the methodology in the case of Pakistan.

Out-of-pocket payments have substantial negative side effects, because they do not protect a person from the costs of illness. They may lead to impoverishment and hardship for the patients due to the fact that poorer people often are sicker, so they may not have the cash to pay out of their pocket for their treatment. Either the illness will remain untreated because of lack of funds or the person will loose what little money he had and end up in dire need. The result may be that poorer people may seek less care and will remain in the vicious circle of illness and poverty.

The estimation of OOP is important, because private expenditures consist of expenditures by households, firms, non-profit organizations and medical insurance schemes. But outside a few high income nations, private expenditures consist predominantly of household out-of-pocket spending. In Pakistan the share of OOP as percentage of total private expenditures on health is relatively high with 98.2% in the year 2000 and 98.0% in 2005.

Overall, the private expenditures on health as percentage of GDP are small compared to other countries. The share of the private expenditures on health as percentage of total health expenditures is relatively high in international comparison.

**Key Terms :**household expenditure, out of pocket, national health accounts, Pakistan JEL Classification: D1, I1

**Presenter's Name: Cunrui Huang**

**Organization:** School of Public Health, Sun Yat-sen University

**Title:** Private healthcare provision in China: a study of its role and potential

**Full Author List:** Cunrui Huang and Haocai Liang

China continues to face great challenges in meeting the health needs of its large population. The challenges are not just lack of resources, but also how to use existing resources more efficiently, more effectively and more equitably. While healthcare services are primarily financed by out-of-pocket spending, healthcare providers, especially the hospitals, are still under government ownership and control. Internationally, private healthcare provision has been proven to play an important role in the healthcare system. However, its role in China has not been adequately assessed.

The objective of this study is to analyse the role of private healthcare provision in China and discuss the implications of increasing private sector development for improving health system performance.

This study is based largely on an extensive literature review to identify, summarize and evaluate ideas and information on issues of private healthcare provision, including the theoretical underpinnings and empirical basis of private healthcare provision from international experience, the problems of healthcare provision in China, the debate on private healthcare provision in China, and the preliminary evidence on the performance of the private health sector in China.

In China, government owned hospitals form the backbone of healthcare provision and also account for most provision of healthcare services. However, even though the public health sector is constantly trying to adapt to population needs and improve its performance, there are many problems in the system such as limited access, inequality, low efficiency, low responsiveness and cost inflation. Currently, private clinics are much more common, especially in rural areas, but private hospitals are relatively rare and usually found in the big cities. Also, preliminary available data suggests that patient satisfaction seems to be higher with the private providers than with the public providers. However, this important component of the healthcare system has received little government policy attention.

Policymakers in China should recognize the role of private healthcare provision for health system performance. Policymakers need to define and achieve the appropriate role for the private healthcare provision in helping to respond to many future challenges, and then regulate private healthcare provision to ensure access, equality, efficiency and quality. At the same time, research is needed to conduct a systematic assessment of private health sector in China.

**Key Terms:** private health care provision, China, health policy

**Presenter's Name: Dina Balabanova**

**Organization:** London School of Hygiene and Tropical Medicine

**Title:** Health Sector Governance: how can governments engage with the private sector and what are the capacities required?

**Full Author List:** Dina Balabanova, Valeria Oliveira-Cruz and Kara Hanson

The private sector plays an increasingly important role in the health systems of low and middle-income countries, and is critical for scaling up the delivery of essential interventions. Public sector institutions often have limited experience with the private sector due to suspicion compounded by a history of a lack engagement, concerns about sustainability, and the complexity of interface required. They also lack the skills and competencies to engage with non-state actors.

This paper develops an analytical framework for conceptualising the governance function within health systems and the role of government in the context of expanded private service provision and financing. Governance failures, in health systems or in the wider society, have been perceived as obstructing progress towards international goals such as the health MDGs. However, existing governance frameworks have not always been explicit about the significant role often played by private sector actors.

