

# Private healthcare providers and PHC: gateway to marketization or untapped potential to strengthen PHC?

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40 YEARS AFTER ALMA-ATA – PRIMARY HEALTH CARE  
IN 2018 AND BEYOND, IN SOUTH AND NORTH

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# Facts

Private sector = important actor, in most countries

## Dimension 1 (private share in health spending)

## Dimension 2 (share of private sector in visits for treatment)

## Dimension 3 (public sector % reliance on fees and charges)

	Column 1: private % of THE in 2000	Column 2: private % of THE in 2012	Column 3: OOP payments as % of THE in 2012	Column 4: prepaid plans plus social security as % of THE in 2012	Column 5: private sector % of total outpatient visits, primary care visits, or all visits (year)	Column 6: private sector % of inpatient episodes or hospital visits (year)	Column 7: OOP payments % of total public facilities' expenditure (year)
India	73%	70%	61%	4%	75% (2014)	62% (2014)	2% (2014)
Nigeria	67%	67%	64%	2%	82% (2008-09)*	NA	64% (2005)
Sri Lanka	52%	61%	51%	3%	50-60% (2008)	5-10% (2008)	0% (2008)
Thailand	44%	21%	12%	14%	34% (2011)	10% (2011)	10% (2007)
Argentina	46%	31%	20%	45%	45% (2010)	47% (2010)	0% (2014)
South Africa	59%	52%	7%	43%	29% (2008)	18% (2008)	8% (2005)
China	62%	44%	34%	41%	18% (2003)	3% (2003)	87% (2001)
Malawi	54%	44%	10%	2%	29% (2003)	30% (2003)	9% (2005-06)
Tanzania	57%	61%	32%	3%	40% (2007)	22% (2007)	38% (2009-10)
Nepal	75%	61%	49%	0%	65% (2003)	46% (2003)	7% (2008-09)
Ghana	50%	32%	29%	17%	36% (2003)	35% (2003)	25% (2009)

