Private health care providers play an increasingly important role in the health systems of many low-income and middle-income countries, easing some of the pressure on governments to provide health care services for all citizens and helping them to overcome funding constraints. The need to regulate the activities of the private sector has become increasingly apparent. However, many countries have little experience of regulation, and in low-income countries the priority of health ministries is to deliver basic health care, rather than implementing what are often "imported" regulatory frameworks.

This book, aimed at researchers and policy-makers in developing countries, explores strategies which may be used to develop and implement the regulation of private health care provision. It is the fourth in a series by the Public Private Mix Collaborative Research Network (PPMNet), a group of 14 universities and other institutions which investigated the interface between the public and private health sectors in developing countries between 1997 and 2000. PPMNet was set up by researchers at the Health Policy Unit, London School of Hygiene & Tropical Medicine and later coordinated by the Centre for Health Policy, University of the Witwatersrand, Johannesburg, South Africa.

The book is divided into four sections, with examples drawn from Africa, Latin America and Asia and dealing with:
- regulation of private health providers
- contribution of private providers to public health goals
- public/private mix in health insurance
- quality and affordability of care in public and private settings.

The book has been published with the support of the Alliance for Health Policy and Systems Research.
The new public/private mix in health: exploring the changing landscape

Edited by
Neil Söderlund,
Pedro Mendoza-Arana
and Jane Goudge

Alliance for Health Policy and Systems Research
Geneva
2003
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An initiative fostered by the Global Forum for Health Research in collaboration with the World Health Organization

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Foreword

The private health sector’s place within the health systems of many low-income and middle-income countries is changing and, generally, expanding. Governments are deliberately promoting private providers, acknowledging their de facto role in increasingly pluralistic health systems and using them to alleviate their own funding constraints.

As the role of the private sector has grown, the need to regulate its activities has become increasingly apparent. However, many countries (especially those former socialist countries in which all private economic activity is relatively new) have little experience of regulation, in the health sector or elsewhere. In low-income countries, the priority of health ministries is to deliver basic health care, rather than implement what are often “imported” regulatory frameworks.

Managing the public/private mix in health care is inevitably a difficult task, and always the responsibility of government. It requires, in part, careful thought about the most appropriate instruments of regulation in a particular context and for a particular action and goal. Equally important, however, is the need to think through the strategies that can be used in developing and implementing those instruments.

This book has been compiled by members of the Public Private Mix Collaborative Research Network (PPMNet). Over the period 1997 to 2000, the Network consisted of 14 member institutions (see below), all of which were undertaking work on the interface between the public and private health sectors in developing countries. PPMNet has existed in a number of forms since 1992, and this book is the fourth in a series of publications by its members. Our aim has been to reflect current thinking on public/private mix issues in health care in developing countries through single-country or multicountry case-studies. This is a new area of research, and our intention is primarily to stimulate enquiry, rather than to reach definitive conclusions.

The book is divided into four sections, with examples drawn from Africa, Latin America and Asia. Chapters 1-3 describe case-studies on the regulation of private health providers. Chapters 4 and 5 deal with the contribution of private providers to public health goals, such as the management of sexually transmitted infections. Chapters 6 and 7 explore the public/private mix in health insurance — an area in which the private sector has been associated with both inefficiency and inequity. The final section (Chapters 8-11) compares quality and affordability of care in public and private settings.
The coordination of PPMNet and the compilation of this book were made possible by funding from the European Union (DGXII) in support of Public Private Mix Concerted Action (contract no. ERB-IC18-CT97-0235), over the period 1997 to 2000. Support was also received from the Alliance for Health Policy and Systems Research.

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- Department of Community Medicine, Trinity College Dublin (Ireland)
- Department of Social Medicine, Shandong Medical University (China)
- Foundation for Research in Community Health (India)
- Health Economics Unit, University of Cape Town (South Africa)
- Health Systems Research Institute (Thailand)
- Institute of Public Health, Muhimbili University (Tanzania)
- Karolinska Institute (Sweden)
- London School of Hygiene & Tropical Medicine (United Kingdom)
- Makerere Institute for Social Research (Uganda)
- Mexican Health Foundation (Mexico)
- University of San Marcos (Peru).

PPMNet website: www.healthlink.org.za/ppmnet
## Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ARI</td>
<td>acute respiratory infection</td>
</tr>
<tr>
<td>Conamed</td>
<td>Comisión Nacional de Arbitraje Médico (National Commission for the Surveillance of Medical Practice, Mexico)</td>
</tr>
<tr>
<td>CSMBS</td>
<td>Civil Servant Medical Benefit Scheme, Thailand</td>
</tr>
<tr>
<td>DRG</td>
<td>diagnosis related group</td>
</tr>
<tr>
<td>EPS (Empresa Promotora de Salud)</td>
<td>health promotion enterprise, Colombia</td>
</tr>
<tr>
<td>EPS (Entidad Prestadora de Salud)</td>
<td>health care provider organization, Peru</td>
</tr>
<tr>
<td>FOSYGA</td>
<td>Fondo de Solidaridad y Garantías (Solidarity and Insurance Fund, Colombia)</td>
</tr>
<tr>
<td>FUNSALUD</td>
<td>Fundación Mexicana para la Salud (Mexican Health Foundation)</td>
</tr>
<tr>
<td>HCS</td>
<td>Health Card Scheme (Thailand)</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>IMSS</td>
<td>Instituto Mexicano del Seguro Social (Mexican Social Security Institute)</td>
</tr>
<tr>
<td>IPS (Instituciones Prestadoras de Servicios de Salud)</td>
<td>health service institutions, Colombia</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine (contraceptive) device</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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<tr>
<td>LMIC</td>
<td>low-income and middle-income countries</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>PDS</td>
<td>part-time district surgeon (South Africa)</td>
</tr>
<tr>
<td>POS</td>
<td>plan obligatorio de salud (obligatory health plan, Colombia)</td>
</tr>
<tr>
<td>PPMNet</td>
<td>Public Private Mix Collaborative Research Network</td>
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<tr>
<td>SHI</td>
<td>social health insurance</td>
</tr>
<tr>
<td>SSS</td>
<td>Social Security Scheme (Thailand)</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted diseases</td>
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<tr>
<td>SWS</td>
<td>Social Welfare Scheme (Thailand)</td>
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<tr>
<td>WCS</td>
<td>Workmen's Compensation Scheme (Thailand)</td>
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Introduction: Intervening in the public/private mix

Lucy Gilson¹, Stephen Thomas

The strategy of policy action

Managing the public/private mix is likely to be a central element of every government’s health policy and management functions. It is, however, a difficult task. It requires, in part, careful thought about the most appropriate instruments of regulation in a particular context and for a particular action and goal (Bennett et al., 1997). Equally important, however, is the need to think through the strategies that can be used in developing and implementing those instruments. As has been recognized more broadly, much health policy “has been simply concerned with the technical features of policy content, rather than with the processes of putting policy into effect. As a result policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved” (Walt & Gilson, 1994:366).

There is little detailed evidence about the specific features of public/private mix management that must be considered in developing strategies to support regulatory or other policy change. This chapter seeks, therefore, to propose some broad issues that could be considered to be largely derived from wider experience of policy change. However, it uses conclusions from an analysis of pharmaceutical policy reform (Reich, 1996) and draws briefly on two different examples of how private health insurance agents were drawn into changes in South African health care financing policy between 1994 and 1999 (Gilson et al., 1999a). These were, firstly, the direct participation of insurance industry actors within ad hoc advisory committees that considered social health insurance (SHI) options for the country and, secondly, strategic engagement with the private insurance industry in the development of proposals to regulate it. Whereas social health insurance remained largely a matter of policy debate only, the regulatory proposals were translated into legislation in the form of the 1998 Medical Schemes Act.

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Issues to consider in developing policy strategies

A review of the few existing analyses of broader health reform experience confirms that the way in which any reform evolves is as likely to have a critical influence over the changes it generates and its impacts as its specific design (Gilson, 1997). The factors that have been found to influence the pattern, pace and impact of reform include:

- the importance of actors or stakeholders and their potential to block reforms – which is itself tied to the balance of power between different actors, often rooted in, and shaped by, conflict over the values and goals underlying reforms

- the potential of reforms to alter the balance of power between actors as a result of the introduction of new or changed incentive structures

- the strategies of policy development and implementation, including the differing contributions of incremental and radical implementation strategies in relation to different contexts – such as the potential of speedy implementation during a “window of opportunity” to deliver change, but also the importance of building consensus and support for change through an incremental process

- the mechanisms used in policy development as strategies for building consensus, legitimizing reforms or even deliberately delaying change (such as formal committees of inquiry)

- the importance of organizational capacity for successful reform – including formal skills and procedures within and between organizations, information and other resource availability and the informal social networks that promote common working practices and support achievement of organizational goals

- the contextual factors that shape the values underlying reforms and actors’ behaviour, as well as determining the nature of selected reform proposals.

In general, Walt and Gilson (1994) suggest that these different factors can be categorized in four groups – factors of context, of policy content or design, of the processes of policy formulation and implementation, and of actors. The term “process” in this instance encompasses the steps in any process of policy change (agenda-setting, design development, implementation and evaluation). It also relates to their speed and timing, the strategies used within these steps to build, for example, legitimacy, consensus or capacity, as well as the specific mechanisms or bodies established to take forward any of the steps. At the heart of these processes are the actors, who by their overt or covert actions in promotion or protection of their primary interests, or by their lack
of action, support or oppose policy change.

Managing any process of change thus requires technical skills to inform and guide the reform process, and political skills to develop and mobilize support (Gilson, 1997). As Crosby (1996:1409) has noted, “The task of implementing policy reform is, then, one of management of peers and peer organizations”.

Policy interventions and the public/private mix

Context

There is some recognition in international health policy debates that a “one size fits all” approach to policy development is ineffective. What works in one context may not be transferable (easily or at all) to a different context, precisely because it was developed in and for a particular setting (Gilson & Mills, 1995; Grindle & Thomas, 1991; Walt, 1994). Features of context help to “mould the manner in which policy formulation and implementation is conducted” (Collins et al., 1999:72). They may directly influence the scope and design of policies, and their speed of implementation, as well as influencing actors’ interests and roles within policy change processes. Through these mechanisms, contextual features, in turn, shape the level and nature of impacts resulting from policy changes (Gilson et al., 1998; Gilson et al., 1999a, 1999b; Lake et al., 2000).

The main factors of context that must always be considered in developing policy and strategies can, following Leichter (1979), be grouped into four categories:

- situational factors, i.e. the specific conditions of a moment in history that impact on policy changes
- structural factors, i.e. the relatively unchanging circumstances of the society and polity, such as the structure of the economy and the political system
- cultural factors, i.e. the values and commitments of society as a whole and groups within it
- exogenous factors, i.e. the events and values outside any one country or system that influence it.

For example, in a liberalized economy, private-sector agents (such as provider groups or insurance bodies) may play important roles within the health system, have power and so be actors that must be considered when developing relevant policy changes, as in South Africa. However, in economies that have been dominated by government investment and action, the private sector as a whole is generally much smaller. Even if those economies are
currently liberalizing, the private sector is likely to play only a small role within the health system and its policy formulation, as in Zambia (Lake et al., 2000). In such contexts, e.g. low-income African countries, nongovernmental health care bodies, particularly churches, are instead likely to be the primary private grouping that may seek a role in policy development.

In either context, however, the attitudes and actions of government towards the private health care sector are also likely to reflect situational factors. Key factors might relate to the prevailing attitude towards the private sector as a whole of a newly elected and powerful government, as well as the international policy environment’s level of support for the private sector. In both South Africa and Zambia, therefore, an economic environment that was friendly towards the private sector has given support to the private health sector since new governments were elected in the first half of the 1990s. Nevertheless, some South African politicians’ caution about the private health sector specifically, and concern about the impact of its functioning on equity, has also enabled the implementation of regulatory change in the health sector (Gilson et al., 1999a).

Contextual factors may shape policy processes, but they are not immutable. Effective policy leaders can create their own policy space, sometimes by drawing on contextual features and sometimes by other actions that create the opportunity to develop policies despite the context (Gilson et al., 1999b; Grindle & Thomas, 1991; Reich, 1996). In part, such action involves being creative in developing the design of policy to reflect local circumstances (rather than importing someone else’s policy prescription). Just as important, however, is the construction of alliances of support to offset potential opposition (recognizing the leader’s own level of influence resulting from contextual factors, as well as the other actors which derive influence from context). Timing policy change in relation to the broader political context, and changes within it, can be particularly important in getting political support for health policy change, including adequate support with which to confront private sector interests (Reich, 1996).

**Actors**

The influence of context over policy change is strongly mediated by actors (Reich, 1996; Walt, 1994). As Grindle and Thomas (1991:32), for example, note: “Policy elites play major roles in the process of policy and organizational change. Because of this the skills, values and experiences they bring to reform situations are important, for they shape the perceptions of what problems need to be addressed through public sector action and how they should be addressed”.

In developing strategies for policy change it is, therefore, critical to begin with a clear understanding of the relevant major actors. In particular, it is...
essential to understand their motivating concerns. Do actors’ interests align with each other and with the overall objectives of the reform? Where there is common ground between public-sector and private-sector actors, this may be an important starting-point for policy development. Where there is significant divergence of interests or of understanding of the policy issue, more tactical action may be required to gain support and offset opposition.

In practice, real or perceived differences in understanding and motivation between reform leaders in government, on the one hand, and private-sector interests, on the other, are often a critical barrier that has to be tackled in developing policy change focusing on the public/private mix. Government is often stereotyped as being explicitly and exclusively concerned with the public interest, in contrast to private agents who are seen as only self-interested—be it for profits, in the case of for-profit providers, or opportunities to proselytize or build empires, in the case of non-profit providers. That perceived divide might encourage reform leaders simply to ignore the private sector, or to give it inappropriate roles in policy development.

For example, the South African private insurance industry was directly involved in policy development committees established to consider health care financing reform in the years immediately after the 1994 change of government. Some analysts have criticized this involvement of the insurance industry as naive, enabling it to promote policy options that would give it an integral role in the proposed social health insurance schemes despite the expressed preferences of some of the reform leaders (Gilson et al., 1999a). Suspicion of private agents’ motives may also preclude the building of alliances of support for policy action among at least some actors on the basis of common interests. Religious organizations, for example, may be sufficiently closely attuned to government policy goals to have the potential to be important and trusted allies in health system development, rather than actors held at arm’s length through, for example, contractual arrangements (Gilson et al., 1997).