In our model, the government interacts with the private sector at three different levels to achieve public health goals: by protecting the public interest; by working with the private sector; and by learning from each other. Possible roles for government (financier, regulator, health systems steward) are identified in the context of a large or growing private sector. Indicators of progress are suggested. The framework recognises the multiplicity of public and private actors including individual consumers, civil society and, in the context of aid-dependent low income countries, donors. These actors are in complex interrelationships involving exchange of funding, skills, inputs, services, information, influence, and accountability. The relationships are shaped by formal rules of engagement and informal rules, values and attitudes. Maintaining engagement between actors – through dialogue, sharing information, and ensuring mutual accountability -- is key to building and sustaining relationships.

The framework is applied to three case studies illustrating how differences in context affect the forms of government engagement and governance function. In India, regulation of a growing private insurance market involved state governments purchasing health insurance packages covering vulnerable groups. In Uganda, government provides subsidies to "private not-for profit" providers (often faith-based) to operate in underserved areas, and in Afghanistan, government acts as a steward and financier, contracting NGOs to deliver first-line health care. The common benefits of proactive government leadership ranged from expansion of coverage, to improved capacity, public-private synergies, reduced fragmentation of the health system, and enhanced communication. There were also challenges to this process including ensuring access, unpredictability of donor funding (Afghanistan/Uganda), side effects of increased competition and difficulties in monitoring and evaluation of policy implementation where information about the private sector is inadequate. Finally, the capacities required within both the public and private sectors to establish working models for multi-actor collaboration are considered.

Efforts to improve outcomes and health system responsiveness depend on developing new models for integrating public and private health resources. Effective public-private partnership requires re-examining governance (both formal rules of engagement and informal societal rules and values), and a focus on capacities for engagement required both in the public and private sectors.

The British Academy provided some funding to D.Balabanova for the presentation of the results for this project

**Presenter's Name: Elizabeth Ekirapa-Kiracho**

**Organization:** School of Public Health, Makerere University,

**Abstract Title:** Disparities in Access To Quality Health Care In Private vs. Public facilities in Uganda.

**Full Author List:** E Ekirapa-Kiracho, S N Kiwanuka, O Okui, G Pariyo and D Bishai

While the developed world has made strides in increasing access to quality care for the majority of the population, in developing countries, access to quality health care remains a challenge especially for the poorest segments of the population.

This study assessed the quality of outpatient care provided by public and Private not for Profit Facilities (PNFP) and the quality of outpatient care provided to patients of different socioeconomic status.

An analytic cross-sectional study was carried out in 10 public and 10 PNFP health facilities in Eastern and Western Uganda. Observations of 1446 patient provider interactions in the outpatients' clinics of the facilities were done. Thereafter exit interviews were also done with the 1446 observed patients. The presence of structural components of the facilities were ascertained using observation checklists. Principal Components Analysis and raw scores were used to construct the indices that were used to assess different components of quality, as well as the socioeconomic status of the patients. Regression analysis was used to asses the relationship between quality of care, ownership of the facilities and socioeconomic status. Ethical approval for the study was sought from the relevant institutions in Uganda.

The analytic framework used was based on Donabedian's framework for quality care. The majority of health workers had low scores on assessment of their general performance and the quality of their communication. Regression analysis showed that there was a difference in the availability of essential drugs (Co-eff -1.58)(C.I -0.29, – 2.87 )and supplies ( Co-eff –1.82) (C.I -.377 -3.24) with the Public facilities more likely to have essential drugs and supplies than the Private not for Profit Facilities There was no statistical difference in the general performance and in the quality of communication care provided to patients of different socioeconomic status.

Although no major disparities were seen in the measured components of quality of care, the general performance of the health workers and the quality of their communication was poor. Public facilities were better stocked with essential supplies and drugs than the PNFP facilities. Since PNFP facilities provide care to a substantial proportion of the population, steps should be taken to revaluate the adequacy of subsidies provided by the government to PNFP facilities. Regular assessments aimed at improving the quality of services provided at PNFP and public facilities should also be undertaken.

The authors acknowledge the Department for International Development who funded this project under the Future Health Systems Research Program Consortium, all staff from the health facilities who participated in the study and the collaborating partners from Johns Hopkins Bloomberg School of Public Health, Institute of Development Studies, Sussex as well as the other institutions in the consortium.

