Primary health care and the private sector in low and middle income countries: Asia in comparative perspective

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Improving health worldwide

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Overview

- Looking backwards: the importance of primary health care – the lessons of the 'Good Health at Low Cost' (GHLC) study
- Looking forwards: primary health care and the private sector in the era of universal health coverage

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Good Health at Low Cost 1985: What matters for good health

China, Costa Rica, Sri Lanka, Kerala case studies:

- Political commitment to health as a social goal
- Strong societal values of equity, political participation and community involvement
- **High-level investment in primary health care and other community based services**
- Widespread education, especially of women
- Intersectoral linkages for health

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Good Health at Low Cost 2011
(Balabanova et al 2011; Balabanova et al 2013)

- Why do some countries achieve health outcomes (especially for women and children) that are better than what might be expected given their income level?
  - Factors related to the health system
  - Factors related to broader determinants of health (policies in other sectors)
  - Factors related to the institutional environment and context (political, economic, social, geographical)

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Country selection

- Gains in health and access, regionally and compared to their income level
- Evidence of innovative system-level reforms that suggested effective government stewardship and capacity to implement change despite financial constraints
- Geographical, economic, and health system diversity

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Ethiopia

Kyrgyzstan

Bangladesh

Tamil Nadu, India

Thailand

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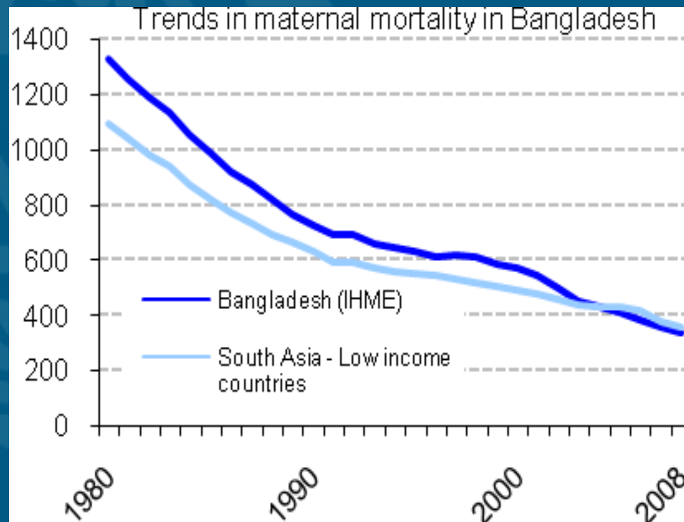
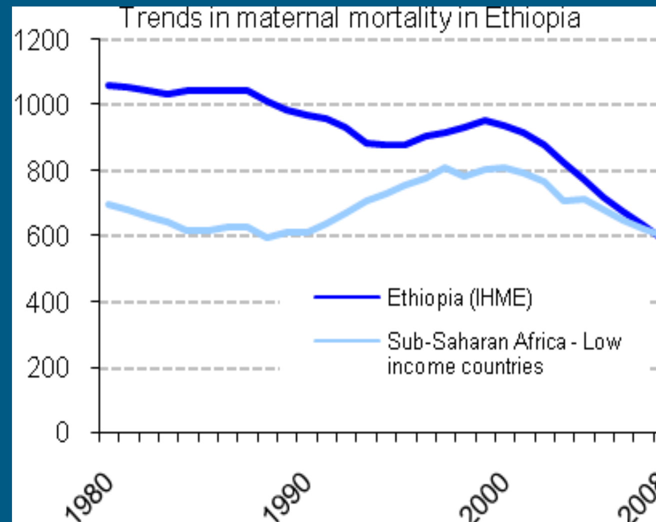
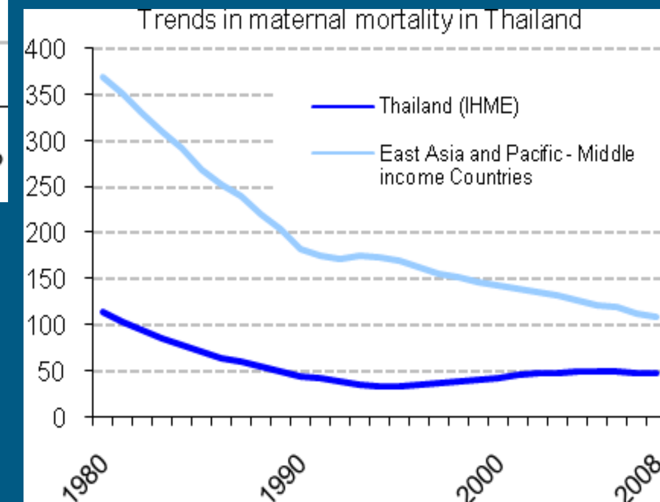
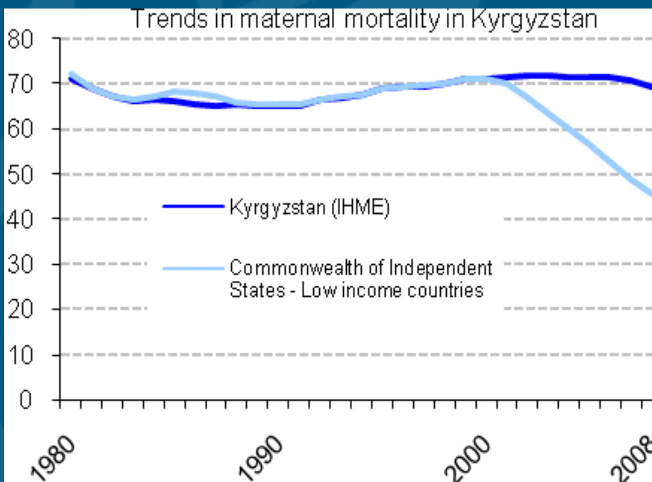
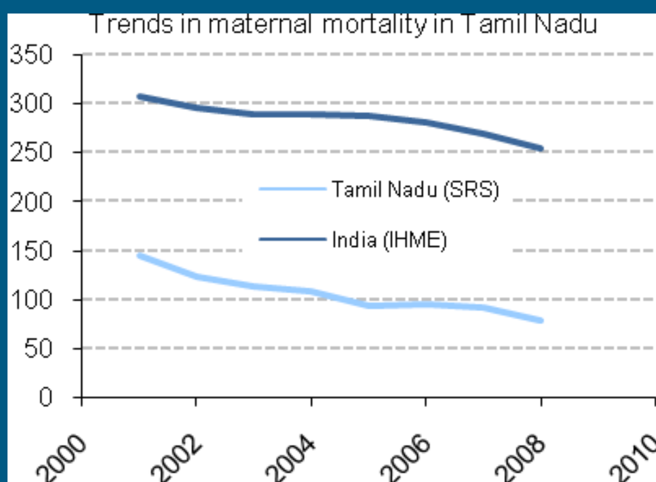
Maternal mortality, study countries