The degree to which interests converge or overlap is, therefore, a foundation for further action. It will fundamentally shape the type of public/private interaction on health policy issues. Building up a careful understanding of the range of interests of the private sector will be an important basis for strategic action. To do this, it must not only be understood that private-sector interests are often heterogeneous, but that in some cases one actor may hold multiple objectives.

A further important factor influencing actors’ engagement in any policy action is their own capacity to become involved. The capacity weaknesses of governments are always an important constraint on their control of policy change processes, especially where they must interact with better-resourced private-sector actors. Weaknesses generally include a lack of staff to manage these processes, a lack of skills and understanding, poor communication and
information systems, for example, and weak procedures for sanctioning regulatory infringements (Bennett & Mills, 1998; Mills et al., 2001). Within government, there may also be differences between specific ministries or even individuals in their attitudes towards the private sector and understanding of its potential role within the health system as a whole. Just as the private sector is rarely completely unified, so there is potential for contradiction and conflict within the public sector. Broader economic policy, usually managed by the central economic ministry, may be more supportive of general private-sector interests than health-sector policy is of specific private health agents. Lack of governmental capacity and interdepartmental differences then undermine its position relative to the private sector within policy debates. Shrewd private-sector managers may well be able to exploit such differences.

However, even the better-resourced private-for-profit sector may suffer from capacity weaknesses that undermine its position relative to government. It may, for example, be itself divided and so unable to develop a common position with which to challenge or negotiate with government. The implementation of legislative action to regulate the private insurance sector in South Africa in 1998 was, for example, partly explained by divisions within the insurance industry. As one private-sector commentator noted, this split “relatively empower[ed] the government to push the Bill through without a voice coming from the industry; or if there [was] a voice it [was] a fragmented and dis-empowered voice ... these differences of opinion neutralise[d] the private sector” (Gilson et al., 1999a:135).

This capacity weakness is likely to be quite common, given the often relatively wide range of private-sector interests in any setting – particularly providers and suppliers. In some instances, government may even want to encourage a single private-sector voice, to enable policy negotiations to be conducted effectively, as when it has encouraged or supported the “umbrella organizations” of religious health care providers who are perceived to share common interests (Gilson et al., 1994). There are drawbacks, nevertheless. While having a single voice may limit the range of actors which government must consider or engage in policy change, it may give too much bargaining power to one interest at the expense of others. It is common, for example, for the medical profession to have considerable power as an organized interest group. Reich (1996:93) has, therefore, concluded that “any effort to reform the health sector must take into account the physicians’ association and must design strategies to coopt, neutralize or mobilize this group”.

**Strategy and tactics**

Strategic leadership is at the heart of any successful policy development process, requiring the development of alliances of support for, and offsetting
opposition to, policy change, making it both politically feasible and sustainable (Reich, 1996).

For those promoting policy change, a first step must be to develop knowledge of their own and other actors’ interests, their capacity and the sources and levels of power each can bring to bear on the related processes. Understanding their own level and sources of power relative to other actors then allows leaders of policy change to judge how to offset their own weaknesses by the ways in which they interact with other, selected actors. For example, as the public sector is often constrained by a lack of human and financial resources, and may even be divided in its objectives, policy reformers may need to bring in capacity and power from outside the public sector to make effective change possible. In addition, as Reich (1996:93) notes, “reform can be protected against full reversal if constituencies are created inside and outside government”.

In addressing public/private mix issues, it will be particularly important to see what private-sector actors can bring to the policy development process – whether it be information and technical skills to help make decisions, or power or resources to allow for smooth implementation of policy. At the same time, the government clearly needs to manage the less desirable features that the private sector may bring to policy development. Chief among these, especially in the for-profit sector, is divergent interests. Thus the reform leader must weigh up the positive and negative characteristics of each private-sector actor in relation to the development of the policy. The critical question is whether, and how, the policy process can utilize the positive characteristics of private-sector actors while avoiding the negative. This will only be possible if careful attention is given to the way in which policy is to be developed. Key parameters might relate to the choice of formal and informal policy processes and the degree to which public and private sectors share resources and power in policy development. Relevant examples drawn from South Africa are explored below.

The “arm’s length” approach adopted relative to the private insurance industry during the development of the South African 1998 Medical Schemes Act allowed reform leaders to draw on the industry’s knowledge without giving it control over the design of regulatory proposals. The box below outlines the strategies that allowed the reformers both to gain understanding of the insurance industry’s positions and, at the same time, to develop policy proposals in response to that knowledge. A final important element of the reformers’ strategy was gaining the support of a policy champion within the Cabinet, who had sufficient personal standing to push for implementation despite concerns about the policy among some ministerial colleagues (Gilson
**Strategic consultation with the insurance industry in developing the 1998 Medical Schemes Act**

**Maintaining a “low profile”**

“What we privately decided on in terms of a process was that we would actually engage directly with the industry in a kind of, not an overt process, but a way of capturing their confidence. We decided that it would be a very low-key process, not a high profile process ... which just attracts disaster, I mean you can’t keep reporters away, all they want to do is kill your process, and anybody that’s scared of an output of that process starts turning the press on you.”

**Establishing the “high bid”**

The proposals were first tested against some of the key actors in the insurance industry to allow subsequent modification. But, recognizing that opposition from the industry was inevitable, the reformers presented a first set of proposals for discussion that even they knew to be unrealistic. “We discussed the issues and out of that we drafted a set of initial proposals on what would be a first run, first brush with the industry on proposals – and they were harsh and deliberately so ... The proposals were a kind of ... high bid.”

**Reacting to initial responses**

In reacting to the responses to the first proposals, the working group was then able to moderate its initial position without losing sight of its main policy objectives. “So what we did was to try to reach a middle ground in a whole lot of areas so that they would realize that we’re not going to get extreme versions of what we wanted through, to moderate it in useful ways so that we still protected the access and equity issues within the Act ...”

**Applying the “divide and rule” strategy**

Throughout the consultation exercise, the working group was mindful of the emerging split within the insurance industry, and used that to its advantage in overcoming the vested interests in the industry. “And we also decided we would select very carefully who we knew would be our friends and our enemies within the private sector, so that when the stuff got debated in public, that there would be key role players that supported them from the private sector, so the proposals were not taken as draconian and socialistic, and so on ...”

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Source: Gilson et al., 1999a (interviews with health policy analysts).

This more informal, strategic and “behind-closed-doors” approach to policy development in insurance regulation was in direct contrast to the more formal processes adopted to consider social health insurance. Not only did the policy committees on social health insurance allow the private insurance industry too close an involvement in the development of policy proposals, but they were themselves undermined by being weakly supported by policy champions within political circles and inadequately structured to enable careful policy development. Their media visibility, including leaks to the press and heated rejection of some of their proposals, may also have added to these problems by deterring political support for their work, while creating unrealistic expectations.

Although formal structures, such as committees, may allow governments to draw in additional technical capacity to support policy development, or to secure credibility for their proposals by allowing interest groups to be represented, they are difficult to manage and can be captured by other actors. Broad-ranging representation on high-profile committees may yield an
unstable cocktail of diverging interests and high expectations. Heavy-handed management of the committee to control these factors may only create a backlash that can produce hostility and unhelpful recommendations. Government attempts to influence the discussions of one of the South African social health insurance committees, for example, created concern even among some of the potential supporters of the government and may also have promoted a hostile reaction from the media (Gilson et al., 1999a).

Conversely, too little direction may allow interests opposing, or tangential to, the reform to push policy off-track. The chairmen of such committees then become extremely important, as does the development of their terms of reference, which may support the effective management of divergent interests by establishing a vision or focus for the group. In any case, formal processes are likely to need the support of more informal strategic and tactical action — to gain consensus within them, to give profile to their recommendations or to ensure their proposals are discussed in official government circles.

Other strategic issues that are important to consider in developing and implementing policy change (Gilson et al., 1999a, 1999b) are the following:

- gaining support by using policy design to influence the configuration of winners and losers from policy change
- building support among a widening circle of actors by demonstrating success in implementation
- planning the sequence of policy implementation to allow the prerequisites for further policy change to be created during implementation
- adapting the speed of implementation to allow capacity development through the process of implementation
- weighing up the relative advantages and disadvantages of phasing implementation or using pilot schemes to initiate it
- identifying the information which can be generated through monitoring and evaluation processes to maintain the momentum of policy change
- publicizing and disseminating information in ways that promote policy change
- maintaining good communication among existing or potential policy supporters.
Conclusions

The importance of actors and processes to implementing any policy change is increasingly recognized. Nonetheless, there are very few published investigations of these issues, particularly in relation to policy action focused on the public/private mix in health care. A critical difference between such policy action and other health policy changes lies in the map of interested actors and the direct impact of policy on frequently powerful, but poorly understood, private-sector interests. Knowing when and how to engage these actors is a central requirement for effective policy development: when and how to talk to them, to consult them, to neutralize them or to oppose them. Developing such strategies also requires a thorough analysis of reformers’ own strengths and weaknesses, as well as reflection on other key actors and careful policy design. Other chapters of this book offer insights into, in particular, the nature of possible policy deficiencies, and possible remedies. In some cases, the results of research have already been incorporated into policy change (Chapters 6, 7 and 9). In others, policy change has been attempted, but influential public or private-sector groups have diverted it from its original intention. A third scenario, which seems especially prevalent in the poorest countries studied, is that appropriate policy change has occurred, but the machinery for implementing it is largely absent, and hence few changes have occurred on the ground (Chapters 2, 3 and 10). However, it remains important to understand better the peculiar characteristics of the actors engaged in policy processes focusing on the public/private mix. Such an understanding will provide the basis for developing the strategic action required in implementing related policy action.

Acknowledgements

This chapter draws in particular on a wider study of health care financing policy change in South Africa and Zambia. The study was funded by the Major Applied Research grants programme of USAID’s Partnerships for Health Reform project, the European Union (through INCO-DEV research funding, contract number IC18-CT97-0218) and the South African Medical Research Council. We are grateful to our colleagues in the Centre for Health Policy, Health Economics Unit, University of Zambia, London School of Hygiene & Tropical Medicine and Swedish Institute of Health Economics, who were involved in this study and whose insights are reflected in the analysis presented here. Lucy Gilson is a part-time member of the London School of Hygiene & Tropical Medicine’s Health Economics and Financing Programme, which receives funding from the UK Department for International Development.
References


INTRODUCTION


1. The impact of health care reform on the professional regulation of physicians in Latin America

Gustavo Nigenda, Maria Helena Machado, Maria Consuelo Castrillón, Juan Arroyo

Introduction

This paper was written to identify changes in the way the medical profession has been forced to modify its role in the provision of services in various countries in Latin America. Within the region, health system reform has taken different forms owing to the original structure of each health system, government policy imperatives and pressure applied by external funding agencies. However, one thing that reform projects have in common is the need to redefine the role of health professionals under a system where market forces play a more important role (Drache & Sullivan, 1999).

In Latin America, the reform of the State in general has been characterized by its reduced participation as a financing agent and purchaser since the 1980s. Nevertheless, since the State keeps control of the legislative and judicial spheres of government, it is still required to regulate agents involved in the provision of health services, including health professionals. Historically, the State and the medical profession have negotiated the nature of that regulation. In the production of health services, the role of the State has recently focused on controlling costs, improving efficiency, decentralizing decision-making and expanding the private subsector (Whitaker, 1999).

This project collected information from five countries (Brazil, Colombia, Mexico, Nicaragua and Peru) aiming to compare processes of medical regulation. The theoretical framework of this project is an adjusted version of Moran and Wood’s (1993) proposal for the analysis of medical regulation. Moran and Wood define four areas of regulation:

- market entry
- competitive practices
- market structures
- remuneration.

Comparing regulation in the different countries, they also arrive at a definition of three modes of regulation:
• independent self-regulation
• State-sanctioned self-regulation
• direct State regulation.

We decided to add “consumer information and action” (Nigenda & Machado, 1997). It was decided, too, that five areas of regulation would be most appropriate for intercountry comparison, and these are shown in Table 1. The dimensions of regulation studied have subsequently been used as a model for intercountry comparative research (González-Block, 1997).

Table 1. Areas of regulation studied in participating countries

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<th>Country</th>
<th>Market structure &amp; entry</th>
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<th>Consumers’ role</th>
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Primary and secondary information was collected in every country. Primary data were obtained through personal interviews with key informants, either professional or institutional representatives. Secondary data were obtained from literature searches, including “grey literature” produced by institutions, professional associations or trades unions. The country descriptions which follow present both primary and secondary data.

Brazil

Background

According to official data, in 1992 Brazil had over 200 000 physicians, over 100 000 dentists and almost 60 000 nurses, thus forming the largest group of health professionals in the five countries involved in the research. The number of physicians is particularly remarkable. In 1960, the country had 30 medical schools, by 1975 it had more than doubled its training capacity to 75, and by 1990 it had 80 schools (Machado, 1996). More recently, there has been a rapid growth in private medical schools, with the number approaching 100 by the year 2000. There remains, however, an undersupply of physicians in many rural areas, together with substantial unemployment of physicians in the cities. Neither the numbers nor the distribution of physicians in Brazil correspond with need.
The Brazilian State is thus involved in rendering and directly and indirectly financing medical services. This has resulted in the health services market being divided into two sectors: the public one, with an exceptional network of outpatient clinics and large general hospitals, and the private one, with a huge network of small and medium-sized hospitals (almost 80% of all hospital beds). In addition, there is a market of private medical consultation services, offered by more than 70% of the physicians in the country from their own offices, funded mostly through health plans and insurance.

**Working conditions**

In the last 30 years, Brazilian physicians have experienced a clear loss of status and social prestige. Over the last two decades, they have experienced important changes in their working conditions: many have become employees, earning low wages, having several jobs, and doing part-time private consultations paid for by health insurance. According to Machado et al. (1997), one of the outstanding characteristics of the medical profession is the intensity of the working process; medical professionals generally have a long working day and work in several places. The excessive emphasis placed in previous decades on medical specialization and high-tech interventions continues to generate much unnecessary medical expenditure.