**Key Terms :** Quality, Poor, Health service, Utilization, Acess , Uganda

**Presenter's Name: Folashade Laoye**

**Organization:** Hygeia Community Health Plan, Nigeria

**Title:** Improving access to health care for the poor using donor subsidized risk pooling schemes

**Full Author List:** Folashade Laoye, Njide Ndili, Abayomi Sule, Onno Schellekens, Chris van der Vorm

Africa is populated by about 14% of the world's population but bears 25% of the global burden of disease in human and financial costs. Africa is plagued by a complex burden of disease characterized by the predominance of infectious diseases and an increasing prevalence of non communicable diseases. Almost half of the global deaths of children under 5 take place in the continent. Africa is home to about 67% of the global HIV/AIDS cases, 60% of malaria cases and 30% of tuberculosis cases. More people in Africa die from the trio of these diseases and other communicable diseases than in any other continent of the world.

In spite of the grave burden of disease, only 1% of total global health expenditure is spent in Africa. Faced by ever-increasing social demands and limited or declining national incomes, government health care funding remains inadequate. About 60% of health care financing which is largely out-of-pocket is from private sources while 50% of total healthcare expenditure goes to private health care providers.

The predominant out-of-pocket payment mechanism which typifies the African health care delivery system constrains many Africans from seeking treatment at modern health facilities due to the lack or inadequacy of personal finance that guarantees admittance or accessibility to such facilities. This payment mechanism excludes low income individuals by default. This exacerbates inequity and the resultant health expenditure may induce a poverty trap for many who are poor or are impoverished by catastrophic health care expenditure. Typically these individuals do not patronize the modern health care centres but rather access medical care through herbalists, patent medicine stores and other similar unorthodox sites. This situation exposes them to significant morbidity and occasionally mortality resulting from inappropriate and sometimes harmful practices which characterize these unregulated alternative health care services.

Risk pooling arrangements such as community health insurance schemes, run on the HMO managed care platform, are proving to be an alternative route of access to health care services which provide a comprehensive array of primary and secondary care services within an integrated care delivery framework with an emphasis on cost effectiveness and quality of health care service delivery. However, even this access route is only viable if it recognizes the need for premium subsidies for certain categories of individuals to facilitate their entry into the risk pooling arrangements. Such categories of individuals include the urban poor, rural dwellers and other vulnerable populations. It also needs to recognize the role of professionally-run private sector Health Maintenance Orgainzations (HMOs), who have the significant twin roles of managing the risk pool and the quality of healthcare services provided.

Hygeia Community Health Plan is a private sector-led HMO, who with the donor support of the Dutch Health Insurance Fund, provides access to quality basic health care services through the provision of subsidized health insurance premiums for low income (poor) populations. The scheme has demonstrated that an effectively structured demand-driven risk pooling scheme can revitalize and strengthen primary care activities at community health centers. The experience and lessons learnt from the commencement and implementation of the Health Plan will be shared.

**Key Terms:** Health insurance, private care, Private financing, Nigeria, Africa

**Presenter's Name: Gerald Bloom**

**Organization:** Institute of Development Studies

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**Title:** Making health markets work better for poor people

**Full Author List:** Gerald Bloom, Claire Champion, Henry Lucas, David Peters and Hilary Standing

During the past two decades there has been a dramatic spread of market relationships in the health sector of many low and middle-income countries. The spread of markets has often been much faster than the capacity of the state and other key actors to establish regulatory arrangements to influence their performance. The growth in largely unregulated markets has resulted in problems with the safety, quality and cost of health services, particularly for the poor. This paper explores the applicability of the M4P (markets for poor people approach) to health-related goods and services. These markets face particular problems with information asymmetry and the danger that providers will abuse the power it gives them. They also face problems with quality and oversight where the potential for harm is high.

Poor people obtain a large proportion of their health-related goods and services in largely unregulated markets. For example, informal providers and drug sellers are an important source of advice and pharmaceuticals in many countries. The spread of the mass media and of a variety of information and communications technologies have greatly increased access to health-related knowledge, including for the poor. These developments are creating major opportunities for enabling people to gain access to effective solutions to their health problems. However, it also exposes them to information, goods and services where judgements have to be made on competence and quality and where different stakeholders may be attempting to influence their behaviour.