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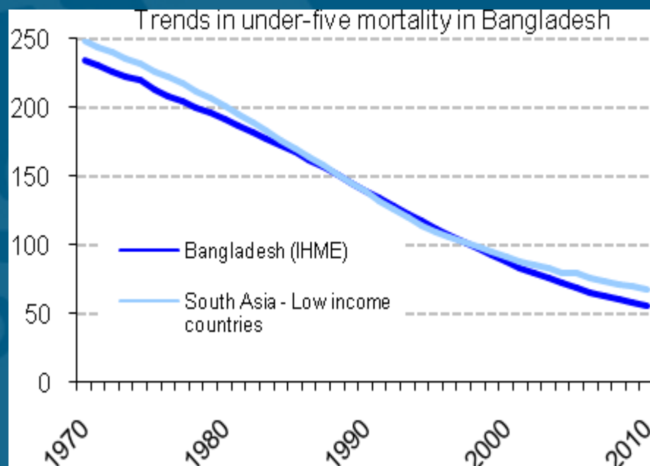
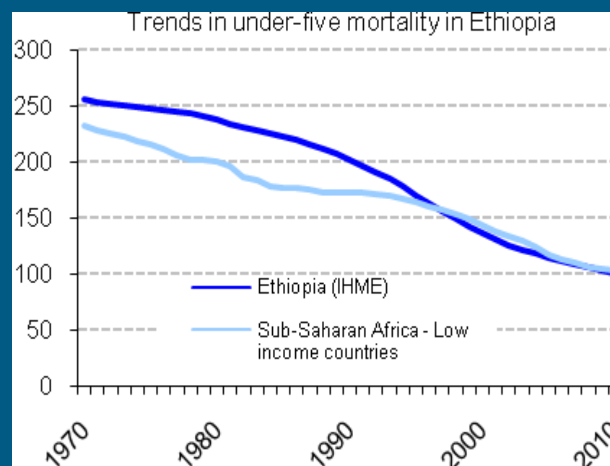
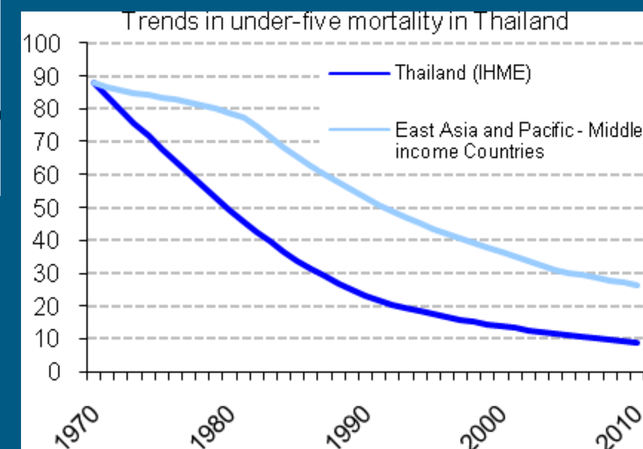
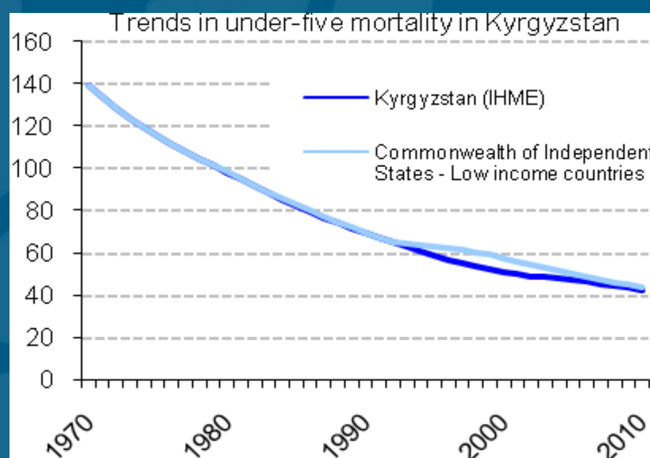
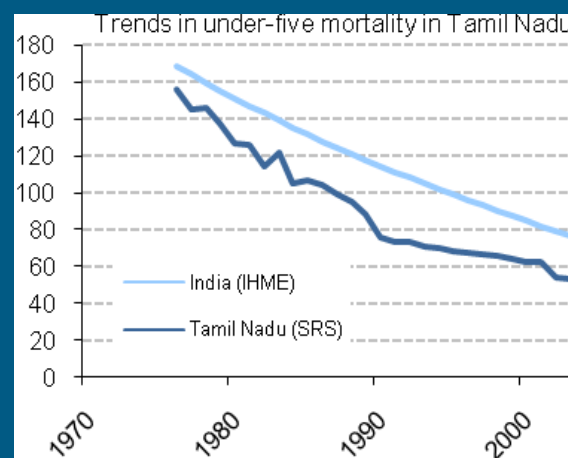
Child mortality, study countries