The Brazilian health system has been restructured to take into consideration two crucial new concepts. The first is the significant increase in the number of physicians who are employees, in either the public or the private spheres. The second change has involved the end of the medical work monopoly, thus reinforcing team work. The reform also stresses multiprofessional work. The recent family physician programme reflects this orientation of the new health system.

**Payment mechanisms**

Most Brazilian physicians experience low salaries and managerial subordination in both the public and the private sectors. The substantial oversupply of physicians in Brazil probably remains the main underlying influence on medical salaries and autonomy.

Research on the profile of physicians in Brazil completed in the late 1990s showed that salaried employment in the public or private sectors represents the most important form of remuneration for physicians (Machado et al., 1997:115). The research further established that financial agreements with insurance companies were difficult to avoid, especially for physicians starting up their own practices, and constituted the second most important source of income.
Technology and the role of consumers

Technological advances in recent years have somewhat reversed the declining prestige of the medical profession. Nevertheless, such advances have produced negative effects on the health system as a whole, making medical products and services expensive and inaccessible. Some individual clients have proved demanding in their claims for highly specialized services from the system. To a large extent, technological advances have led to high-cost, extremely specialized medical practice. The Brazilian public health system has generally not been able to meet the technological expectations of either physicians or clients, leading to frustration and disappointment.

Consumer organizations are flourishing in Brazil, demanding not only better and more integrated care, but also more participation in the government’s decisions to allocate financial resources to the health sector. It is not yet clear to what extent these organized groups will influence the balance between high-tech, specialized interventions and appropriate integrated care.

Labour market regulation

With the recent trend towards salaried employment for physicians, the strong presence of the State, and the growth of the private sector, there have been shifts in the supply and demand of medical labour. Managerial and bureaucratic controls introduced into health organizations (public and private) are viewed by some physicians as new forms of medical regulation. Furthermore, users are demanding greater and greater accountability from health care professionals, as well as greater participation in decision-making and management in the health sector. Both managerial and consumer changes have thus led to a significant loss of technical and economic autonomy on the part of physicians. The increased control over physicians by means of salaried employment is diametrically opposed to the market-based reform of health care that has occurred elsewhere in Latin America. Finally, the Brazilian government has announced its intention of requiring physicians to register before they take up salaried employment, although the details of this plan have yet to be finalized.

Colombia

Background

In Colombia, article 48 of the 1991 Political Constitution states that “Social Security is a public, compulsory service offered under the direction, coordination and control of the government ... The inalienable right to social security is granted to everybody ... Social Security can be offered by public and private entities, according to the law” (Presidency of the Republic of Colombia,
Health care reform in Colombia originated in the 1980s and was established in Law No. 100 of 1993, whose general principles are: universality of coverage, solidarity, integrity, efficiency, equity, quality, social participation in health and choice of institutions and physicians. The law envisages a system of services where public and private subsectors compete. Through the obligatory health plan (plan obligatorio de salud – POS), a basic basket of services is provided for the population (Pulgarin, 1998, personal communication).

Funding follows the demand for care and not the supply, thus requiring that health care providers compete with each other for a large enough patient base. A solidarity and insurance fund (Fondo de Solidaridad y Garantías-FOSYGA) has been established under the direction of the Ministry of Health with four separate funds:

- compensation of contributors
- compensation of people who cannot contribute
- health promotion
- catastrophic risks and traffic accidents.

Each fund is financed by contributions from the population, the government, fund transfers and private insurance.

The objective of the newly-created health promotion enterprises (empresa promotora de salud – EPS) is to affiliate, register, collect contributions and guarantee the provision of services to which affiliates are entitled. Services are directly provided by the health service institutions (instituciones prestadoras de servicios de salud – IPS) that are contracted by the health promotion enterprises. As a consequence of this, there are enterprise physicians who are both employees and owners of private health promotion enterprises, and other organizations, e.g. physician cooperatives, which sell services to the health promotion enterprises (Ahumada, 1997).

Labour market

At the beginning of the twentieth century, the medical profession in Colombia controlled its own practices; by the middle of the century, the State had begun its involvement in regulation. Current regulations include the following (ANMC, 1996).

To enter the labour market, the recently graduated doctor must:

- register his/her diploma at the relevant university; in the case of courses taken abroad, the Colombian Institute for the Promotion of Higher Education (ICFES), which reports to the Board of Education, must evaluate and validate the qualification
- undertake the obligatory period of social service, according to Law No. 50
of 1981 and its regulations; this service lasts about a year

- register with the Ministry of Health
- obtain a “professional card”, depending on the demands of the employing institution where the practice will take place; the professional card is an official document accrediting the practice of medicine in Colombia, issued by the Ministry of Health.

Although Resolution 5078 of 1992 restricts the practice of alternative therapies and traditional medicines to those who are able to demonstrate their qualifications, in practice these are used freely and with no control. Law No.14 of 1962 regulates the practice of medicine and surgery and classifies and penalizes the illegal practice of medicine. Once received, however, the accreditation to practise is indefinite. No mechanisms exist for medical decertification in Colombia.

**Payment mechanisms**

Two significant changes in payment mechanisms have occurred for Colombian doctors. The first involved a change from the liberal system of fees-for-service to salaried employment, where the health institution became an intermediary between the physician and the patient. The second involved the transition to more sophisticated output-based payment systems, such as payment per event, where mediation is in the hands of the health promotion enterprises and health service institutions. From the perspective of the salaried doctor, payment per event is perceived as a disadvantage, owing to the loss of a guaranteed salary and constraints imposed on practice. Interviewees frequently bemoaned their loss of status, comparing themselves to other workers who also receive a payment per service, such as taxi drivers, hairdressers and bus drivers.

Although multiemployment is not a new phenomenon, it is now being practised more for financial reasons than from a desire to do a mix of different work, as was previously the case. For this reason, doctors feel they must obtain work with different institutions until they complete, in many cases, up to one and a half workdays per day. Lower incomes have also led to a “battle for patients”. Doctors are required to see a specified number of patients, so that the income both for the doctor and for the health promotion enterprise is adequate. Professional responsibility tends to be diluted across a chain of interventions which create a greater gap in the doctor-patient relationship, and this is a key element of quality in the users’ minds. In these cases, one doctor checks the patient in, another operates on him/her, and yet another is responsible for his/her discharge from hospital. The hierarchical organization,
excessive paperwork and endless chains of responsibility make medical work more bureaucratic and less pleasant.

**Medical organizations**

To date, public health policies have been drawn up by government representatives and client interest groups belonging to traditional political or civil society organizations, such as organizations of medical professionals. Doctors participate in parliament, but they are not recognized by the medical organizations as their representatives. Recently, some medical organizations have begun promoting their own candidates for parliament.

Owing to the increased importance of the market in the health sector, new institutional actors, such as the health promotion enterprises and professionals from other disciplines, are increasingly involved in regulating the medical profession. This has prompted medical organizations to regroup into the Colombian Medical Association, which defends the interests of the profession.

Under the present social security system for health, two areas of dissatisfaction are reported by doctors. One is that market pressures make it difficult to achieve the interpersonal and humanitarian objectives of their practice. The other relates to the low salaries, poor working conditions and restrictions in technical autonomy that doctors experience, despite their high levels of training and extensive responsibilities.

**Conclusions**

Medical organizations are adjusting to the competitive market reform in the health sector. Many standards regulating professional practice are inconsistent with the current environment, particularly those which refer to the obligatory social service period and the law which regulates medical and surgical practices. There are few methods for controlling the quality of professionals who stay in service, despite the fact that new reimbursement methods put downward pressure on quality of care. In Colombia, there was no real participation of the medical profession, nor of other health professions, nor of civil society in general, in the reform of the health system. The professional medical model is clearly changing from that postulated by the sociology of professions. Today’s physician feels that he/she has lost technical and economic autonomy, social status and buying power in the health institutions. The doctor-patient relationship has deteriorated as a result of pressure of time and costs, increased paperwork and procedures, poor continuity of care and
dissatisfaction amongst users of health care services.

**Mexico**

**Background**

Mexico’s health system is undergoing a long and unnecessarily complicated process of reform. In 1982, the organization of health services began to change in response to a scarcity of financial resources, and there is still a debate about what the reform means for every subsector of the system. Since the 1940s, the system had been divided into three subsectors, with different organizational and financial capacities:

- social security
- social assistance
- private

(Frenk & Gonzalez-Block, 1992).

Working conditions in each subsector have also changed considerably. The reform process has essentially altered the balance between the subsectors in terms of the volume of available resources and the capacity to care for various population sectors. This new balance has also had an impact on the participation of physicians.

Throughout this period, the State has been the main regulator of all areas of medical practice, from market entry to the definition of working protocols. Until 1990, most physicians in both public and private institutions had been trained in public universities, where the State played a major role in the definition of new enrolment policies and the quality and orientation of medical education (Frenk, 1990). The licensing process was also under the control of the State, rather than professional organizations (Nigenda & Solorzano, 1997). Working conditions in the public sector were defined and frequently imposed by employing institutions, while the private sector, which until recently represented only a small part of the market of health services, was left largely unregulated.

**Working conditions**

The authorities have increasingly shown concern for the failure of institutions to improve working conditions for doctors. It seems likely that a new programme of primary health care will be launched by the Mexican Social Security Institute (*Instituto Mexicano del Seguro Social* – IMSS). This programme may change the way doctors have been managed and remunerated for the last 45 years. Doctors will no longer be expected simply to treat patients presenting at health care units, but will instead become more active in the identification of health problems in the community. So far, there has been a tendency for working hours to decrease. Even though doctors are paid for eight hours’ work per day, they can spend one-and-a-half hours in...
study or any other activities which they think will improve their knowledge and technical capacity.

Within the Ministry of Health Services, the need for new financing is leading some units to establish new organizational models. One of the National Health Institutes, a tertiary referral hospital, has attempted to attract people who can pay for services. National Health Institutes are considered the best hospitals in the country, staffed by highly trained physicians. Patients may be covered by private insurance or social insurance, or pay from their own pockets. Doctors may see these patients in restricted numbers after their normal duty hours. The Ministry of Health is waiting to see the results before attempting to expand the practice throughout the system.

New ways to regulate market entrance

Licensing has not been used to regulate the quantity or quality of physicians in the labour market. The strong influence of public institutions on both the supply and the demand side of the market has made this unnecessary. In recent years, however, the growth of the private sector has increased the regulatory requirements. Since the early 1990s, the certification councils have begun to be regarded as the new way to guarantee the high standards of medical practice (CNNCEM, 1996). The National Academy of Medicine, an elite, unelected group of physicians which has been the formal advisor of the Mexican State on health affairs since the beginning of the twentieth century, was given control of the councils. The oldest councils started to develop an accreditation process in the 1960s, but this was previously of little benefit in the employment market. Now, most major private hospitals in the country demand that specialists should be certified by the council of their speciality. Private insurance companies have also restricted their networks to certified physicians. Although this cannot be considered a licensing process, it is certainly working as a filter to sort out better-trained doctors from the rest. In the public sector, doctors need not be certified in order to guarantee their jobs, but it is probably increasingly advantageous when they are competing with other doctors for the same job.

Payment mechanisms

In the public sector, physicians are paid a salary. However, salary levels differ between social security and social assistance institutions. The physician's basic salary within the social security system does not distinguish between clinical specialists and family physicians. The basic salary increases in line with the time the physician has been in post, his/her punctuality and the amount of overtime performed. The financial weakness of the Ministry of Health has made it impossible to pay salaries at the level of social security institutions. The State plays no role in setting or regulating remuneration in the private
The Mexican Social Security Institute plans to pilot a new model of professional remuneration in four states. Family doctors will be paid on a capitation basis, and will be responsible for the health care of a defined group of the population. Since the system is still relatively undefined, firm positions for and against it have not yet been formed. The largest public-sector union has tried to extract assurances from the Social Security Institute that this will not involve privatization of primary care functions, while physicians have yet to articulate a firm position on the suggested changes.

Role of consumers

The Mexican State was able to control the political participation of the population for over 60 years during the last century. The country is now entering a new era of greater political openness. This openness has been extended to the health sector. In 1994, the National Commission for the Surveillance of Medical Practice (Comisión Nacional de Arbitraje Médico – Conamed) was created under the control of the Ministry of Health (Conamed, 1997). Conamed was supposed to be a neutral organization dealing with the thousands of alleged malpractice complaints from the population. Its members are physicians and members of the public. It is not able to impose sanctions, but instead makes recommendations to the judicial authorities. Its president is appointed by the Minister of Health. Although doctors have treated Conamed with a great deal of suspicion, it has so far had little impact on the regulation of malpractice, and its role has mainly been one of conciliation between doctors and consumers.

Dynamics in the private sector

In Mexico, there is still a widespread idea that physicians in the private sector work on their own as sole practitioners. Since the early 1980s, the private sector in Mexico has become more capital-intensive and corporatized. New ways of regulating physicians’ participation have also been implemented, particularly in the field of specialist medicine. Private insurance companies have played a prominent role. Their clientele consume only 4% of health services in the country, but planned changes to allow a refund of social security payments for private insurance holders and private financing of primary care are likely to boost membership. Insurance companies have already organized physicians’ networks in major cities. So far, only accredited specialists can join these networks. Insurance companies have also defined the length of the
physician’s working week, clinical practice protocols and payment levels.

Nicaragua

Background

In Nicaragua, there is a weak legal framework for the regulation of medical practice. Some regulations cannot be considered legal, since they have not been formally passed by the health authorities, but they nevertheless have a significant impact on medical practice. Since 1968, the Law on the Establishment of Compulsory Social Service has obliged all medical students to spend between six months and two years working in rural areas for the public services, receiving a small allowance, before they can receive their university degree. Once the degree is granted, the physician can legally practise. There is no licensing process (Ministry of Health, Nicaragua, 1993).