The health systems of the advanced market economies have evolved complex arrangements to address these problems. These are adapted to a context of highly regulated markets and well organised and largely accountable governments. Health systems are also path dependent in that early institutional and technical choices are highly determining of future pathways. For both these reasons, arrangements do not therefore necessarily transfer predictably or appropriately to other country settings. This paper argues that local innovations are much more likely to address the problems of unregulated markets and that we are now seeing considerable dynamism in a number of developing countries in response to the grwoth in health markets

The paper develops a framework for designing and implementing innovations aimed at making markets work better for poor people. Focusing on the social contract between providers and users, it reviews a number of arrangements that have emerged with a particular focus on the providers largely used by the poor. Noting that there are major risks of unintended consequences in attempts to alter the performance of markets about which there is very little systematic information, it argues for a learning approach in which innovators and health systems analysts collaborate in the design and redesign of innovations to address the needs of the poor and in the development of indicators to evaluate their impact. The aim is eventually to enable appropriate institutional actors – whether in or outside government – to monitor and regulate their performance.

**Key Terms:** markets, reputation, innovation

**Presenter's Name: Hanna Pernefeldt**

**Organization:** ACCESS Health initiative

**Title:** Bringing innovations from the private sector to public sector - for improved health service delivery

**Full Author List:** Sofi Bergkvist and Hanna Pernefeldt

The private sector has proven free to innovate and come up with low cost and high quality solutions in health care delivery, while the government has an advantage to achieve equity and scale. Recent health sector reforms have acknowledged opportunities to strengthen health care delivery by having the governments efficiently buy services from private providers, illustrating a redefinition of the roles of the public and the private sector. There is, however, still vast delivery of services by public providers and there are opportunities to improve efficiency in the delivery mechanism by adopting innovations from the private sector.

The phenomenon is highlighted by bringing forward Indian examples of innovations sprung from private providers and adopted by the public sector for a broader reach and implementation. The emphasis on these models and programs will feed the discussion regarding how innovations can be adopted by the government to provide the services or be purchased from private providers.

The Home Based Newborn Care model, initiated by the Society for Education, Action and Research in Community Health (SEARCH), and the School Health Program spearheaded by the NICE Foundation will serve as two examples, discussed in further depth. Representatives from these two organizations can be present for further elaborations of their experiences.

The Home Based Newborn Care model, developed by SEARCH, has been endorsed by the Indian Government under the National Rural Health Mission. Since most deliveries are performed at home in rural areas, the model engages existing cadres of health workers, such as the government appointed ASHA workers. With a sound evidence base, the model complement the overall aim to increase the number of institutionalized deliveries, giving proof of a meaningful partnership between the government and a non-governmental organization to reduce the overall maternal and neonatal mortality. With a standard package for intervention, including methods of selection of community health workers, training, supervision and management, it has been piloted in a total of six states and can be leveraged for national and international scale-up. The NICE Foundation's School Health Program has been recognized and leveraged, starting in Andhra Pradesh covering 60,000 children and brought to Rajasthan covering 188,000 children. The program enables poor government school going children total health care coverage with zero cost to the family. Including screening of all the children, awareness creation about sanitation and hygiene and covers medicines for common cold to cardiac surgeries at a cost of less than US$5 per child per year. The Government of Rajasthan has requested NICE Foundation to roll out the program in the entire state.

These two initiatives are merely examples of innovations that have been brought from the private sector to the public sector for a broader public health coverage and impact. An active approach by the public sector to identify and leverage solutions like these is called for and the discussion at the symposium will serve as a guiding example for policy makers on how to engage and take action to scale proven concepts.

**Presenter's Name: Indrajit Hazarika**

**Organization:** Public Health Foundation Of India

**Title:** Potential Impact of Medical Tourism on The Workforce And Health System In India

**Full Author List:** Indrajit Hazarika

Globalization has had a significant impact on diverse establishments of the Indian subcontinent. Medical tourism is one such example of how India is affected by globalization and outsourcing.