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Methods

- Historical case studies – comparable analytical framework and mix of quantitative and qualitative methods:
  - Secondary analyses/synthesis of existing data and evidence
  - Analysis of documents
  - Semi-structured interviews (policy-makers, providers, managers etc.)
  - Focus group discussions (in some settings)
- Aimed to:
  - construct rich analytical case studies tracing pathways to good health to understand how and why health has improved over long periods of time
  - establish temporal and plausible relationships - pattern recognition within and between countries

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Steps in the analytical approach in each country

1. Why is the country an example of 'good health at low cost'?
2. What key areas of health improvement have secured 'good health at low cost' over the last few decades?
3. How has the country achieved these specific health gains (what diseases/conditions have been tackled)?
4. How did the health system and other sectors support the effective delivery of these interventions?
5. How and why were these health system developments and wider policy interventions possible?
6. What other socio-cultural and political factors may explain health gains?

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Example of timelines: Thailand

Figure 7.6 Under-5 mortality, development of human resources and infrastructure, and financial protection, 1970–2010

Mortality per 1000 live births

100
80
60
40
20
0

-4.2/year
-3.3/year
-2.2/year
-1.3/year
-1.0/year
-0.8/year

Low-income card scheme
Civil Servant medical benefit scheme
Community health funds
Social Security Act 1991
Voluntary health card scheme
Universal coverage scheme

Mandatory rural service for doctors
Village health volunteers
Scaling up of district hospitals
Introduction of technical nurse curriculum

Asian economic crisis

National economic and social development plans
3rd 4th 5th 6th 7th 8th 9th 10th

1970 1975 1980 1985 1990 1995 2000 2005

Human and infrastructure resources
Financial risk protection

Source: Under-5 mortality data from reference 9.

Responding to population needs

- All countries strengthened primary health care and increased access to affordable drugs
- **Ethiopia: 2003 creation of** health extension programme managed by districts made primary health care available across Ethiopia
- **Kyrgyzstan**: shifted care out of hospitals (42% of hospitals closed 2000-3) to strengthened primary care system
- **Bangladesh**: district-supported expansion of maternal and child health services at facility, community and household levels; creation of local drugs industry made essential drugs affordable/available
- **Tamil Nadu**: vast network of primary and sub health care centres created; high coverage of MCH services; reliable essential drugs supply
- **Thailand**: progressive expansion of district health services

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Innovative approaches to human resources

- Task shifting and changes in skill mix were common themes
- **Ethiopia**: Health Extension Programme used paid community workers to scale up essential primary care; by 2007 34,000 trained, reaching two thirds of population
- **Kyrgyzstan:** large scale retraining to create family doctor cadre
- **Bangladesh**: expansion of mid level staff (health assistants serving 6000 pop, family welfare assistants serving 5000 pop), and community health workers
- **Tamil Nadu**: in early 1980s 60 training schools opened to train multipurpose health workers for health centres serving 5000 population; creation of district-level public health management cadre
- **Thailand**: strengthened cadres of community health workers and nurses
- **Thailand and Tamil Nadu**: posting of medical graduates to rural areas

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Pluralism and role of the non state sector

- **Tamil Nadu, Bangladesh, Thailand**: long history of private provision; range of pragmatic solutions for engagement with non state sector
- **Tamil Nadu**: 80% of outpatient treatment and 60% inpatient treatment in private sector, but core maternal and child health services provided in public sector; contracting out clinical and lab services and information campaigns
- **Bangladesh**: Huge role of NGOs: eg BRAC reaches 110m people through 64,000 village health workers; Former government-trained village health workers continued to work as unlicensed practitioners; believed to play role in reducing child mortality through basic medical advice and low cost drugs
- **Thailand**: Social health insurance scheme contracts hospitals to provide health care paid through capitation; hospitals can subcontract to primary care clinics; 241 main contracted hospitals in 2014: 156 public; 85 private; 2234 subcontracted units/networks

