PRIVATE SECTOR OPTIONS FOR HEALTH CARE

DESK REVIEW

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

SEPTEMBER 2010

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

AIDS Support and Technical Assistance Resources Project

The AIDS Support and Technical Assistance Resources (AIDSTAR-One) project is funded by the U.S. Agency for International Development under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in PEPFAR non-focus countries in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support.

Recommended Citation

Smith, Tamara. 2010. *Private Sector Options for Health Care, Desk Review*. Arlington, Va.: USAID | AIDSTAR-One Project, Task Order 1, 2010.

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CONTRACTING OUT

The Cochrane Library published a review in 2009 of the impact of contracting out health services to the private sector (Lagarde and Palmer 2009) and found only three studies that met their criteria for objective measures of at least one of the following outcomes: health care utilization, health expenditure, health outcomes, or equity outcomes. While the evidence in the article suggests that contracting out health services may increase access and utilization of health services in underserved areas, the evidence presented is relatively weak. The authors mention several variables that can have an impact on the success of contracting out, including the following:

- Public sector ability to manage the contracting process, including the contract design
- The feasibility of monitoring contract services in remote areas
- The addition of private sector management expertise and style, organizational culture, and reputation of contractor, which may increase service quality, and thus utilization.

The complexity of the intervention may make it very difficult to link the effectiveness of contracting out with any particular intervention. The authors conclude that, "Although the channels through which contracting out increases service delivery are unclear, it seems to be an effective option in settings where the government is unable to reach populations adequately. However, due to the limited evidence available on contracting out in low and middle-income countries, policy-makers should closely evaluate the effects and describe the components of their strategies" (Lagarde and Palmer 2009).

Another recent review article on contracting out (Liu, Hotchkiss, and Bose 2008) concluded that while the evidence shows that contracting out has improved service accessibility, evidence on the impact of quality, efficiency, and equity are not yet known. Four studies rigorously evaluated in this review showed that contractors were consistently more effective in providing access to services as compared to government. Evidence on equity and quality was mixed, as was evidence of efficiency—in fact, data from several studies indicate that contractors are more costly than government. Most of the contractors evaluated for the review article were either local or international nongovernmental organizations.

A *Lancet* review of primary health care service contracting (Loevinsohn and Harding 2005) found that contracting out can achieve impressive results in real-world settings. First, the review found that contracting was able to work on a large scale—in the case of Bangladesh, 30 million people were covered by contracted health services. Secondly, in several studies, particularly those in South Asia, contracted services were more cost-effective than government services. Contracting also achieved an increase in coverage, even among rural poor. And, finally, although contract management was difficult, it still resulted in improvements in service delivery. The authors of this article conclude that

successful contracting focuses on outputs and outcomes, not inputs. In both this review article and the 2008 article by Liu, Hotchkiss, and Bose, the authors found that greatest gains in health services were made by those contractors with the most rigorous evaluation, perhaps demonstrating that performance was directly related to clear objectives and regular monitoring and evaluation.

A Department for International Development (DFID)-funded review article (England 2004) identified several key issues that must be addressed in order to successfully implement contracting out. Those issues are as follows (England 2004):

- "Sustainability/scope for contracting – most of the contracting experiences have relied on special funding e.g. project support; this raises questions over how the arrangements can be sustained. It is difficult for governments to re-deploy public funds to private providers when available funds are already committed to public services (mostly for wages and salaries). Also, contracting with private providers requires substantial political commitment and, typically, more funding if the services are to be of reasonable quality.
- Institutional capacity to develop and manage contracts and targeting mechanisms – this needs to be in place or developed.
- Identifying the poor – the same issues arise as with other mechanisms intended to benefit the poor (e.g. fee exemptions) – the ideal is to use an existing mechanism for identifying the poor which is reasonably reliable; new systems can be costly.
- Provider payment methods and other contract terms are key – as in other health financing arrangements, the incentives built into contracts are critical.
- Monitoring and evaluation – ideally, contracts should require providers to commission regular consumer surveys as part of their work, otherwise occasional independent surveys will be needed to assess whether the poor are actually benefiting as intended, and to guide remedial steps if not. This includes baseline studies (or other ways) to assess impact and how far the changes are affecting the poor."

PUBLIC-PRIVATE PARTNERSHIPS

The state of Gujarat tested an innovative private sector contracting model in 2005. In a state with only seven public sector obstetricians/gynecologists for a population of 32 million, the government of Gujarat decided to make more effective use of the 700 private obstetricians/gynecologists who had their own rural delivery centers (Krupp and Madhivanan 2009). The doctors were reimbursed for deliveries through vouchers provided to poor women. By the end of 2007, of the 642 maternal deaths expected among the 143,000 women who delivered at one of the participating clinics, only 31 maternal deaths were registered. This model demonstrates a way for contracting private physicians to care for patients living with HIV.

In Botswana, the government had to decide whether to hire more staff or to contract out routine HIV care to private providers. An evaluation (Dreesch, et al. 2007) of the pilot test showed the following:

- Almost 40 private providers had been contracted to offer antiretroviral therapy (ART) follow-up services and two providers were contracted to deliver laboratory and diagnostic services.
- The reimbursement system was functioning well.

- Private providers had been involved in system monitoring through monthly reports and this was supported by supervisory visits.
- So far, over 4,500 patients have been referred to the private sector.

FRANCHISING

In a country with an active private sector, such as India, diagnosis, care, and treatment for patients living with HIV by private sector practitioners must be explored. Although the private sector is an expanding work force and the public sector is contracting, quality is often low. A 2006 report commissioned by DFID (England 2006) discusses the possibility that franchising may offer a way of achieving higher quality with lower cost through the private sector, improving the prospects for universal access to HIV services and associated prevention. Much of the evidence (and there is little) for franchising success comes from the area of reproductive health services, where clients are unable or willing to pay for the full cost of preventive care, which may be different from the provision of HIV care and treatment. A model using a franchise approach for the provision of HIV services would require the following:

- Identifying those in need of therapy
- Providing therapy and related services
- Integrating with prevention
- Costs and sustainability.

While the author of this article feels that franchising offers a possible model for HIV services, "It is neither desirable nor possible to create a franchise only to deliver ART. Franchisee providers could not make a living if ART was all they did, and ART delivery has to be built on services including at least counseling, HIV diagnostic capacity, primary care for diagnosis and treatment of opportunistic infections, and ideally some degree of immunological monitoring capability. HIV and AIDS interventions for prevention and treatment must become part of the normal, routine 'business' of relevant health services, whether they are franchises or conventional public sector delivery mechanisms" (England 2006). Franchise services may raise the quality of health services and impose common standards in return for the increased income provided by a provider network. A franchise can extend services rapidly and in places where public provision of HIV services is weak.

SUMMARY

A summary of key points is as follows:

- While the strength of the evidence for contracting out is weak, what evidence there is supports the hypothesis that contracting out can increase access to services even in remote areas.
- Evidence for efficiency of contracted services is mixed—some data suggest that contractors may be more expensive for governments than if governments do it themselves.
- Providing for direct provider payments or client vouchers for fees and medication may be one option to expand access to HIV services without scaling up the public sector work force.
- Franchise services may extend service access while improving service quality, utilizing available private providers already working in remote areas.

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