The Sandinista administration of the 1980s controlled professional practice from university onwards through the “unified health system” (Ministry of Health, Nicaragua/World Bank, 1996). The social service period was also the first step towards the integration of physicians into the public system. Working conditions for students were improved, making them workers with full employment rights on the Ministry’s payroll. Subsequently, more Ministry of Health internal laws were passed to regulate the activity of undergraduate and postgraduate internships. In 1986, the contractual conditions agreed between the Ministry of Health and the Union of Health Workers aimed to guarantee a job for all students on obtaining their degree, and for all interns on obtaining their specialist diploma. As was the case with Mexico, there was little need for the State to regulate physicians through any means other than its employment contract with them.

Major changes in regulation in the 1990s

During the 1990s, the role of the government in health care changed fundamentally. Firstly, the close relationship between the Ministry of Health (still the most important employer of physicians in the country) and the University of Nicaragua began to deteriorate. While the Ministry began a new policy to reduce the number of physicians on the payroll, the University created a new medical school in Managua and increased the number of physicians in training. According to the General Secretary of the Federation of Health Workers (Federación de los Trabajadores de Salud – FETSALUD), a group of trades unions with legal representation to negotiate working conditions with the Ministry of Health, since 1991 over 3 000 workers have been taken off the Ministry’s payroll, including 1 000 professionals (FETSALUD, 1994). Since 1993, medical interns have no longer been considered employees, but rather students receiving a scholarship from the Ministry.

Post-Sandinista administrations have also attempted to reinstate services
provided by the National Social Security Institute. The health facilities previously owned by the social security sector were integrated into the unified health system by the Sandinista government. Social security funds pay private hospitals and health centres to provide services for the insured population. Furthermore, new public-sector institutions have emerged, such as the Policlinica Oriental, a specialist hospital employing 100 workers in total. These do not fall under the Collective Convention, and every employee signs his/her own contract with the employer (Ministry of Health, Nicaragua, 1995a, 1995b).

Another policy modifying medical practice is the search for new sources of financing for public services. In 1995, the Ministry launched a programme, creating so-called “differentiated services”, which allows health care units to charge fees to users. Within this programme, the patient chooses whether or not to pay for services. If the patient decides to pay, he/she is granted a selected set of services. The health centre may charge for the services provided, while physicians may charge as they do in their private practice.

In 1990, a decree on the Law of the Ministries of State was published, giving the Ministry of Health the responsibility of “assessing the practice of the medical profession”. However, no specific regulations have been promulgated from this decree for the medical profession, only for optometrists and nurses.

The labour market
A recent study (Ministry of Health, Nicaragua/World Bank, 1996) found that in Nicaragua in 1996 there were around 3,500 physicians. The majority of them (85%) worked for the Ministry of Health, with 40% of the whole group combining two or more jobs, typically in both the public and the private sector. Women represent 40.5% of this labour force, which is also characterized by a high proportion of young people (73% of all physicians are 40 years old or younger). The medical workforce is highly specialized (52% have a clinical speciality). Working conditions within the public sector are regulated by the Collective Convention, but no regulations apply to private practice. Because many physicians combine public and private practice, almost half of them (47%) work more than 40 hours per week, which is the figure for full-time working laid down in the Collective Convention. Many physicians spend only three or four hours a day in the public service to justify their salaries, using the rest of their time for private practice. The Ministry of Health has never shown deep concern over this issue, as they implicitly acknowledge that physicians’ salaries are below market rates. The average salary in the Ministry of Health is around 100 US dollars per month.

The role of consumers
Medical malpractice in Nicaragua is probably as common as in any other Latin
American country, but it has yet to be taken seriously by the Ministry of Health. There is no entity within the Ministry to deal with users’ complaints, and all malpractice cases go straight to court for settlement by a judge. There is no health ombudsman.

However, a number of channels have been established to allow direct public influence on health-sector decision-making. The Sandinista government began a system of health-sector decentralization based on the creation of local health systems (Sistemas Locales de Atención Integral en Salud – SILAIS) when it came to power. The National Health Policy of 1993 encouraged the promotion of a new managerial culture which continued to draw on the local health systems for guidance at the local level. While local mechanisms thus exist to enable users to influence their health care providers, they have not been able to deal with professional performance. User surveys carried out by the Ministry of Health suggest that, while the levels of care delivery show significant room for improvement, public satisfaction levels are fairly high. For example, the average time that a person has to wait before receiving care is around two-and-a-half hours, but users surveyed felt that this was acceptable.

**Professional organizations**

For many years, physicians have been interested in creating organizations to defend their professional and labour interests. While physicians have enjoyed social prestige as a group, they have to negotiate their working conditions just like any other professional in the country. When the Sandinistas came to power in the late 1970s, the medical elite fled the country, significantly weakening the profession. During the Sandinista period, physicians lost their position at the top of the medical hierarchy, and were treated similarly to all other health workers. Although a medical union, FETSALIJD, was set up, it was controlled by the government of the day, and thus did not perform any representative role for physicians.

Before the Sandinista period, a College of Physicians had been created, but it was never considered by the government as representative of physicians’ interests. In recent years, the College has been active in mobilizing support for a role for itself in regulating medical practice. Its first target is to ensure the compulsory registration of physicians by the College. Through this strategy, the College intends to:

- regulate medical practice by granting a registry or licence
- introduce a compulsory ethical code among physicians
- introduce a system of ranking for physicians in terms of their skill, qualifications and experience
- regulate the way physicians advertise their services.

Health care unions have not received much support from physicians, with
many physicians complaining that they have poor knowledge of work processes and the pressures which physicians experience. Despite the government's implicit policy of discouraging small professional bodies, other professionals have been able to gain some representation. Pharmacists, for example, have negotiated control of a registry of practitioners held by the Ministry of Health.

**Peru**

**Background**

This research analysed three aspects which have a bearing on the regulation of the medical profession in Peru. The first is related to payment mechanisms for physicians, the second is related to the impact of citizen empowerment on professional practice and the third deals with the role of associations and medical guilds. The main finding of the research is that regulation of the medical profession is weak in Peru and that the transition from professional self-regulation to State regulation has been inconclusive. Reform of the health sector has become proregulatory and not deregulatory. Up to now, at least, market reform has not been particularly prominent in the Peruvian health sector. Cultural or symbolic reform is as strong as, if not stronger than, the explicit, legal reform in health care.

**Labour market and payment mechanisms**

In recent years, payment mechanisms for the medical profession in Peru have slowly changed. There has been a trend towards temporary contracts and a remuneration system based on payment per product or service, but this transition is still very new. The starting point for the change in payment mechanisms in Peru is not a salaried medical service, as is the case in countries where the State is an important employer, but rather a combination of fee-for-service and a monthly salary on a dual-employment basis. When, in the 1960s and 1970s, the State became the main medical employer, physicians avoided an exclusive dependence on the State and prolonged their liberal medical status by negotiating salaried employment that still allowed them to maintain their private practices.

In the mid-1960s, Hall (1969) found that of a total of 5 235 physicians in Peru, 28.6% were in salaried posts only and 3.7% lived exclusively from their private practices, while 34.3% were both salaried and self-employed. The remainder had at least two sources of income.

Lip et al. (1990) showed that, in 1988, 36.5% of doctors had two jobs, 22.3% had three jobs, 5.4% had four jobs and 0.3% had five jobs, while only 28.9% had one job. However, the main source of income for seven out of 10 doctors
was their salary.

More recently, the Second Infrastructure and Human Resources Census of 1996 revealed that 39.09% of the 24,708 registered physicians were employed in the Ministry of Health, 18.19% at the Peruvian Social Security Institute, 32.43% in the private sector and 7.13% in the armed forces/police and welfare institutions (Ministry of Health, Peru, 1996). An average of 1.92 jobs per doctor has been estimated. While medical multiemployment has thus existed for a long time, the main change over the last five years has been towards a system based on contracts in the public sector. These often have a productivity-related component, and may define a specific task to be fulfilled for a specified period only. Most government agencies are in the process of switching towards contracted employment. For example, under the Basic Health for All Programme and the Shared Management Programmes of the Ministry of Health, the number of contracted employees has grown from 1,154 in 1992 to 3,846 in 1996 (Ministry of Health, Peru, 1992, 1996, 1998). The social security system under Dr Castañeda Lossio (1990-95) ended the existing appointment regime in 1991, and since then all new appointments have been on a contractual basis. Graduates recruited into the Marginal Rural Urban Service (SERUM) are now employed on contract (Ministry of Health, Peru, 1998), as are many doctors employed in managerial and nonclinical support roles in the Ministry of Health.

To sum up, most physicians in Peru are still in salaried posts, but a large proportion also have a private, fee-for-service practice. Amongst younger doctors, contracted forms of employment are increasingly common, although still less frequent than permanent salaried appointments.

The role of consumers

Our research showed that the importance of the population's opinion with respect to medical regulation is generally increasing, although this process of empowerment is slow and patients in Peru still cannot find satisfactory channels to express their demands and resolve complaints. The population's influence has been exerted through a number of mechanisms.

**As individuals:** Because of patient lawsuits following medical negligence, iatrogenic illness and malpractice, the concept of the “legal patient” appeared in Peru in the 1980s. The increase in lawsuits led the medical profession to hire lawyers to represent its members for the first time. The population submitted its complaints to the health care establishments where malpractice had occurred, to the police and to the National Institute in Defence of Competition and Protection of Intellectual Property (INDECOPI). The leaders of the Medical Federation estimate that from the beginning of 1994, in Lima alone, over 1,000 reports were submitted, of which 400 entered the judicial system. Before this, reports had been submitted, but more sporadically.

**As a group:** Social participation in health preceded the current reform of
the health sector, particularly through the local committees for health administration (comités locales de administración en salud – CLAS). Since 1994, the Peruvian State has promoted a new model of social participation with the Programme for Shared Administration. Under this programme, up to December 1997, 700 local committees for health administration were established in health centres and stations. Since then, the local joint administration committees (comités locales de administración compartida), civil, non-profit associations with private legal status, have been responsible for the administration of health establishments at the primary care level, receiving financing from the State. Research on this type of model has concluded that supervision by the population has had a favourable impact in improving service quality, but has not yet been able to improve the level of collaborative community participation (Salazar et al., 1999).

Through media reports on medical negligence cases and scandals. Discussion of poor quality practice in the media has had much more effect than individual lawsuits or community participation in health. As a result of patient empowerment, a new physician-patient relationship is emerging. The National Association of Physicians of the Health Ministry (ANMMS), aware of the new challenge, unanimously approved a Declaration on the Rights of Patients in its III. National Convention in December 1995 (National Physicians Association, 1995). This process of empowerment of the population has also led to more widespread levels of defensive medicine in Peru and the organization of legal protection mechanisms for doctors.

Professional organizations

Our research verified that the medical profession has gone through three stages of professional regulation. In the first, “aristocratic” stage, professional regulations were set by the profession itself, prevailing medical opinion being the determining factor. In the second stage, between 1940 and 1960, a distancing began to take place between the State and the medical establishment, with large State medical institutions beginning to challenge the hegemony of physicians. In the mid-1960s, the concept of the State providing services became widespread, and the medical profession sought to influence regulation through its presence in parties in the government, particularly Acción Popular (Popular Action). In the third stage, which began in 1980 with the national crisis, ongoing confrontation and negotiation between the profession and the State have become the norm. Much of the 1980s was characterized by conflict about low medical salaries. With the passing of the Medical Work Law in 1990, which allowed for better salaries in the profession, the open conflict ended and the current situation of divergent, but more amicable relations between the Ministry of Health and the medical profession began (Ministry of Health, Peru, 1996).
The most recent plans by the Ministry of Health for the reform of the health sector have not yet made proposals for medical employment, but suggestions are that it will involve significant layoffs. The medical profession has united in defence of its basic interests, but has not suggested an alternative scheme. In recent years, however, there has never been a complete rupture between the State and the medical profession. Negotiations involve many small issues, many of which remain unresolved. Furthermore, no-one takes full responsibility for the position of the State. The Ministry of Health must negotiate with the cabinet and its bureaucracy, social forces and the Dean of the College of Physicians. Regulation is thus being built up in a series of small battles and settlements.

Analysis

Five country cases have been described. Each country is going about health system reform in a different way. While Colombia has revamped the whole health care system, Brazil has reformed remuneration and contractual systems only, and has done little to regulate the practice of physicians per se. Nicaragua has been able to decentralize its monopolistic system of health services, whereas Mexico and Peru have had only partial success in this area. Table 2 compares each of the countries for the factors studied.
### Table 2. Comparison of findings by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Market entry</th>
<th>Payment mechanisms</th>
<th>Consumers’ role</th>
<th>Professional organizations</th>
<th>New developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>Attempting to introduce new mechanisms for entry</td>
<td>Salary as the main mechanism in both public and private subsectors</td>
<td>Participation of population in decision-making at the national level and creation of mechanisms to protect consumers</td>
<td>Reorganization of pre-existing groups</td>
<td>Cost escalation and dissatisfaction at the excessive use of technology</td>
</tr>
<tr>
<td>Colombia</td>
<td>No new mechanisms after reform</td>
<td>More diverse under the new structure</td>
<td>Legal definition of consumer participation</td>
<td>Reorganization of pre-existing groups</td>
<td>Displacement of the functional role of physicians after the reform</td>
</tr>
<tr>
<td>Mexico</td>
<td>Accreditation of specialists to protect private practice</td>
<td>Expansion of new mechanisms in the private subsector</td>
<td>Creation of parastatal mechanisms to protect consumers</td>
<td>Reorganization of pre-existing groups</td>
<td>Regulation by multiple agencies after a long period of direct State control</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>No new mechanisms after decentralization of Ministry of Health services</td>
<td>Exploration of new mechanisms in the private subsector</td>
<td>Participation of population in decision-making at the local level</td>
<td>Call for the integration of new organizations</td>
<td>Confrontation between physicians’ interests and the future development of the health system</td>
</tr>
<tr>
<td>Peru</td>
<td>No new mechanisms</td>
<td>Changes according to new contractual arrangements</td>
<td>Civil society pressing for the opening of channels for complaints</td>
<td>Corporate behaviour to deal with State decisions</td>
<td>Definition of new strategies to deal with the reform</td>
</tr>
</tbody>
</table>
A trend identified in all countries is the medical profession's attempt to promote a cohesion that has been absent in previous years. This has been partially successful in the Mexican case, as physicians have been able to force the State to place licensing and certification processes on hold. A recent national strike that practically paralysed the provision of services all over the country showed that physicians in Nicaragua can put pressure on the government's policies when their interests are affected. In some countries, however, such as Brazil, the oversupply of physicians and intense competition for jobs and patients has probably weakened the potential for medical organizations to influence regulation in a unified way.