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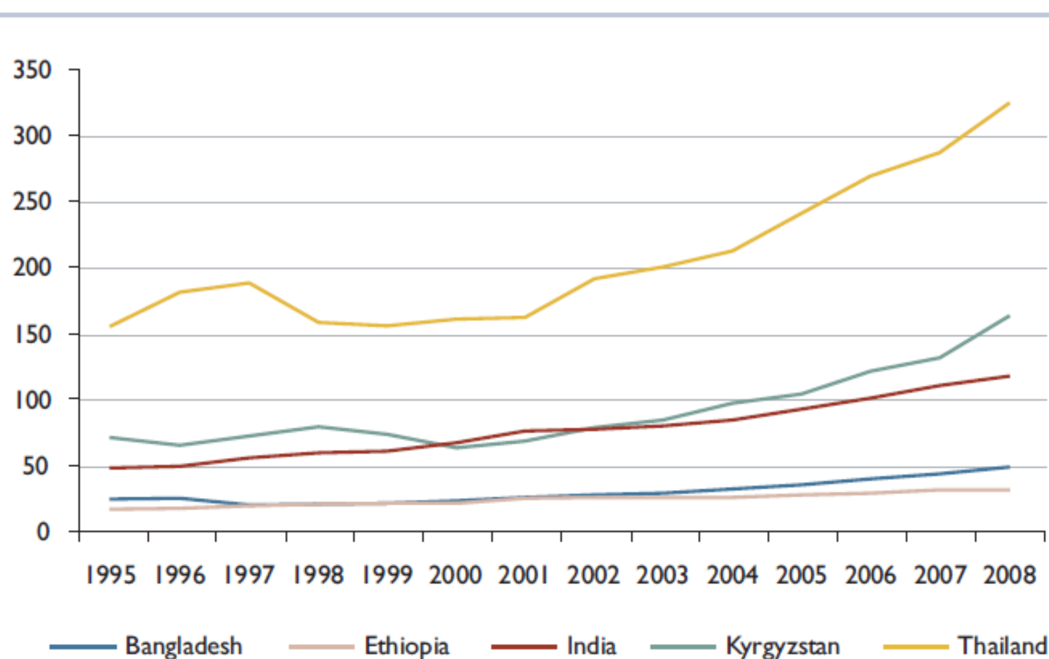
Health financing

- Some increase in health expenditure pc (esp Thailand) but stable as % GDP



- Health improvements seen under very diverse models of financing
- Relatively stable shares of different financing sources and high out-of-pocket payments in all countries except Thailand

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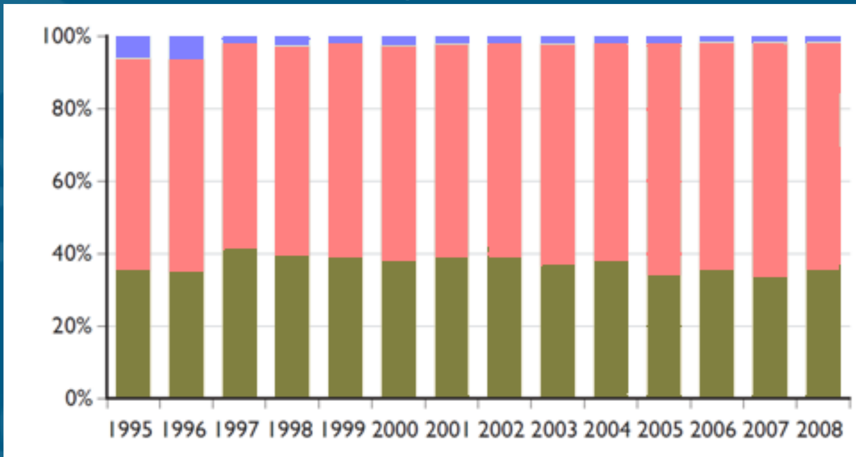
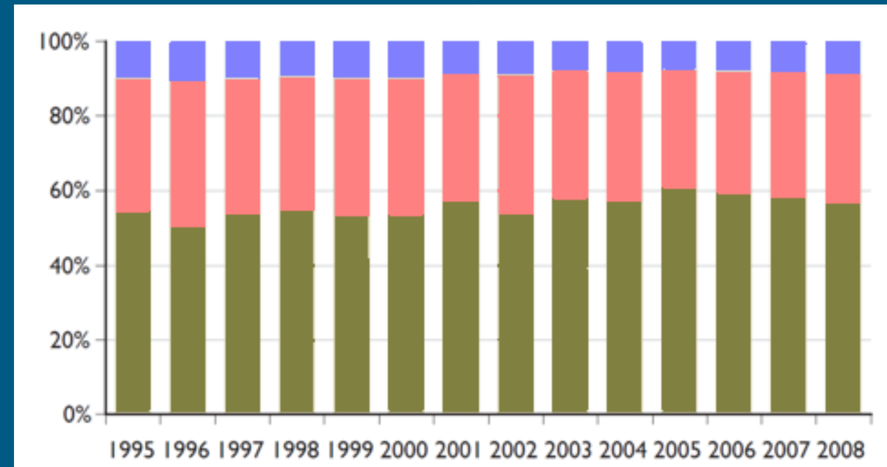
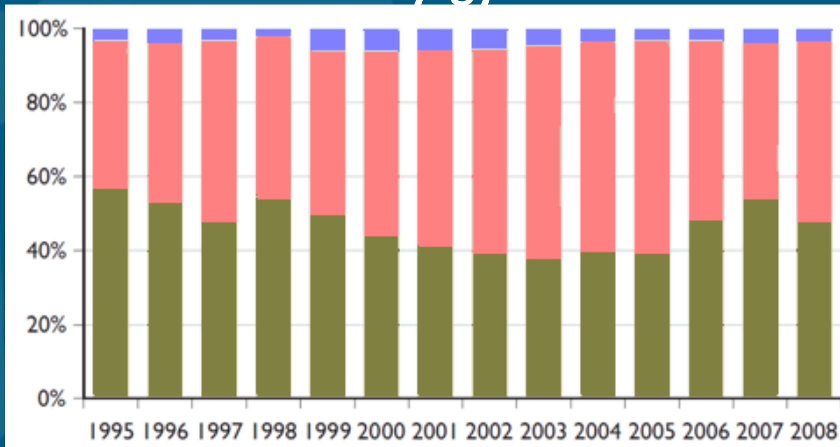
Bangladesh