India has a large and unregulated private health care sector, which provides good quality care at a price. However, the cost of health care even in this sector is economical as compared to similar services in the western world. This provides a unique opportunity for this sector to materialize upon. Realizing the immense potential of this field not only has the private sector capitalized on it; even the Indian government has made several efforts to promote it. In its endeavor to promote India as a "global health destination" several measures that have been undertaken to encourage more international "clients" for medical tourism e.g. there have been improvements in the airport infrastructure to ensure smooth arrival and departure of medical tourists.

Although there are no verifiable statistics regarding the magnitude of medical tourism, the available information suggests that a substantial number of patients travel to developing nations for healthcare. In 2004, 1.2 million patients traveled to India for healthcare. One source projects that 750,000 Americans will go offshore for medical services in 2007, with this number increasing to 6 million in 2010. It is estimated that medical tourism to Asia could generate as much as $4.4 billion by 2012, with approximately half of this revenue going to India. It has been estimated that the global medical tourism industry currently generates annual revenues up to $60 billion, with 20% annual growth. However, another valuation suggests that the industry is somewhat smaller, with growth to $40 billion projected by 2010.

Supporters of medical tourism argue that it promotes patient choice, gives consumers access to treatment alternatives not found in their local communities, permits expedited access to care, fosters global competition, and puts pressure on more expensive health care facilities to lower their prices. As well, say advocates, the practice promotes economic and social development by building health care economies in developing societies.

However, the opponents of medical tourism express concern regarding its impact on the health systems and the health workforce in the country. The private sector has always been prominent as a source of medical care in India even though it is expensive catering to the elite and poor quality public-funded care serves the poor. When the poor are forced to seek private medical services they face pauperization; more than 40 per cent of patients admitted to hospitals borrow money or sell assets and 25 per cent of peasant families with a member needing in-patient care are driven below the poverty line. The consumerist culture inculcated by the globalization and medical tourism has been detrimental to the already frail health care system in the country. Though the advent of medical tourism has brought with technical expertise and more professional services, it has further widened the gap of health care access between the poor and elite. Besides, this the exodus of the trained and skilled, from public health facilities to the private establishments has debilitated and exacerbated the existing shortage of skilled health staff.

Given, the above circumstances it has become inevitable to take notice of the deleterious impact of globalization albeit medical tourism on the Indian health system. The present paper will evaluate the potential impact of medical tourism on the health workforce and health systems in India.

**Key Terms :**Medical Tourism, health systems, health workforce

**Presenter's Name: Keerti Bhusan Pradhan**

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| **Organization:** Aravind Eye Care Hospital |
| **Title:** Private-Private Partnership for High Quality, High Volume and Sustainable Eyecare Services-A model in Africa |
| **Full Author List:** Keerti Bhusan Pradhan |
| Although much of the attention on health care in sub-Saharan Africa centers on government activity, the private sector plays a surprisingly significant and growing role in meeting the region's health care needs.<br><br>International Research found that the increasing demand for health care due to improved economic growth across much of the region could translate into $20 billion of additional investment in the region's private-sector health care infrastructure in the coming decade.<br><br>The findings suggest opportunities for private enterprise to help improve the region's woefully poor health outcomes. At the same time, the research also highlights challenges—such as inconsistent quality of care, health worker shortages, and inadequate regulation—that must be addressed if the private sector is to most effectively benefit the health of Africa's people.<br><br>Right to Sight has piloted a private-private partnership model in providing eye care services in Democratic Republic of Congo. A private business concern in Lubumbashi with catalystic support from right to sight has established an eye hospital in Lubumbashi which is providing high volume, high quality and self sustainable eye care services. This pilot would provide road map for many private partnerships to have eye care services in Africa leading towards the goal of eliminating avoidable blindness by 2020. |

**Presenter's Name: Keerti Bhusan Pradhan**

**Organization:** Aravind Eye Care Hospital

**Title:** Doing Right Things vs Doing Things Right-An example of a National Plan for Prevention of Blindness in Rwanda.

**Full Author List*:** Keerti Bhusan Pradhan

Purpose: Development of relevant, evidence based, practical and need specific National Plan for Prevention of Blindness

Method: An expert agency was identified who has experience in facilitating national plan development and design and all the stakeholders were invited for a three day planning workshop.