# Facts

Private sector = important actor, even for the poor

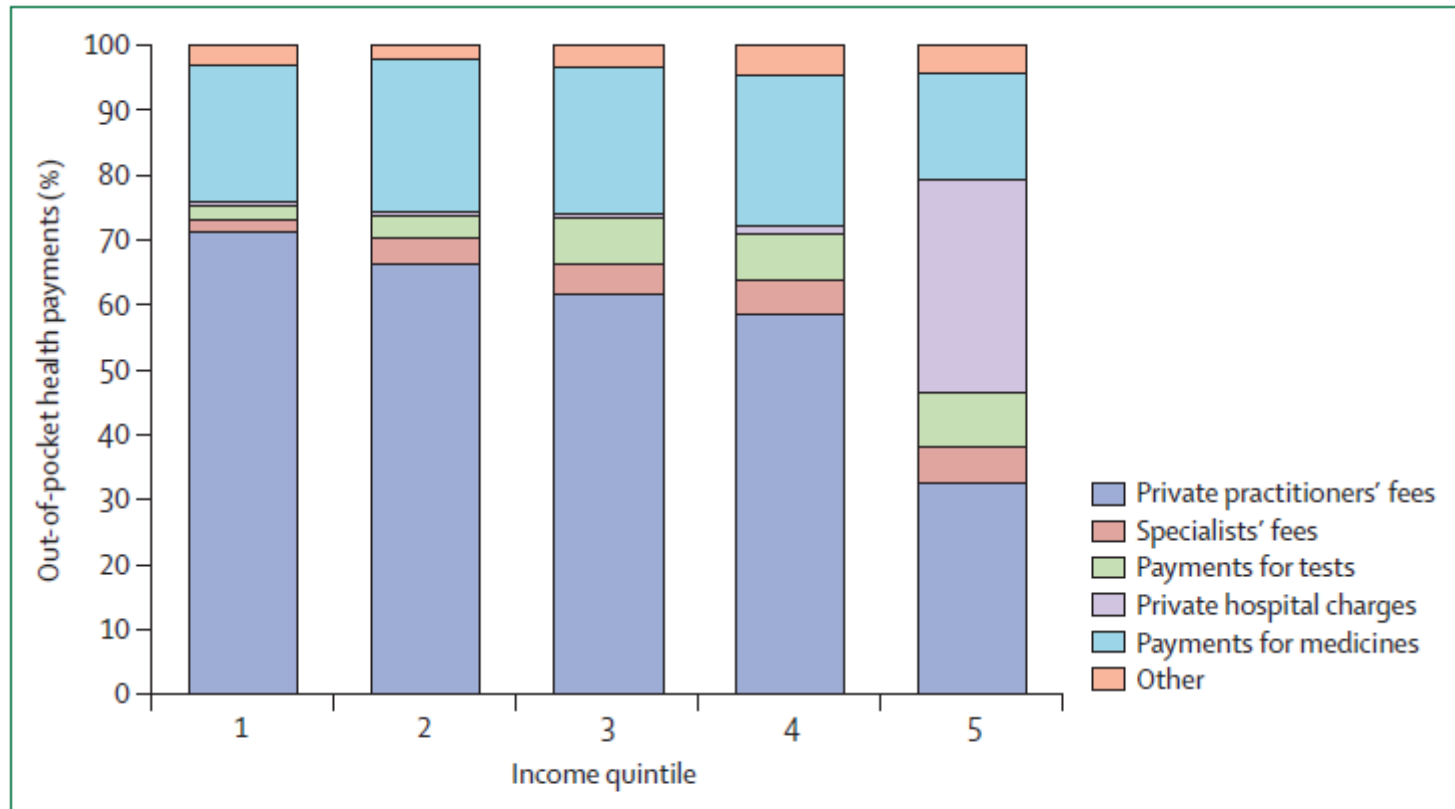


Figure 2: Structure of out-of-pocket health payments by income quintile, Sri Lanka 2009-10  
Values were calculated from the Sri Lanka Household Income and Expenditure Survey data (2009-10).<sup>42</sup>

# Facts

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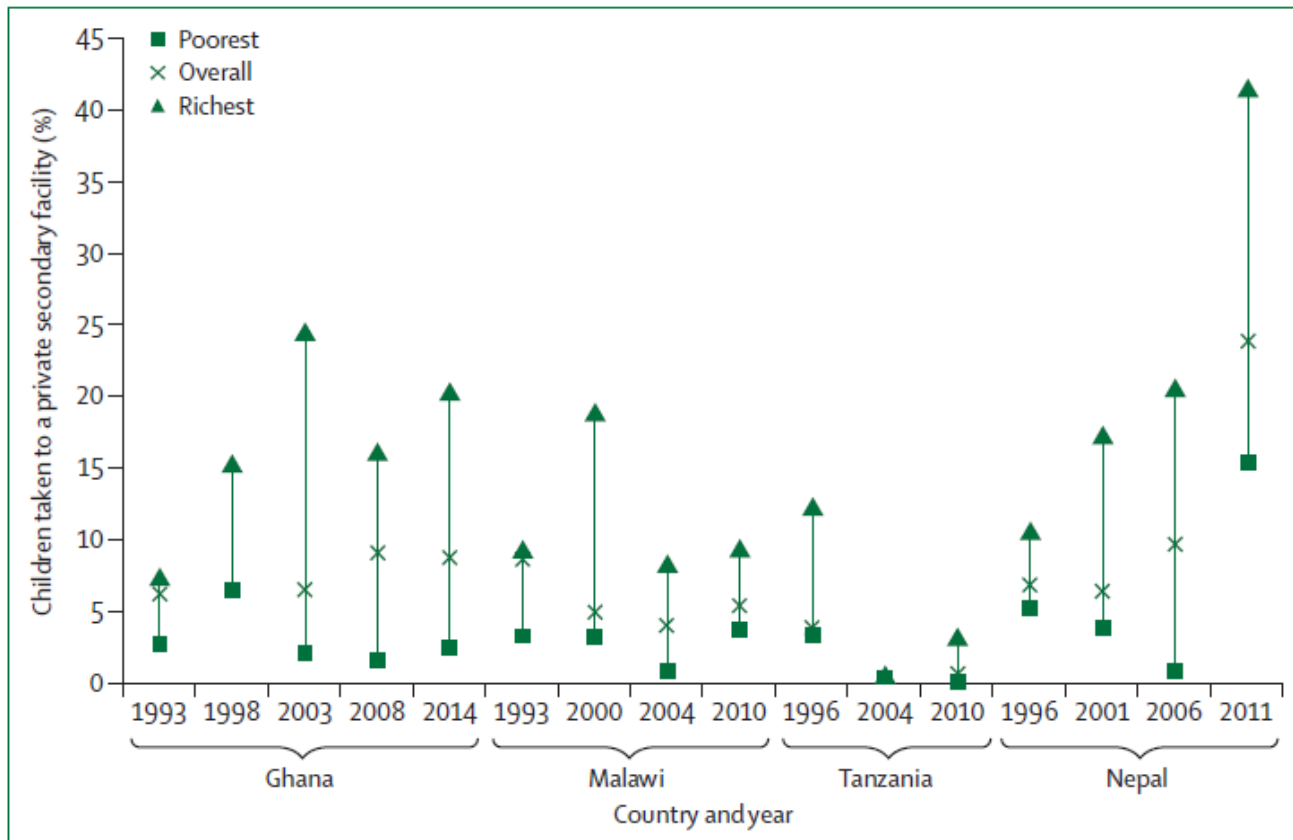