By international standards, access to the medical labour market is relatively relaxed in all the countries studied. Licensing mechanisms controlled by the State are generally bureaucratic procedures, or do not exist at all, as in Colombia. Where changes are happening, market forces, especially the oversupply of physicians and increased involvement of health insurers, are the driving force rather than quality or safety concerns. Mexico is the only country that has been able to set up a mechanism to certify currently practising physicians, but this is controlled by an unrepresentative medical elite.

Remuneration methods are becoming more diverse as countries move further down the path of reform. In countries where there is significant private-sector growth, there has generally been a shift towards episode-based payment. This has been most pronounced in Colombia, and relatively slow in Mexico and Peru where the majority of physicians are still hired by public institutions. In Brazil, despite a large private sector, salaries are still the most common method of remuneration, possibly reflecting the weak market position of physicians in that country.

Consumer influence over the practice of medicine appears to be increasing throughout the countries studied. In the health sector, the dominance of public services over the last 40 years has lowered the public's expectations of influencing care. Mechanisms to address complaints about physicians' performance have appeared not only in the health system, but also in the judicial system. As complaints and demands increase, physicians have taken a more defensive position. The contraction of the public system in all countries is leaving physicians more exposed to market forces and increasing levels of individual responsibility. While, in public institutions, responsibility for malpractice is normally absorbed by the institution, in the private sector individual negligent physicians are more likely to be identified. The public is also potentially more exposed to unskilled independent physicians who are no longer under the supervision of their publicly employed colleagues. In Mexico, acknowledgement by the Ministry of Health of the growing importance of public complaints about the health service has led to the establishment of the National Commission for the Surveillance of Medical Practice. In Nicaragua, a market/consumer culture has yet to take hold, and
malpractice is therefore not yet an important issue. Nicaragua, Brazil and Peru have all established mechanisms for public participation to foster greater medical accountability, but these have probably not had a great impact on clinical practice as yet.

One final consideration about the regulation of physicians’ practice in the cases studied is that the process is widely permeated by ideological issues. The trends shown by the report can be considered, at least partially, as an outcome of the structural changes that health systems are experiencing all over the region. In many Latin American countries, heavy State involvement in the delivery of care meant that the regulation of health care practice was poorly developed. Reforms creating more pluralistic systems now require independent regulation to be developed. In cases where the State has not legislated for such regulation, it has often arisen spontaneously on the part of other market players, such as health insurers or consumers. The success of both legislative and spontaneous regulatory initiatives appears to be related to the market power of physicians. The loss of influence resulting from regulation is both directly frustrating to physicians, and indirectly a cause of their loss of earning power. Even where privatization has not been extensive, the State has introduced relationships with physicians which are more typical of the private sector, such as fixed-term contracts and capitation arrangements. Finally, third parties, such as health insurers, are increasingly becoming involved in executing regulatory initiatives. While the State keeps the judicial instruments, social security institutions and insurance companies exercise significant control via financial resources, delegated authority, protocols and other means. While the end-result of these changes is far from evident, the external influences on clinical and financial practices of physicians are already marked.

Acknowledgements

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Further reading


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REGULATING HEALTH CARE PROVIDERS — NEW CASE-STUDIES


2. Regulating private drug outlets in Dar es Salaam - perceptions of key stakeholders

Phare Mujinja, Rose Mpembeni, Sally Lake

Background

Several sub-Saharan African countries have adopted a broad package of reforms over the past decade in an attempt both to address equity and efficiency failings in the health systems they inherited from their colonial past, and as a response to the economic crises of the late 1970s and early 1980s. Tanzania is no exception. Commonly, this reform package includes a greater role for private-sector financing and provision, and a corresponding change in the focus of the public sector, as championed by the World Bank (World Bank, 1993, 1997). One area where attention has focused once again is the need for governments to strengthen their capacity to regulate an increasingly pluralistic health sector.

This paper reports part of a wider study that investigated the regulatory framework in health facilities reported elsewhere (Mujinja et al., 1999). The paper aims to explore the effectiveness of regulation and identifies factors which influence it by means of a case-study of the retail pharmaceutical sector. The study was conducted in Dar es Salaam, Tanzania. A total of 42 retail Part I and Part II shops were randomly selected and involved in the study. (Part I drug outlets are those that, by law, are allowed to dispense both prescription and nonprescription drugs, while Part II are allowed to dispense nonprescription drugs only.) Owners and dispensers were interviewed using a semistructured questionnaire, and consumers were interviewed as they left the drug outlets.

A growing private sector

A general government policy of liberalization in Tanzania began in 1986 with the Economic Recovery Programme, but the impact of this policy on the health sector began with the 1991 amendment to the 1977 Private Hospitals (Regulation) Act. This ended an extended period of proscription, whereby only nongovernmental organizations, mostly missionary groups, were permitted to own health facilities. While private pharmacies were not covered under this particular legislation, their growth has been affected by the changed approach to private-sector activity in the sector. Although there was a rise in the number
of such facilities from three in 1986 to 20 at the start of 1991 as a result of the economic liberalization, they increased a further threefold between 1991 and 1993 (Munishi, 1997). At the time of the study in 1999, there were 537 registered private pharmacies (Part I) and drug shops (Part II) in Dar es Salaam alone, as shown in Table 1. And, according to the Pharmacy Board Report of 2001, the number of Part I drug outlets in Dar es Salaam rose to 207 by the end of 2001 (Pharmacy Board, 2001).

After liberalization, the number of private health facilities also grew fast. By 1990, there were 173 hospitals, 276 health centres and 2 840 dispensaries. According to the 1997 Health Statistics Abstract, by the end of 1997, private hospitals, health centres and dispensaries on the Tanzanian mainland (both for-profit and not-for-profit) constituted 56%, 16% and 35%, respectively, of the 224 hospitals, 344 health centres and 4 276 dispensaries (Planning Department, Ministry of Health, 1997).

The existence of a growing private sector can, however, lead to concerns regarding equity and quality of service provision (Møgedal et al., 1995). In its 1994 proposals for health sector reform, the Ministry of Health stresses that privatization does not remove the burden of health management from the government. There still has to be a strong regulatory authority to monitor the supply and quality of both health services and manufacturing industries, such as pharmaceutical companies (Ministry of Health, 1994:32).

### Table 1. Distribution of private pharmaceutical retail outlets in Dar es Salaam municipal councils

<table>
<thead>
<tr>
<th></th>
<th>Temke</th>
<th>Kinondoni</th>
<th>Ilala</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I</td>
<td>22</td>
<td>59</td>
<td>79</td>
</tr>
<tr>
<td>Part II</td>
<td>123</td>
<td>167</td>
<td>87</td>
</tr>
</tbody>
</table>

Source: Health Department, Dar es Salaam City Council, 2000. The former districts of Temke, Kinondoni and Ilala were changed to municipal councils in July 1999. They still come under the Dar es Salaam City Council, but have some autonomy.

The Pharmaceutical regulation in Tanzania

Pharmaceutical products are classified into two types in Tanzania, and the regulations governing their sale differ between the two. Part I poisons are those for which a prescription from a duly qualified physician, dentist or veterinary surgeon is required, and which may only be dispensed under the supervision of a qualified pharmacist. All antibiotics fall into this category. Part II poisons are those which are in more common use (e.g. analgesics, and antimalarials such as chloroquine) and “which it is reasonably necessary to include if the public are to have adequate facilities for obtaining them” (United Republic of
Tanzania, 1978, Part IV 33(3)). In general, premises licensed to stock Part I poisons are referred to as pharmacies and are registered by the Pharmacy Board, while those with a Part II licence only are referred to as drug shops and are registered by the appropriate municipal or district council. In Dar es Salaam, this role is played by the City Council.

A number of different regulatory instruments govern the pharmaceutical sector in Tanzania. The main legislation is the Pharmaceutical and Poisons Act (United Republic of Tanzania, 1978) together with the Pharmaceutical and Poisons Regulations of 1990. The need to review and update this legislation has long been recognized, but there appears to have been little progress to date (Ministry of Health, 1992, 1998). In addition, the cabinet approved a national drug policy in 1991, covering all aspects of pharmaceutical selection, procurement, distribution and quality assurance (Ministry of Health, 1991). On the basis of this policy, an operational plan was subsequently developed, the **Masterplan for the pharmaceutical sector of Tanzania mainland: 1992-2000** (Ministry of Health, 1992).

The agency charged with the formal regulation of the private pharmaceutical sector is the Pharmacy Board. Established under the 1978 Act, the Board is chaired by the Chief Medical Officer of the Ministry of Health. The other members are a lawyer from the Attorney-General's office, the Chief Veterinary Officer, the Chief Agricultural Officer, the Chief Pharmacist and the Chemist, together with two additional pharmacists, a qualified medical practitioner and three other members appointed by the Minister of Health (United Republic of Tanzania, 1978). Designated inspectors outside Dar es Salaam are regional pharmacists and regional medical officers (Ministry of Health, 1998).

Before this study, no-one had investigated the extent to which existing regulations governing the private pharmaceutical sector are being enforced. However, shortages of drugs in the public sector because of reduced drug budgets, wastage and irrational prescribing and use, coupled with better geographical access to private pharmacies, mean that an increasing number of Tanzanians are turning to such private outlets. A further factor in this trend has been the introduction of fees at public health facilities (Hussein & Mujinja, 1997). A 1995 study of health-seeking behaviour in Dar es Salaam found that 25% of respondents had opted to self-treat at some point during a recent illness episode (Wyss et al., 1996), illustrating the need to ensure that the supply of pharmaceuticals through the private retail sector is adequately monitored.

**Study objectives**

While low-income countries have been quick to adopt international policy recommendations encouraging them to expand their private sectors, and the
need to ensure effective regulation of those growing private sectors is broadly
acknowledged, there has been relatively little empirical work undertaken in a
low-income setting. The extent to which existing regulatory instruments meet
their objectives is, therefore, largely unexplored. This study was undertaken
as one of two country case-studies under the Public Private Mix Collaborative
Research Network (PPMNet) to help redress this research gap.

Using a conceptual framework developed by participants at the 1995
PPMNet conference in Worthing, England and summarized in Kumaranayake
(1996), the overall objectives of the study were to:

- describe the existing regulatory framework governing the overall private
  health sector
- assess the effectiveness of regulation in the retail pharmaceutical sector
  through a case-study approach
- identify factors influencing the effectiveness of the regulatory
  instruments
- explore different groups’ perceptions of the regulatory instruments.

Data and methods

The study was undertaken in two phases. Phase 1 involved mapping the
existing regulatory framework governing the private health sector more
generally, and is largely reported elsewhere (Mujinja et al., 1999;
Kumaranayake et al., 2000). Phase 2 focused on the effectiveness of regulation
in the private retail pharmacy sector, and took place in the three districts of
Dar es Salaam. On the basis of experience from elsewhere, seven retail outlets
of each type were selected in each district in order to give a total of 42,
according to recommended practice (Management Sciences for Health, 1997).
Sampling was random, and based initially on the lists of registered outlets held
by the Pharmacy Board for Part I facilities, and by the respective municipal
pharmacists for Part II facilities. During the fieldwork, several of these outlets
were found not to exist (e.g. because the establishment had moved, gone out
of business, or not yet started to do business), in which case the nearest
geographical alternative from the list was visited.

A number of methods were employed. Structured interviews were held with
28 pharmacy owners and 36 dispensers to ascertain their awareness of the
regulations governing the sale of pharmaceuticals, their perspectives on
whether these were effective, and if not, the reasons why they were not. Three
different types of simulated client encounters were staged in order to gauge
the extent of regulatory failure in the selected pharmacies (not reported here).
Two of these took place in both Part I and Part II pharmacies, resulting in 252
encounters, while the third was relevant only for Part II drug shops. In addition,
exit interviews were held with 210 consumers, five from each of the 42 selected outlets. The interviews undertaken with the Registrar, three members of the Pharmacy Board and the Chief Pharmacist of the Ministry of Health during Phase 1 are also drawn upon in this paper.

Locating pharmacy owners and getting their consent to be interviewed proved the most time-consuming part of the study. This is reflected in a success rate of only 67%, with 28 of the 42 owners agreeing to be interviewed. Of these, only 24 completed all parts of the interview. Among the reasons for this lack of response were:

- failure of researchers to trace the owner at all
- owner’s unwillingness to volunteer information without payment
- fear of having the information exposed to the authorities (in particular the tax authority or the Pharmacy Board)
- lack of time to undertake the interview.

**Findings**

**Description of respondents**

The 24 pharmacy or drug shop owners who agreed to participate and completed the questionnaire were drawn from a mix of backgrounds. Of the group of 24, four were pharmacists or pharmacy technicians (16.7%), 11 came from other health-related backgrounds (45.8%), and seven (29.2%) were businessmen/women. Eleven of them owned Part I pharmacies, while 13 owned Part II drug shops. They were fairly evenly spread between the three districts, and 50% had registered their outlets in or since 1995.

Thirty-two (32) dispensers completed all or part of the questionnaire, 14 from Part I pharmacies (43.8%) and 18 from Part II drug shops (56.2%). While the Part II dispensers were evenly distributed throughout the districts, only one Part I dispenser came from Kinondoni.

An almost equal number of male and female consumers were interviewed following their visits to private outlets. Two hundred respondents (95.2%) stated both their age and occupation. Of these, 97 (48.5%) were females, of whom 38 (39.2%) were housewives, 16 (16.5%) were students, and the remainder had a range of formal and less formal occupations (e.g. barmaid, civil servant, nurse, secretary). Among the men, the main occupations were listed as businessman (16.5%), peasant (14.6%), petty trader (13.6%) and student (10.7%).
Knowledge regarding the regulations

The level of knowledge which can be expected of the various stakeholders obviously differs. Members of the Pharmacy Board were asked about specific provisions of the Act and the role and functioning of the Board itself. The four members of the Board (including the Registrar) gave consistent answers about its composition, the nature and duration of appointments and the frequency of meetings. There was also broad agreement regarding the Board’s task as a regulator, with respondents citing a number of areas:

- enforcing standards in the manufacture of pharmaceutical products
- controlling professional conduct and ethics
- ensuring that the people do not consume poor-quality drugs, as a way of safeguarding the health of Tanzanians.