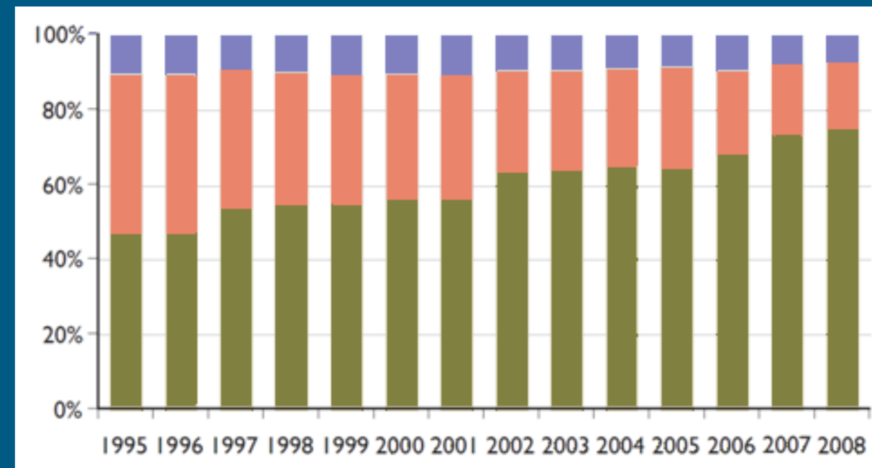
Ethiopia



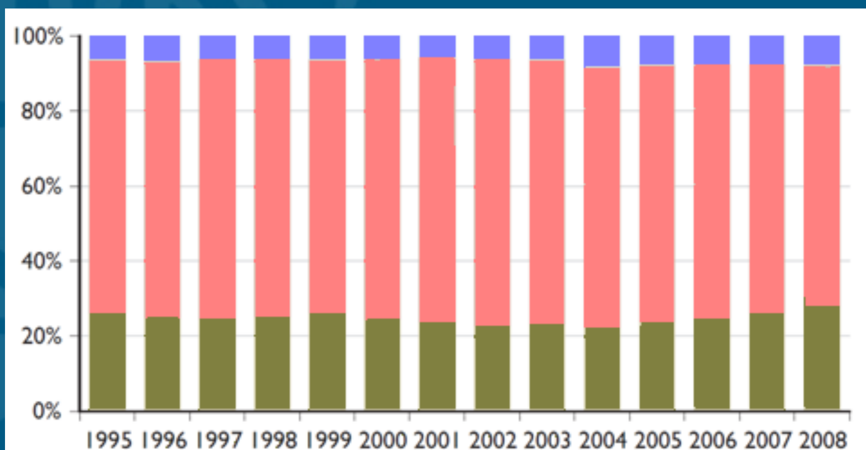
Kyrgyzstan



Thailand



India



Other private expenditure on health (excluding OOP) as % of total health expenditure