The workshop had a pre designed format to guide the sessions and daily plan of the workshop. Also a detailed background work and secondary research was done on the previous national plans and eye care programme in the country.

The outcome of the three day workshop was a participatory and realistic national plan which was accepted by all stakeholders and had a higher level of buy in from the government. A participatory process of developing national plans with a thorough background work helps in development and design of a practical and realistic national plan which helps in achieving the goals. Doing Right Things is of utmost importance as that guides the implementation.

**Presenter's Name: Lan Yao**

**Organization:** Center for Basic Medical Security Research, Huazhong University of Science and Technology

**Title:** Study on developmental policy of non-state owned medical facilities

**Full Author List:** Lan Yao

Through studying on the present conditions and existing policy barriers in non-state owned medical facilities (private medical facilities), this paper is to put forward some policy recommendations on how to promote the healthy development of private medical facilities in China.

Literature review method was utilized to know about the present development, facing problems, experiences and lessons of private medical facilities in China and some international experiences related to private hospitals. Through field trip, quantitative data related to health resources distribution in sampling City, profiles and operation of sampling private and public hospitals, as well as patients, general public and health workers' satisfaction were collected. Individual in-depth interviews were also conducted with some key informants, such as health bureau officials, directors and some health workers in public and private hospitals.

Chi-squared test, logistic regression and descriptive analysis were adopted in quantitative data analysis and descriptive content analysis method was used in qualitative data analysis.

In China, private medical facilities constituted a small proportion, had smaller scales and provided fewer services and lower efficiency compared with public medical facilities. In 2006, private hospitals accounted for 21.3% in the hospital systems; private health resources were rare in terms of beds (6.2%), health professionals (13.4%), fixed capitals (4.7%) and revenues (4.7%); total outpatient and inpatient services volumes in private medical facilities respectively made a share of 3.6% and 2.7%; average bed occupancy of private medical facilities was 46.0%, a long gap compared with public hospitals (73.8%). Besides, most private hospitals were for-profit.

Private medical facilities were confronted with some policy-related problems in their development, including: equal policy environment and monitoring and information revelation systems were not established; health workers couldn't migrate freely between public and private hospitals because of delayed personnel system reform in public hospitals; tax imposed on for-profit private hospitals according to commercial tax policy added to their financial burden; Hospital Management by Categories Policy (under which, private medical facilities were usually classified into for-profit organizations), No Return from Investment Policy (seeking return was not allowed through investment for non-profit medical facilities ) and Ownership of Property Rights Policy (property rights of initial investment of the non-profit medical facilities should be owned by the collective organizations or the nation) prevented for-profit private medical facilities from transforming into non-profit facilities.

In view of international experiences, most private medical facilities should be non-profit. Besides, under the background of the developed public hospital system in China which can adequately provide essential and specialized health care, private medical facilities should focus their priority on providing high specialized services with their own features for high-end clients. Correspondingly, related policies should be formulated and implemented efficiently to catalyze healthy development of private medical facilities, including: firstly, equal policy environment, monitoring and revelation systems should be established; secondly, personnel system reform in public hospitals should be implemented timely; thirdly, commercial tax policy imposed on private for-profit medical facilities should be reconsidered as medical facilities play important role in protecting people's health which are not equal to general for-profit companies; fourthly, private medical facilities should not be defined as for-profit organizations with bias and compensation should be considered if seeking returns or retaining ownership of property rights are not allowed to facilitate their transformation into non-profit facilities. **Key Terms :**non-state owned; medical facilities; development; policy

**Presenter's Name: Lydia Esther Buzaalirwa**

**Organization:** JsiR&T: Uganda Hiv Services Project (Uhsp)

**Disclosure:** UHSP is implemented with funding from USAID. The information in this paper is based on results and experiences from project implementation and monitoring .