However, there was some confusion regarding the mechanism for regulation. The Registrar stated that, outside Dar es Salaam, regional medical officers were responsible for registration and inspection of private pharmacies. One Board member said that this was the task of the Board secretariat, another that it was the task of regional pharmacists, and the third did not specify any particular group. Board members did not know how many inspectors there were in total.

Both owners and dispensers were asked whether they were aware of any laws or regulations which:

- governed the operation of private pharmacies
- protected consumers of pharmaceutical products.

Consumers were asked the second question only. The proportion of respondents who mentioned the Pharmaceutical and Poisons Act or any specific regulations stipulated in the Act are summarized in Tables 2 and 3 below.

Table 2. Awareness of regulations governing private pharmacy/drug shop operation.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Owners</th>
<th>Dispensers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Name of the Act or the Regulations</td>
<td>1</td>
<td>2.6</td>
</tr>
<tr>
<td>Part I drugs/antibiotics to be dispensed only on prescription</td>
<td>9</td>
<td>23.7</td>
</tr>
<tr>
<td>Part I pharmacy to be staffed by pharmacist</td>
<td>8</td>
<td>21.1</td>
</tr>
<tr>
<td>Part II drug shop not permitted to sell antibiotics</td>
<td>13</td>
<td>34.2</td>
</tr>
<tr>
<td>Not allowed to sell expired drugs</td>
<td>3</td>
<td>7.9</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>10.5</td>
</tr>
<tr>
<td>Total responses</td>
<td>38</td>
<td>100.0</td>
</tr>
</tbody>
</table>
When these responses are broken down by the type of retail outlet, there is a clear distinction between the particular knowledge of Part I and Part II respondents. As might be expected, a higher number of both owners and dispensers were aware of the particular regulations governing their own type of activity. For example, of the 13 owners and 14 dispensers citing the regulation that Part II drug shops are not permitted to sell antibiotics or other Part I poisons, 77.0% and 85.7% respectively came from Part II outlets. On the other hand, when it comes to citing the need for a prescription for Part I drugs, 77.85% and 69.1% of owners and dispensers, respectively, came from Part I outlets.

Consumers were far less aware of any regulations, as shown below.

**Table 3. Consumer awareness of regulations**

<table>
<thead>
<tr>
<th>Pharmacy type</th>
<th>Heard of regulations?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Part I</td>
<td>97 (92.4%)</td>
<td>8 (7.6%)</td>
</tr>
<tr>
<td>Part II</td>
<td>100 (95.2%)</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>197 (93.8%)</td>
<td>13 (6.2%)</td>
</tr>
</tbody>
</table>

Of those consumers who were aware that private pharmacies were subject to regulation, eight could not identify any individual regulation, while five mentioned that pharmacists were supposed to explain the use of the drug and any side-effects. In response to a question about what they would do in case of malpractice, eight said they would report the matter to the police, three to the Pharmacy Board, three to the Ministry of Health, two to the owner of the shop, and two stated that they would take legal action.

**Adherence**

A number of respondents, both owners and dispensers, admitted that they were not adhering to the regulations for their particular outlet type, while others referred to contraventions by staff at other similar facilities. Two main factors were identified as reasons for the perceived lack of adherence to the regulations, whether by themselves or by other drug outlets.

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1Space was given for up to four different regulations to be cited, but the maximum cited was three. While this does not necessarily imply that the respondents do not know of the other regulations, it may indicate which ones they consider most important.
Reasons cited for lack of adherence

- On why Part I pharmacies sometimes employ lesser qualified staff:
  "It is very expensive to employ a pharmacist full-time. Employ pharmacist on part-time basis in order to minimize the amount of money to pay them"
  "Sometimes the qualified staff are not available so the shops have to be operated with unqualified staff most of the time"
- On why Part II drug shops sometimes sell Part I drugs or Part I pharmacies sell drugs without a prescription:
  "Because by violating some of these principles they can get more money, for example selling antibiotics in Grade II pharmacies"
  "More than half of our clients come in our shops without prescription, so if you are strict you will remain with your drugs"

One rather surprising fact was that 16% of the dispensers admitted that they were operating against the regulations. This “admission of guilt” was more prevalent in Part II drug shops (23.5%) than the Part I pharmacies (6.7%), and confirms other study findings using the simulated client method[^1].

Effectiveness

Owners and dispensers were asked whether they felt the government had the capacity to regulate private pharmacies effectively. The overwhelming opinion among owners was that it does not. One reason given for this was the multitude of licensing agents. Of the 22 owners who responded to the question, 13 (59.1%) referred to the low frequency of inspection of retail outlets, while four Part II owners stated that their premises had never been inspected. However, 13 (72.2%) Part I facilities had been inspected within the last six months, suggesting that it would be useful to know what the owners feel a suitable interval would be. Of these inspections, the majority were undertaken by members of the Pharmacy Board, although the City Council had also visited five Part I outlets. No indicator of quality of inspection was sought or offered.

Interestingly, the view of dispensers was quite different, with 21 of the 29 who answered a similar question responding that the government had the expertise and the personnel to monitor and enforce the regulations. Unfortunately, dispensers were not asked when their outlet had last been inspected, as it was felt that the turnover of staff was too rapid to make the responses reliable.

Factors influencing effectiveness

Two main factors were identified by respondents as hampering the ability of the government to regulate private drug outlets, and there was broad agreement between Board members and pharmacy owners and dispensers with respect to these. The first was the large (and growing) disparity between

[^1]: Reported in Mpembeni, R. et al. (2000). See also Chapter 3.
the number of outlets and the human resources available to the Pharmacy Board. As Table 1 showed, the number of facilities within Dar es Salaam is substantial, particularly when compared with a regulatory body with 11 members, the majority of whom have other duties as well. Secondly, it was felt by the Registrar, one Board member, two dispensers and two owners that the transport available to inspectors was inadequate to enable regular inspection. This is linked to the more general observation by several respondents that inspectors are allocated insufficient funds with which to visit premises.

Both owners and dispensers were asked how regulation in the sector might be strengthened. Among the proposals were that pharmacy technicians should be permitted to operate in pharmacies in order to overcome problems caused by the relative shortage of trained pharmacists, and that the public should be educated to report cases of malpractice.

Discussion

Kumaranayake (1998) outlines a number of reasons why regulation may be ineffective. These fall broadly into the categories of capacity, information, self-interest and context. The findings of this study suggest that, of these categories, capacity has been the major constraint on regulation of the private pharmaceutical retail sector in Dar es Salaam, at least as far as key stakeholders are concerned.

Capacity is a broad term which encompasses the quantity and quality of personnel, financial and other resources, and which is determined to some extent by the institutional context. The effect of any shortage of trained pharmacists, financial resources and transport required to carry out inspections can only be heightened by the apparent confusion, even among members of the regulatory body itself, about exactly who should be inspecting and how frequently. If the authorities consider that regulation is an important ingredient in quality assurance, there is an argument in favour of increasing the resources available for that purpose. There may be a case for transferring inspection responsibilities to the district level, but this must be accompanied by resources if it is not merely to move the constraints to a different level of the system.

At the same time, information remains a problem. As mentioned above, even the supposedly up-to-date information obtained from the City Council regarding location and ownership of registered drug outlets was found to be unreliable. To some extent, this is a vicious circle, and linked to the capacity constraints. Without inspection, locations cannot be verified and information systems kept current, and there is little incentive for owners to update the regulators.
The economic incentives behind the failure to adhere to known regulations were clearly identified by study respondents.

“Because not all patients come with prescription, pharmacy shops cannot only depend on prescriptions to sell drugs, they will make less profit.”

“Drugs supposed to be sold by [Part] II shops are not that profitable, so people open [Part] II as a shadow with the aim of selling [Part] I to make profit.”

“Allowing businessmen to open pharmacies, the professional part of the business is not adhered to.”

Conclusions and recommendations

This paper relies largely on qualitative data from interviews and structured questionnaires. However, the findings support both those from other elements of the broader study (see Mujinja et al., 1999), and those from countries with similar resource constraints and legislative instruments (Ngalande-Banda & Walt, 1995; Bennett et al., 1994).

Given that the resource base of the health sector is unlikely to expand rapidly in the absence of substantive economic growth, it may be that attempts to regulate the private pharmaceutical sector through the enforcement of formal legislation are unrealistic. Keeping track of the rapid development of private outlets requires systems which provide up-to-date information, as well as the human and financial resources to carry out inspections both prior to initial registration and once outlets are operational. There is a need, therefore, to explore other regulatory mechanisms, such as the use of incentives, i.e. the “carrot” as opposed to the “stick” (Bennett et al., 1994), and less formal approaches involving key stakeholders (e.g. peer review) or increased accountability between providers and consumers through advocacy and an increased role for consumer organizations.

Acknowledgements

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3. Coping with private health markets - regulatory (in)effectiveness in sub-Saharan Africa

Lilani Kumaranayake¹, Charles Hongoro, Sally Lake, Phare Mujinja, Rose Mpembeni

Introduction

In many low-income countries, while a substantial proportion of health care is privately provided, government capacity to develop and enforce regulations to ensure adequate quality of care is often extremely limited. There are few studies which provide a detailed examination of regulation in a low-income country context or consider how, or to what extent, regulation can be used as a mechanism to achieve policy goals. In order to fill this gap, the 1995 meeting of the Public Private Mix Collaborative Research Network (PPMNet) developed a comparative research framework to explore these issues. This chapter discusses the implications of results from studies undertaken in two countries: Tanzania and Zimbabwe.

The chapter outlines the research methods used and an overview of the main research findings, and then considers how and where current implementation of regulation can be strengthened. The detailed study results may be found in a number of papers, including Hongoro et al. (2000), Hongoro and Kumaranayake (2000), Kumaranayake et al. (2000), Mujinja et al. (1999), Mujinja et al. (Chapter 2 of this book), and Mpembeni et al. (2000).

Methods for country case-studies

Regulation occurs when government controls or deliberately tries to influence the activities of individuals or actors by manipulating target variables such as price, quantity and quality (Maynard, 1982; Kumaranayake, 1997).

The research on regulation was designed both to examine the nature of existing regulatory structures and to explore issues related to effectiveness. The research strategy was designed in two phases (shown in Figure 1). In the first phase, a comparative mapping exercise was undertaken in order to describe the existing network of regulations at a national level within the health sector.

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Particular attention was paid to determining whether there were any specific regulations or instruments targeted at the private health sector. Information was collected by reviewing existing documents and legislation. This secondary data was supplemented by data obtained through structured interviews with key stakeholders. Analysis of the mapping was carried out using an analytical framework, looking at what variables were regulated (e.g. entry and quality), which actors were regulated, and how they were regulated (Kumaranayake et al., 2000).

The purpose of the second phase of the research was to focus on specific areas of interest and to examine the effectiveness of particular instruments or interventions in greater detail. This was supplemented by micro-level cases of regulatory success or failure. The sources of information for these examples included newspapers, interviews and reports by regulatory bodies. The focus of regulations for the second stage of research varied by country. In Zimbabwe, two pieces of legislation affecting for-profit health care providers were examined¹. In Tanzania, the focus was on the regulation of pharmaceutical outlets. There were only limited attempts to distinguish between private and public providers in the legislation, and the research focused on the impact of this legislation on the private for-profit providers targeted by the Pharmaceutical and Poisons Act. The main pieces of legislation for Phase 2 research are summarized in Table 1.

¹ Five pieces of legislation were examined in all: Medical, Dental and Allied Professions Act (MDAP) 1971/1996; Public Health Act (PHA), 1925/1996; Drugs and Allied Substances Control Act (DAS), 1969; Traditional Medical Practitioners Act (TMA), 1981; Dangerous Drugs Act (DDA), 1956. However, there was extremely limited knowledge regarding the latter three acts, and so the analysis of impact effectively focused on the first two (Hongoro & Kumaranayake, 2000).
The methods used to explore effectiveness also varied by country. In Zimbabwe, effectiveness was measured qualitatively by means of in-depth stakeholder interviews. A total of 122 stakeholders from public, private and professional health organizations, local authorities, medical aid societies (i.e. private insurers) and civic/consumer groups were interviewed. They were asked about their knowledge of the regulations, perceptions regarding their effectiveness in relation to the private health sector, identification of factors

| Medical, Dental and Allied Professions Act, No 27:08 (1971, 1996) | Provides for the establishment of the Medical, Dental and Allied Professions Council (Health Professions Council – HPC) Registration of all health professions, except natural therapists and traditional medical council practitioners who have their own council Registration of all health institutions in accordance with defined structural minimum standards Monitoring and control of practice standards in health Inspection of training institutions and supervision of training | Provides for the establishment of an Advisory Board of Public Health Prevention and guards against the introduction of diseases from outside the country Promotion of public health and the prevention, limitation or suppression of infectious or contagious diseases Advising and assisting local authorities with regard to matters affecting public health Promotion or undertaking of research and investigations in connection with the prevention or treatment of human diseases Preparation and publication of reports and statistics or other information relating to public health |
| Pharmacetical and Poisons Act; Pharmaceutical and Poisons Regulations (1978, 1990) | Creation of Pharmacy Board Decisions regarding qualifications for pharmacists Registration of pharmacists Regulation of manufacture, importation, sale, etc. of pharmaceuticals and their inputs Prescription of minimum quality standards for manufactured or imported pharmaceuticals Designation of pharmacies as either Part I or Part II shops. Part II shops are more restricted in terms of the types of drugs which they can dispense, but they are not required to employ qualified pharmacists |

Table 1. Legislation studied in effectiveness research

Sources: Hongoro et al., 2000; Mujinja et al., 1998.
and constraints in implementation, and their views on the Health Professions Council (HPC) – the main regulatory body (Hongoro & Kumaranayake, 2000). In Tanzania, two main methods were used to explore the effectiveness of the pharmaceutical regulations. Firstly, 264 stakeholders, including owners of drug shops, dispensers and consumers, were asked about their knowledge and perceptions of effectiveness. Secondly, simulated patient surveys, with 252 encounters, were undertaken to examine what would happen as clients came in to buy drugs mentioning specific symptoms, or asking for specific drugs without the required prescriptions (see Chapter 2 of this book). This method allowed for some quantitative analysis of the degree of regulatory failure related to specific provisions of the legislation.