Out-of-pocket (OOP) expenditure as % of total health expenditure

General government expenditure on health as % of total health expenditure

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The era of universal health coverage

- Historical lessons: primary health care focused on women and children critical element in health gains
- But:
  - Low hanging fruit already picked
  - Health systems need to address growing burden of non communicable diseases
  - Increasing incomes and higher expectations of health services
  - Scope for impoverishing out-of-pocket payments much greater, given growth of private sector and increased accessibility of health services
- Strong primary health care system still important – but countries need to:
  - Link it to hospital facilities
  - Make use of resources in private sector
- Consider two key issues:
  - Pooled financing
  - Outsourcing

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Pooled financing

- How best to extend financial protection to people in informal sector
  - Voluntary health insurance schemes? (China)
  - Voluntary enrolment in formal sector social insurance scheme? (Philippines)
  - General tax funding (Thailand)
- Dangers of hospital coverage only eg India RSBY
- Decisions on payment mechanisms critical for cost containment
  - Fee-for-service payment fuelled cost inflation in Korea
  - Capitation and DRG within global budget controls cost increases in Thai UHC

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Harnessing the private sector

Numerous options for public private partnerships: eg

- Outsourcing service provision – public finance, private provision of services
- Outsourcing public facility management
- Outsourcing financing scheme management

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Outsourcing service provision

- Relative cost and quality of public and private service provision?
- Value of paying private providers to deliver services on behalf of the public sector?
- Study of primary health care in South Africa:
  - Private GPs paid to care for ‘public sector’ patients
  - Construction company required to provide primary health care for workers and local community
  - Private clinic chain providing services in townships for flat fee
  - Public clinics

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Contracted private GPs (Palmer and Mills 2003)

- Qualitative case study testing hypotheses drawn from contract theory; 11 practices studied in 2 provinces
- Formal aspects of contracts had little influence (eg design, monitoring, sanctions)
- Social and institutional factors important
- Contracts highly 'relational' and context specific
- Policy implications: emphasise cooperation, shared interests, professionalism

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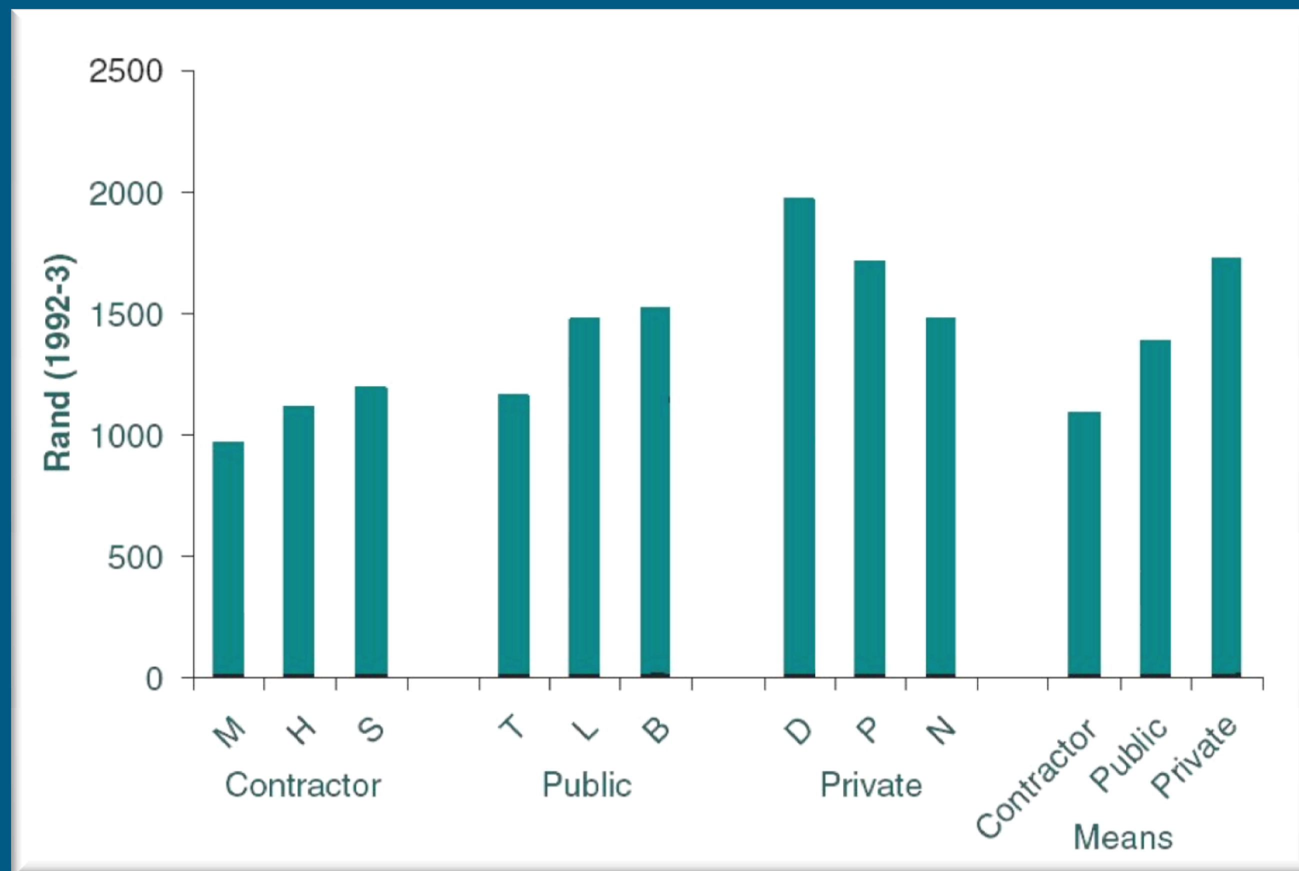
Cost and performance of different models of primary care in South Africa (Mills et al 2004)