**Title:** Efficient Delivery of HIV and AIDS services in Uganda: Lessons from the Uganda HIV Services Project (UHSP)

**Full Author List:** Samson Kironde, Alexander Mugume, Lydia E Buzaalirwa, Naome N Wandera and Josephine Kasaija

Uganda is currently experiencing a growing and vibrant private sector including the health sector at the moment; this is rooted in a couple of factors such as the changing political situation in the country, economic, epidemiologic and demographic transitions within the country. The other possible contributing factor to the rapid growth of the private health hector in Uganda is the possible limited scope of reach and functionality of the public health sector.

The utilization of health services is influenced by a combination of demand, supply and need for services. In a country like Uganda as a result of the inadequate capacity within the public sector and the rapid population growth, there is a great unmet need for health services which is driving the private health sector to bloom. In addition, the reforms prescribing restrictions to recruiting spending in the public health sector limit entry of newly trained cadres into the public sector hence widen the knowledge gap and well as shrinking the human resource base in the sector.

The context: The private sector in Uganda is comprised of the private for profit providers, and the private not for profit providers/ civil society organizations which include Faith- Based Organizations, Foundations, most of which are donor funded either by religious institutions or bilateral organizations such as USAID, DANIDA and DFID (to mention a few).

The civil society organizations tend to work at community level filling in gaps in the health and social sectors providing services such as medical consultations, nutritional support, health education and complementary services such as aiding schooling of vulnerable populations among others

The Uganda HIV Services Project (UHSP) is a one year project implemented by JSI R&T with support from USAID, with operations in 32 districts in the country. The project services are delivered through 12 CSO's which are a mix of private for profit and private not for profit organizations. The core areas of operation of HIV Counseling and testing, promotion of HIV prevention interventions namely, abstinence, faithfulness among partners and prevention beyond abstinence and faithfulness as well as palliative care for people living with HIV (PLHIV).

Through this contract, UHSP was able to meet between 85 and 190% of the set targets in less than ten months. For example, 94% of the targeted 340,000 individuals had received counseling and testing services with 49% of these being couples

Some of the reasons for this success include: The workforce in the private sector tends to come up with pragmatic ways of achieving set targets and delivering results. During the course of the year, innovations such as 'community camping', youth centers for internally displaced persons and 'model couple' mobilizers as mechanisms put in place to reach most-at-risk and hard-to-reach populations

**Key Terms:** HIV, Uganda, private sector

**Presenter's Name: Maki Ueyama**

**Organization:** IKP Centre for Technologies in Public Health

**Title:** Integrated Rural Health Care Solutions in Rural Tamil Nadu, India

**Full Author List:** Maki Ueyama, Sunayana Sen and Zeena Johar

The health sector in India is faced with severe challenges as the country tries to tackle the problems of a significant increase in disease burden, dismal primary health care facilities as well as a rise in disparity in health status. The national health care system in India is delivered by both public and private players. While both players are indispensable to the nation's health care delivery, the later predominate in the sector.

Health care delivery in the public sector is targeted towards sections of the population that cannot afford appropriate health care. The 52nd Round National Sample Survey revealed that during the 1986-96 period, there was a drop in the utilization of public health services and a decrease in the access of free care reflecting the failure of the public sector to achieve its goal and raising questions pertaining to the quality of public health services. On the other hand, the private sector is often profit oriented and places its focus on curative care. This has led to an inadequate use of preventive care and an overt dependence on doctors among the Indian population. The failure to seek timely care has driven up health expenditures because by the time patients seek care, their conditions often require high skilled interventions by doctors and expensive methods for treatment. Consequently, India has seen an increase in the number of people refraining from seeking care due to financial incapability in the last few decades. These situations call for an urgent need to make health care more accessible to the poorer sections in remote rural locations in the country, as well as to innovate, develop and implement models that render affordable and financially sustainable health care solutions.

This paper outlines the need, key features, underlying assumptions and the vision for an effort directed at building a robust health care delivery system that reaches out to the remote rural locations in the country. It proposes to achieve this target by setting up nurse-led primary health care centres coupled with strong referral networks. The centres will be established following a hub-and-spoke model, with each unit connected to a back-end doctor. The system is designed to address the primary health care needs of the community and will also serve as the focal point for preventive-promotive exercises, directed towards encouraging people to seek timely care to reduce health care expenditure. The whole setup will be financed through sustainable mechanisms including health insurance schemes that are designed to be effective in terms of outreach, continuity and growth for the rural population.