Overview of research findings

The results of the comparative mapping analysis found that there was still a strong “social” focus in regulation, e.g. the traditional standard-setting role, rather than an “economic” orientation, looking at regulation in the context of market practices and discipline (Kumaranayake et al., 2000; Ogus, 1994). Although there have been recent changes which attempt to address aspects of private health provision, there are some key gaps. In particular, current regulations in Tanzania and Zimbabwe:

- focus on individual inputs rather than health system organizations
- aim to control entry and quality rather than explicitly controlling quantity, price or distribution
- fail to address the market-level problems of anticompetitive practices and lack of patient rights.

The second phase of the research focused on specific pieces of legislation and their effectiveness. This work included exploring the relationships between various institutional structures involved in the regulatory process. In particular, the research explored the relationship between the “regulator” and the “regulatee”, i.e. the specific body or authority responsible for implementing the regulations and the entity being regulated (whether a person, institution or good). Details of these relationships are shown in Figure 2.
In Zimbabwe, the Phase 2 research showed that there was a clear consensus that regulations are not being implemented and enforced effectively. A variety of opportunistic practices have been documented among private providers, including: referral to other services in which the provider has a financial interest; over-servicing; doctor-patient collusion to claim health insurance payments; and the use of unlicensed staff in private facilities.

Key factors limiting the effectiveness of regulation in the health sector include overcentralization and lack of independence of the regulatory body, the absence of legal mechanisms to control the price of care, and patients’ lack of knowledge of their rights. The Zimbabwean study also identified a number of potential strategies for improving the current regulatory environment, including improvements in arrangements between the centralized regulatory body and local authorities and professional organizations to enforce regulations more effectively (Hongoro & Kumaranayake, 2000). While it has historically been difficult to change the prices charged in the private sector, interventions working with medical aid societies to regularize prices and increase information about the relative prices charged by different providers may be potential paths to consider.

The work on pharmaceutical outlets in Tanzania found that existing regulation is not effective, particularly the distinction between Part I and Part II drug outlets (see Chapter 2). The simulated client surveys found that of 126 encounters in Part II drug shops, where patients asked for drugs that may only be legally provided in Part I facilities, 87% of clients were actually sold the drugs. In 252 encounters where patients asked for antibiotics without the required prescription, 85% of the patients were immediately granted the drugs
in both Part I and Part II drug shops. When clients entered and presented their symptoms, 68% were provided with antibiotics without a prescription (Mpembeni et al., 2000). There were some problems owing to the outdated nature of the legislation, but simply revising it was not thought to be sufficient to ensure effective implementation. Consumers were unaware of the existing nature of regulations, and owners and dispensers often justified their illegal practices as being in response to consumer demand (see Chapter 2).

Coping with regulatory ineffectiveness: areas for change

In addition to considering the extent of regulatory ineffectiveness, the research also examined factors influencing its impact, as well as identifying areas where implementation could be strengthened: the design of regulations, the need to tailor interventions to private actors and the role of alternative institutional structures such as consumers, professional organizations and private insurance companies in improving implementation and inspection and enforcement of existing regulations.

Designing regulations: tailoring interventions to private actors

The mapping phase of the research found that much of the legislation was relatively old and written at a time when the public sector was the predominant provider and financier of health services. In Tanzania, most of the legislation was over 20 years old. All but one of these regulations was legally based. The legislation in Zimbabwe has been updated more recently, with three of the 10 pieces of legislation being changed or enacted since 1996 (Kumaranayake et al., 2000). The recent changes in legislation, which allow private practice (focusing on registration and licensing), have continued to take into account the nature of market relationships as private-sector activity develops.

Markets are a phenomenon arising from the interaction of agents buying and selling health services. While the focus has been on private providers of health care (individuals and health-care facilities) and private pharmacies and dispensaries, there are also new private actors in the health sector with little or no regulation. These include medical aid societies, which have traditionally been accorded charity status, but are now effectively functioning as private insurance firms maximizing their own profits. The larger firms are now starting to operate as managed health care companies, gaining ownership of a range of revenue-generating private facilities such as laboratories and clinics. There is little knowledge of how these firms operate and the restrictions that are imposed on patients in terms of the choice of clinic or laboratory. Currently,
these structures are largely unregulated and are operating in competition with private facilities that do not benefit from charity status (through income-tax exemptions, for instance), giving them a competitive advantage in the market. Other private entities with little or no regulation include private laboratories and other diagnostic facilities and private nursing homes. There is also the ownership by health professionals of ancillary facilities, such as private pharmacies and laboratories.

Another important distinction in the private medical sector that needs to be considered is the nature of ownership and provision of services. Owners may come from a range of backgrounds, and simply be operating facilities as a means of making a profit. The separation of ownership and actual provision which is seen in the private sector means that there are very different incentives facing owners and providers in these facilities. In Tanzania, there were only a few cases where pharmacists or dispensers owned the private drug outlets: these were principally owned by nonprofessionals. Regulations require that licensed staff dispense drugs, which means that nonprofessional owners must hire appropriate staff. In practice, these regulations are widely flouted. The main reason cited for lack of adherence to the regulations was the cost of following regulations, both in terms of hiring qualified staff and losing revenue by refusing to dispense without a prescription (see Chapter 2).

In Zimbabwe, current legislation forbids medical practitioners to have a financial interest in pharmacies, clinics, nursing homes and other facilities. The research found clear evidence of private providers owning private laboratories, etc. and referring their private patients to these facilities, which illustrates the beginnings of vertical integration, contrary to regulations. Clearly, these types of structure may lead to a concentration of market power and less competition (and so potentially increase the price to the consumer).

While there has been some attempt to establish a requirement for basic registration for some of these new private-sector entities, the way they function under current legislation, the nature of ownership and competition in this context and their relationship to other private entities need to be considered in order to minimize the potential problems.

**Role of third parties in implementation**

While it is clear that regulatory effectiveness is limited, one of the central ideas to emerge from the work is the notion that the regulatory arrangements in place need to go beyond the standard regulator-regulatee relationships, in order to improve the implementation and effectiveness of legislation. The research highlighted the importance of other key actors and institutional structures, in particular the role of consumers, professional organizations and other third parties.
Consumers

Patients as consumers now have an additional role when purchasing health services from the private sector. By definition, in the private sector, people are willing to pay for services. Within the private sector, the patient has changed from being a passive recipient, using the provider as the agent for making decisions, to become an active consumer whose purchasing power can potentially influence the nature and extent of services, as well as adherence to regulations. The role of the consumer is important in bringing to light information on the functioning of the healthcare system and the impacts of regulatory interventions. The key channels for consumers are the complaints procedures and legal action, as well as the influence of direct purchasing power. For example, in India, the role of consumer groups was vital in overcoming the lack of action by the Indian Medical Council on malpractice and negligence complaints by patients. Consumer groups took the case to court and argued that paying for medical services was like paying for any other good, so patients should receive the same consumer protection as for other goods, as set out by the Consumer Protection Act of 1986 (Yesudian, 2002).

In Tanzania, consumers were very unfamiliar with pharmaceutical regulations. Of 210 consumers interviewed in pharmacy exit interviews, only 13 (6%) could identify any individual regulation and even fewer could describe what the regulations stipulated, e.g. the need to explain side-effects or the complaints procedure (see Chapter 2). In Zimbabwe, the stakeholder interviews found that consumers of health services were not conversant with their rights with respect to health care providers, be they public or private. As such, they were not certain what they should do if they felt that they had been wrongly treated or had received services that fell short of the expected standard (Hongoro et al., 2000). Consumers’ knowledge of regulations was poor. The current regulatory environment is associated with Acts of Parliament and there was no real knowledge of specific laws or regulatory instruments. Consumers were not aware of the specific functions of regulatory bodies, nor did they have any awareness of how to initiate a complaint against a provider. There were also substantial information gaps: some consumer respondents had never heard of any complaint brought before the regulatory board being successful.

The research in both countries highlighted the large gap between the potential and the actual role of consumers in improving the adherence of private provider behaviour to existing regulations (e.g. as seen in India: Bhat, 1996). The research has shown that there is a potential impact of both purchasing power and provision of information on the functioning of the system. This has not yet been translated into active influence over providers, largely because of the lack of knowledge among consumers of regulations and appropriate provider practices. There is a twofold challenge in working with consumers in a private-sector context. Firstly, there is the need to empower consumers to make use of their existing rights through education and
information. Secondly, the experience in Tanzania finds that consumer expectations and demand were among the reasons why regulations did not function. This highlights the importance of alerting consumers to good medical and pharmaceutical practice, and is an important area for further action in order to improve the implementation of existing legislation.

Professional organizations

In contrast to consumers, the research in Zimbabwe and Tanzania found that private-sector actors were fairly well aware of the particular regulations that govern their specific activities. Almost 65% of private providers in Zimbabwe were aware of the requirements for licensing and registering of individuals and facilities (Hongoro & Kumaranayake, 2000). In Tanzania, more than one-third of pharmacy owners and dispensers had some knowledge of the requirements stating which pharmacies can sell which type of drug (see Chapter 2).

The professional organizations which were interviewed in Zimbabwe were much better informed about existing legislation and were also more cognisant of its failure. Membership of these organizations is voluntary, and many of the organizations had their own codes of professional conduct. There was a broad consensus among stakeholders that these professional organizations needed to play a more active role in the regulatory structure. Two roles were identified. Firstly, these organizations could influence their peers to strengthen the implementation of existing mechanisms. This could involve provision of education and information about regulation, as well as assisting with inspections, helping design standards and formulating disciplinary measures for members. Secondly, as there was little in the way of existing mechanisms related to improving quality of health care services, professional organizations were identified as better placed to undertake a new array of nonlegislative interventions. These interventions could include peer review, medical audits and continuous medical education and be undertaken by professional organizations among their members.

Other third parties

In addition to strengthening the role of the consumer and professional organizations, the research has also highlighted the potential role of other

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1 Representatives from the following professional organizations were interviewed: Zimbabwe Medical Association, Zimbabwe Nursing Association, Psychiatric Association of Zimbabwe, Radiographers Association of Zimbabwe, Dental Association of Zimbabwe, College of Primary Health Care Physicians, Urological Association of Zimbabwe, Pathologists Association of Zimbabwe, secretariat of the Zimbabwe Association of Church-related Hospitals, Association of Pharmaceutical Industries and Pharmaceutical Manufacturers Association.
parties in regulation. In both Zimbabwe and Tanzania, it was very clear that lack of information was a crucial problem. The Health Professions Council in Zimbabwe was felt to be too centralized and did not have the resources to inspect its regulatees or obtain adequate information about them. In Tanzania, even members of the Pharmacy Board were unclear about the mechanisms for implementation and responsibilities related to registration and inspection (see Chapter 2). However, in the course of the research, two groups were identified which might potentially be able to play a greater role in the implementation of current legislation.

Firstly, the research in Zimbabwe highlighted a potential inspection function for local authorities. In both countries, there has been decentralization within the health system, with greater resources being distributed from the centre to the districts. The research in Zimbabwe found that, although the inspection function was legally entrusted to the Health Professions Council, the recognition of its lack of ability to carry out its functions led to an “informal agreement” between the Council and local authorities. These local authorities undertook the inspection function and were found to be much better informed about what was happening in their own regions. However, their lack of formal authority meant that they were unable to impose sanctions when regulatory violations had occurred (Hongoro & Kumaranayake, 2000). Thus, formally decentralizing regulatory authority and resources may be one way of improving regulatory effectiveness.

The second group which was identified as being well-informed about both the nature of the regulations and what was actually happening in the private sector was the group of third-party payers. In Zimbabwe, the number of medical aid societies has mushroomed over the past five years (Hongoro et al., 2000). Although largely unregulated themselves, the medical aid societies were fully conversant with existing regulations relating to private providers. Owing to their interaction with individual private providers, they were able to acquire a substantial amount of information relating to ongoing practices within the health sector (including abuses such as use of untrained staff, etc.). By linking payments more explicitly to adherence to regulatory criteria, as well as potentially involving the medical aid societies in the investigation of claims and complaints, existing resources related to the inspection and implementation of regulation may be augmented by private-sector resources.

The research has highlighted the potential (and in some cases actual) role that different institutional structures and actors can play in improving the implementation of existing legislation. This is summarized in Figure 3. The relationships mapped out in this figure clearly illustrate the web of broader relationships which could be strengthened to improve implementation. They show the need to go beyond the standard regulator-regulatee relationship illustrated in Figure 2.
Conclusions
The research in Zimbabwe and Tanzania shows that current regulation is, by
and large, ineffective in meeting its overall objectives with respect to the
private sector. The research has also highlighted that there may potentially be
a number of ways to strengthen the regulatory framework, both through the
design of legislation and by explicit involvement of other institutional
structures and actors, including consumers, professional organizations, local
authorities and third-party payers. However, the different regulatory
environments in Zimbabwe and Tanzania must also be kept in mind. The
research has shown that, while in Zimbabwe many of the preconditions for
effective regulation were largely in place, the regulatory environment in
Tanzania was much weaker. Thus the question of whether, and how, these
“coping” strategies for improving implementation will actually have an impact
in different low-income countries requires further study, including a
consideration of the minimum level of regulatory capacity, particularly existing
regulatory bodies.

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School of Hygiene & Tropical Medicine. Lilani Kumaranayake is a member of
HEFP. Sally Lake was a member of the HEFP at the time of writing.
Further reading


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Yesudian, C.A.K. Policy research in India: the case of regulating private health providers
4. Potential of private practitioners to deliver public health services in Peru

Pedro Mendoza-Arana

Background

Traditionally, the public sector has been the main provider of public health services, such as infectious disease control and health education and promotion. There is a clear international trend, however, towards higher levels of participation of the private sector in the provision of health care services (World Bank, 1993; WHO, 2000). A number of authors and policy documents have suggested that private health care providers may be an important resource, not only for the provision of medical care for the individual, but also in improving public health more generally. Additional functions which go some way towards achieving the goals of public health may be “tagged on” to services for which there is a high demand in the private sector. Private health care providers may achieve a closer relationship with the patients, have easier access to them, and offer shorter waiting times and more flexible booking arrangements (Kloos et al., 1987; Griffin & Paqueo, 1993; Aljunid, 1995; Swan & Zwi, 1997). Some or all of these features may contribute to greater user satisfaction.