	Contracted GPs		Company contract		Private clinic chain		Public clinics	
	WC n=4	EC n=5	n=2		n=2		Large n=4	Small n=3
Clinical staff/visit	17.28	20.44	42.53	53.07	9.17	12.92	21.32	9.44
Medical & surgical supplies/ visit	15.58	10.14	32.69	29.51	9.06	6.76	12.44	10.80
Recurrent cost/visit	36.94	35.96	128.58	139.14	31.41	35.84	44.48	29.37
Capital cost/visit	4.25	6.05	29.49	20.18	8.27	9.48	10.44	3.85
Total cost/visit	41.19	42.01	158.08	159.32	39.68	45.31	54.92	33.21
Structural quality	68%	64%	80%	85%	90%	83%	83%	84%

Outsourcing public facility management: using a private company to run public hospitals in South Africa (Broomberg et al 1997)

- Contractors' cost per admission lower than public; similar quality
- Cost advantage largely due to higher staff productivity
- Contract cost to government > government cost of provision
- Study focused attention on capacity to contract out and relationship between purchaser and provider



Conditions affecting the success of outsourcing

THE ENVIRONMENT
- Functioning legal and banking systems
- Procedures resistant to patronage or corruption

GOVERNMENT CAPACITY TO MANAGE CONTRACTS
- Awareness of costs
- Capacity to design, manage and monitor contracts

GOVERNMENT CAPACITY FOR SERVICE PROVISION
- Relative costs and quality
- Scope for improvement

PRIVATE SECTOR CAPACITY FOR SERVICE PROVISION
- Relative costs and quality
- Interest in government contracts

NATURE OF SERVICES CONTRACTED

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Outsourcing management of financing scheme: Rashtriya Swasthya Bima Yojana (RSBY)

- Targeted at families below the poverty line
- Premium of max Rs750 (£7.50) per family: shared 75%/25% by central/local government; beneficiary family pays Rs 30 pa for registration
- Insurance companies bid for contract to insure families in each district
- Hospitalisation benefits up to ceiling of Rs 30,000 per family pa (max of 5 beneficiaries per family)
- Insurance company contracts a Third Party Administrator to manage the smart card system
- Started 2008; currently 37m active smart cards (families)

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Emerging lessons

- Power of private sector to:
  - Move faster than public bureaucracy
  - Respond to incentives – eg for cost control
- But requires public capacity to
  - Design good contracts
  - Pay on time
  - Monitor performance
- Risks of carving out outsourced services from rest of health system

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