Figure 3: Percentage of infants treated for diarrhoea who were taken to a private secondary facility by wealth level, year, and country

# Facts

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Private sector = **multiplicity of actors**:

- For profit / not-for-profit
- Faith-based / ideology-based / other
- Modern / traditional

Private health sector ⇔ **3 functions**:

- Private healthcare providers
- Private health insurers
- Private “producers of resources” (training, leasing, pharmacies...)

Beyond institutional/administrative identity of healthcare provider: have a look at **5 health service purpose and nature of outputs** (public = social, non-discriminatory, population-based, government-policy guided, non-lucrative) (Giusti et al. 1997)

High **heterogeneity** in qualification (McPake & Hanson 2016)

**Limited conceptualisation** and difficulty in exploring the relations between factors, and their effect on overall performance (Roehrich et al. 2014, Morgan et al. 2016)

**Limited and mixed empirical evidence** on health PPPs – and esp. on efficiency and quality of private sector PHC in LMICs (Basu et al. 2012, Roehrich et al. 2014, Coarasa et al. 2017)

# Opportunities

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Increase coherence of health system

Expand coverage (population, specific services – e.g. SRHR)

Increase innovation and responsiveness to specific demands

Open the way to “third sector” actors’ values

Infrastructures and equipment: increased investment, economies of scale

Improve efficiency: ??

Wide variety of possible PPPs! ⇔ adapt and frame to local contexts

- “Although some evidence shows that targeted supply-side interventions such as social marketing and vouchers can increase coverage of focused services, less evidence is available for accreditation and contracting, which seek to affect broad areas of service availability and quality” (Montagu & Goodman 2016)

Role of private sector in progress towards UHC varies; **interaction of many factors** affects how the sector performs in different contexts (Morgan et al. 2016)

# Conditions

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## Think systems!

- Complex interactions between private-public health sectors (Mackintosh et al. 2016)
- “Changing the performance of the private sector will require interventions that target the sector as a whole, rather than individual providers alone” (Morgan et al. 2016)

**Regulation** (for all 3 functions) – but difficult (inadequate in many LMICs? Montagu & Goodman 2016)

**Quality** controls – or support/encouragement to improve quality (Montagu & Goodman 2016)

Ensure **equity** (private sector ↔ increased access often inequitable)

## **Financial protection** of individuals

- “Where the private sector dominates the health system, the poor struggle to access fee-for-service care, which is generally of low quality” (Mackintosh et al. 2016)

Limit increases in **total costs**

Don't improvise **implementation!** Set goals clearly, prepare well, and address challenges (communication, HIS, etc.) (e.g. Thomas et al. 2016)

Continue **financing the public** sector!

# Limits

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Back to basic economics: objective function of...

- Public sector: “multi-principal”, multi-objective problem: Max [coverage, quality of care, equity, responsiveness, financial protection, broader objectives of health system]; different ponderations according to societal values (and political pressures)
- Private sector: Max  $\pi$  (profit)

PPPs are increasingly criticized in HICs (Hall 2015, ECA 2018)

“The purchaser-provider split is typically justified in the name of improved cost effectiveness, although the effects are usually the opposite [...] truly universal and equitable healthcare [...] can best be achieved by maintaining healthcare in public hands” (Kumar & Birn 2018)

Role of the State very important in PPP/contractualisation ⇔ capacities?



# Questions to be addressed by the WG

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1. What are the most promising approaches enabling to involve private healthcare providers for stronger PHC?
2. What are the preconditions that need to be met prior to involving the private sector more systematically?

*Transversal thread: in what context?*

*Transversal thread: pragmatism and not ideology!*

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