The envisioned model lays the foundations of a sound health care mechanism designed to achieve affordability, accessibility and sustainability. This will be enabled by innovative human resource deployment, health financing schemes, and a focus on preventive care.

**Key Terms :**Private health care, Access to health care, Rural India

**Presenter's Name: Preethi John**

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| **Organization:** Aravind Eye Care System |
| **Title:** Critical workforce motivation strategies-Healthcare |
| **Full Author List:** Preethi John |
| Background: Human resource in healthcare who interface with the patients is a very critical workforce. They have direct links to improving the customer or patient satisfaction. However there are differences between human resource practices applied by public sector eye hospital as well as NGO eye hospitals in India.<br><br>Action: A not-for-profit hospital in Madurai, the Aravind Eye Hospital, which is the largest tertiary eye care hospital is studied along with a tertiary independent government eye hospital. The factors studied were employee satisfaction, patient satisfaction. A total of 450 employees were interviewed through a structured questionnaire to obtain their perception on human resource practices as well as different dimenions of employee satisfaction.<br><br>Results: Different cadres the opthalmologists, paramedical staff and administration have differing expectation. Both perception regarding human resource practices as well as employee satisfaction differs in the public sector as well as NGO eye sector. This has implication for how the eye hospitals are managed to bring out the best in eye hospitals. Factor analysis is done to identify the key dimensions of employee satsiafction as well as human resource practices. |
| **Key Terms:** Human resource practices, employee satisfaction |

**Presenter's Name: Subodh Kandamuthan**

**Organization:** Administrative Staff College Of India

**Disclosure:** The author is also a consultant to the Health department in Government of Andhra Pradesh for the DFID sponsored Andhra Pradesh Health Sector Reforms Programme and this study was done for the Government as part of it.

**Title:** Managing Primary Health Care Centres Through Public Private Partnersip In Andhra Pradesh In South India

**Full Author List:** Subodh Kandamuthan

Public Private Partnership (PPP) in the health sector is seen as an instrument by governments to improve efficiency, reliability and availability of services in health system. PPP is undertaken to improve access of services to the poor and socially vulnerable sections of the population especially in the remote and underserved areas. For the study, "Public" was defined as Government or organizations functioning under State budgets, "Private" was the Profit/Non-profit/Voluntary sector and "Partnership" meant a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms. One such initiative in India which has been prominent since the eighties is the management of Primary Health Centres (PHCs) through PPP. Numerous states in India like Orissa, Arunachal Pradesh, Gujarat, Karnataka, Himachal Pradesh etc have such initiatives in their states. In 2008, the Government of Andhra Pradesh had considered giving two tribal PHCs to be managed by an NGO through PPP.

The objective of the study was to look into the feasibility of giving two tribal PHCs to be managed by NGO through PPP in Adilabad district, in the state of Andhra Pradesh in India.

A review of the existing models of managing PHCs through PPP was done initially to derive the most suitable model for Andhra Pradesh. Once the model was arrived, it was discussed at the district level with various stakeholders like District Collector, District Medical and Health officer, People's representatives, Medical officers etc in a workshop to get their views on the model. Based on the suggestions from the workshop an NGO was selected which had experience in other states in managing PHCs.

The study provided numerous insights into the various models of PPP in managing PHCs in India. There were various issues like retaining/transferring of staff, percentage of government contribution for the PPP, performance indicators for the monitoring of the PHCs. Based on the suggestions from the workshop conducted, the government of Andrhra Pradesh decided to select an NGO which had experience in other states in managing PHCs through PPP.

The study gives a clear justification on the importance of PPP in delivering health care services to the poor. Along with the Government sector, the private and Non-profit sectors are also very much accountable to overall health systems and services of the country. The synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen the policies and programmes needs to be emphasized. It should be noted that PPP would not mean privatization of the health sector and such partnerships are not meant to be a substitution for lesser provisioning of government resources nor an abdication of government responsibility but as a tool for augmenting the public health system.

**Key Terms:** Public Private Partnership, Primary Health Care, Health Care Service Delivery.

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