The private sector includes both profit-making and non-profit-making health care providers. This report is concerned with for-profit private practitioners, defined as certified physicians who provide medical assistance at their homes or in private facilities (Swan & Zwi, 1997). Public health activities can be broken down into three main service types: programmes directed toward the environment (such as vector control activities, supply of adequate drinking water and mass health education), personal preventive services (such as immunization and family planning), and personal care services of public interest (such as the treatment of tuberculosis, sexually transmitted diseases and malaria) (Swan & Zwi, 1997). Because of their own training, it is to be expected that private practitioners will basically deliver personal preventive services and personal care services of public interest. We will thus explore these areas in particular.

The Peruvian Ministry of Health’s policy guidelines for the period 1995-2000 (Ministry of Health, 1995a) proposed greater participation of the private sector in the provision of health services. This chapter focuses on the potential for increasing the coverage, range and quality of the public health services...
rendered by for-profit private providers. We also take into account the need for information to improve epidemiological surveillance systems and disease control programmes.

A number of questions need to be resolved before channelling resources toward the private sector for public health services. What are the range, coverage and quality of the public health care services already provided by the private sector? What type of relationship (both real and potential) between the private and the public sector would allow for an expansion in the role of private providers? What are the potential effects on equity, efficiency and quality of care? How might the financing and regulation of public health service provision by private providers be structured?

The private sector in Peru

The Peruvian health care system is a typical three-tier system: a public system targeted on the poor, a social insurance system for the formally employed, and a private sector, constituted by private insurers, private hospitals and private practitioners. This private sector accounts for 25% of all health care, according to the National Health Accounts for 1995 (LAC-HSR, 1998). The private sector produces 14% of total outpatient care, 13.1% of discharges, 14.8% of surgical operations, 5.6% of deliveries, 5.9% of haemodialysis and 18% of intermediate services (laboratory tests, radiology, etc.). Table 1 shows the figures in terms of available resources.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total</th>
<th>Public</th>
<th>IPSS</th>
<th>Private</th>
<th>% private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>31 750</td>
<td>10 932</td>
<td>4 785</td>
<td>16 033</td>
<td>50.5</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>178 954</td>
<td>47 265</td>
<td>101 998</td>
<td>29 691</td>
<td>16.6</td>
</tr>
<tr>
<td>Hospitals</td>
<td>473</td>
<td>158</td>
<td>67</td>
<td>248</td>
<td>52.4</td>
</tr>
<tr>
<td>PHC facilities</td>
<td>6 659</td>
<td>5 946</td>
<td>216</td>
<td>497</td>
<td>7.5</td>
</tr>
<tr>
<td>Small practices</td>
<td>5 483</td>
<td>72</td>
<td>18</td>
<td>5 393</td>
<td>98.3</td>
</tr>
</tbody>
</table>


As we can see, the pattern is one of many private physicians working in small practices, with a gross average of 2.97 physicians per practice. This is certainly an overestimate, because we have not discounted those physicians working for private hospitals only.

On the other hand, the figure of 31 750 physicians-in-duty registered in the national health accounts clearly indicates a phenomenon of dual practice because, according to the last general registration performed by the Peruvian College of Physicians in 1997 (College of Physicians, 1997), there are only 20 165
registered physicians altogether in the country. Publicly employed physicians in Peru are legally permitted to run their own private practices, either alone or in groups. Because of legal restrictions and the rigid controls on working time at the social insurance facilities, physicians cannot work at both Ministry of Health and social insurance facilities. Thus, around 10 000 physicians must be working simultaneously for a public institution and for the private sector. However, the productivity of private facilities is comparatively low. According to the National Health Accounts 1995 (LAC-HSR, 1998), only 16% of people go to a private physician when they are ill. Thus, we have a figure for available investment and facilities, mainly served by physicians who also work in the public sector and therefore know the public protocols on public health issues.

**Objectives**

In methodological terms, we were interested in the “implementation process” (Walt, 1994), meaning the process of getting the policies working in practice. Although there are various models of the way implementation proceeds, the bottom-up model developed by Walt proposes that health workers and managers behave like isolated actors when facing a new policy, being active forces either to facilitate or to oppose the transformation of “policies on paper” into “policies in action”.

Therefore, we tried to discover how mid-level officers, in charge of developing and executing specific policies based on broad guidelines, perceive what the policy proposes, and how this perception affects the policy implementation process.

The present paper is the first stage of a research project which aims to assess the current role of the private sector in the provision of public health services in Peru, and to elucidate its potential as well as the necessary conditions to enhance its role.

Hence, the specific objectives for this work are as follows.

1. To describe the current national policy and formal mechanisms instituted to facilitate the involvement of the private sector, and in particular private practitioners, in the provision of public health services in Peru

2. To identify factors contributing to positive or negative opinions within the government about the involvement of private practitioners in the provision of public health services.
Materials and methods

The study used two approaches to meet objectives 1 and 2 above. The first was a policy analysis to examine the context in which private providers operate by means of a document review. We collected written official policy statements from the Ministry of Health for the period 1995-2000, as well as published laws and decrees from the Ministry of Health database. Similarly, we collected the specific policy documents for national programmes which (a) were concerned with the goals mentioned by the Prime Minister in his speeches to Parliament, which we took as a signal of top-level political support, and (b) were included in the scope of public health activities, as defined in the introduction of this chapter (following Swan & Zwi, 1997).

We reviewed the data regarding national policy, goals and desirable levels of coverage for the public health services covered in this research: immunization, family planning and the national regulation regarding control, management and treatment of tuberculosis and sexually transmitted diseases.

We also analysed the extent to which national programmes took account of the private sector. The main topics included availability of national protocols and mechanisms for their diffusion within the private sector and the extent to which the information systems of the Ministry of Health accommodated the private sector both for receiving and disseminating information.

The second approach was an analysis of the attitudes of public servants, through a substudy of representatives of the Ministry of Public Health.

Key informants interviewed included:
■ representatives of the top echelon of the Ministry of Health
■ the Director-General of the People's Health, Ministry of Public Health
■ the directors of the following national programmes:
  ■ immunization
  ■ family planning
  ■ maternal and child health care
  ■ AIDS and sexually transmitted diseases.

These were semistructured interviews with the aim of eliciting attitudes and perceptions about the advantages and limitations of private-sector provision of public health services.

Results of the policy analysis

Health policy guidelines 1995-2000

The health policy guidelines (Ministry of Health, 1995a), published in December 1995, mark the beginning of a new relationship between the public
and private sectors in Peru, based on a drive for more rational use of the current capacity.

“This diagnosis of health care services and the characteristics of the country certainly indicate the urgent necessity of building a pluralistic health care sector, based upon public/private cooperation” (Ministry of Health, 1995a:16).

“Since the middle of the past decade ... [there has been a] great diffusion of small and medium-sized private practice, modernization of private clinics, and the launching of several modalities of health insurance” (Ministry of Health, 1995a:17)

“We still have to create a framework in which both sectors can consistently perform their activities” (Ministry of Health, 1995a:27).

It was proposed that this framework should operate through multiple networks of health care providers, defined as groups of facilities able to guarantee the provision of priority health care activities. As long as private facilities were able to provide the same level and range of services as public facilities, they would be eligible to be incorporated into these networks (Ministry of Health, 1996a).

“To promotetheformation of multiple webs of providers, of public and private renewed organizations, with graded and certified health care services, promoting competence, efficacy and efficiency as well as quality of care to the whole population with no exceptions” (Ministry of Health, 1996a:39).

**General Health Care Law**

The Ley general de salud (General Health Care Law – Law No. 26842) was passed by Parliament in July 1997 (Congreso de la República Peruviana, 1997a). It was intended as a general code to update the Peruvian legal framework, which dated back to 1960. Its main features are the rights of the patient, including ownership of information collected about oneself and the right to obtain copies of one's own medical records; the definition and broadening of the duties and responsibilities of the health authority; and the introduction in Peru of the concept of accountability of health care institutions to the public and other authorities.

Even though the law carefully avoids any mention of private providers, it clearly includes them within the scope of regulation. It also ratifies the policy guidelines by referring to a standard-setting and financing role for the State, and an increasingly important provision role for the private sector. It also envisages public funds being used to fund private providers dealing with public health issues.
“The provision of health care services is of high public interest, no matter what person or institution provides it” (preliminary title, Section VI).

“Financing by the State focuses particularly on public health activities and totally or partially supports medical care for the poorer population” (preliminary title, Section VIII).

Law on Modernization of Social Insurance in Health

Possibly the clearest example of the political importance accorded to increasing the role of the private sector is the Law on Modernization of Social Insurance in Health (Ley de modernización de la seguridad social en salud, Law No. 26790) (Congreso de la República Peruviana, 1997b), with its accompanying regulation, the Supreme Decree 009-97-SA (Ministry of Health, 1997). The Law on Modernization defines health care provider organizations (entidades prestadoras de salud – EPS), as “enterprises and public and private institutions other than the Peruvian Institute of Social Insurance (IPSS), whose principal aim is to deliver health care services, with their own or other people’s resources” (Article 13).

Likewise, in the article dealing with the principles behind the law (Article 1), it is clearly stated that the resources of the Treasury will be applied to health care “through the network of State facilities, as well as public or private organizations, which may include agreements to achieve the desired results”.

Besides, within the regulation of this law, the concept of the “simple layer” is introduced, defined as a “group of high-frequency and low-complexity interventions detailed in Annex 1. These may be provided by the Peruvian Institute of Social Insurance or by employer organizations through their own services or under contract with an EPS”. Since the “simple layer” contains many public health services, there is an implication that the social insurance system might contract with the private sector (i.e. with the health care provider organization) for these services.

Health care programme documents

Tuberculosis Control Programme

The Peruvian programme for tuberculosis control (Ministry of Health, 1995b) has achieved high standards, and received an award from WHO in 1997 as a model programme. It has been one of the most stable programmes, as shown by the fact that its executive director, Dr Guillermo Suarez-Aguilar, has been in post since July 1990.

The political support for the programme is also reflected in the investment in, and expansion of, the programme for reliable diagnosis and standardized treatment of tuberculosis. In 1990, only 800 health care facilities (25%) were
able to diagnose and treat tuberculosis. By 1999, diagnosis and treatment were available free at point of use in 100% of 6,200 facilities.

In the current regulations governing the tuberculosis control programme, participation by the private sector is neither stipulated or excluded.

Programme of Reproductive Health and Family Planning 1996-2000

The reproductive health programme (Ministry of Health, 1996b) is a key programme because of its high political profile. Population policy was an acknowledged priority of the government of President Fujimori, which he championed in international forums, the mass media and various personal presentations. The programme is based on Article 6 of the Political Constitution of 1993, which states that the national population policy has the objective of promoting responsible maternity and paternity, recognizing the right of families to decide how many children to have and when.

The Programme of Reproductive Health and Family Planning contains one of the clearest statements about private-sector participation. The latter is clearly mentioned among its strategies, under the heading “intersectorality”, when it proposes that “the supply of experience by nongovernmental organizations and the participation of the commercial private sector are complementary and necessary elements for success in this programme” (Ministry of Health, 1996b:30).

Similarly, when describing implementation, the programme proposes “complementary functions with the services provided by the private sector and nongovernmental organizations” (Ministry of Health, 1996b:32). Moreover, within the functional programme it is recognized that “the actions planned affect both public and private institutions” (Ministry of Health, 1996b:42).

Mother and Child Health Care Programme

No mention is made of the participation of the private sector. The chapter regarding intersectoral coordination (Ministry of Health, 1995c:32), points out the importance of intersectoral coordination, especially for preventive and promotional efforts.

Special Programme for Sexually Transmitted Diseases and AIDS Control

The Special Programme clearly states that coordination with organizations interested in the implementation, support and promotion of the prevention and treatment of sexually transmitted diseases and HIV/AIDS will be encouraged (Ministry of Health, 1996c:30).
Interview results
Experiences

Current experience of public/private collaboration on public health issues is quite varied, and not always consistent with policy documentation. The most advanced collaboration is in family planning and control of sexually transmitted diseases and AIDS, while relatively little is happening in tuberculosis control or immunization. The type of activities undertaken and the programme users seem to depend on the degree of public/private interaction.

In family planning, there seems to be a perceived complementary relationship between the public and private sectors. In this perception, public services specialize in serving “limiting users” (those who do not want more children), while the private sector tends to provide services for “spacing users” (those who wish to delay the birth of their next child). In the case of sexually transmitted diseases and AIDS, the relationship has been mainly with nongovernmental organizations, because of their work in prevention.

In addition, both the sexually transmitted disease service and the family planning service had a good perception of the quality of private care, believing that this allowed private providers to focus on very poor populations or specific groups of users. The director of the sexually transmitted diseases programme was particularly happy with the innovative capacities of the private sector, such as “prevention fairs”, educational games and outreach activities that allowed private providers to work with groups that are difficult for the public services to reach, such as sex workers (both male and female).

In the areas of immunization and tuberculosis control, there is no relationship between the public and the private sector. Directors claim that the reason for this poor relationship is the very low level of provision of these interventions by the private sector. The director of the immunization programme cited a 1990 study intended to determine how many doses of vaccine were given by private practitioners and how this information could feed into Ministry of Health statistics. Results indicated that levels of provision by private institutions were very small, although they did not give exact figures.

Another reason for the lack of interaction, stated by the director of the tuberculosis programme, is that “every successful programme in the world is vertical in design and horizontal in execution”. He stated that the success of the programme depended on rigid adherence to the rules (e.g. the DOTS regime1) and it would be difficult to exert the necessary degree of control over private practitioners.

Directors reported that several mechanisms had been tried to increase the data supplied by private practitioners about patients they had treated for

1DOTS: directly observed treatment, short course (therapy for tuberculosis).
conditions of public health significance. High levels of resistance were encountered, probably owing to a fear that such data might be used to estimate the practitioners’ income for taxation purposes. Nevertheless, interviewees considered the incorporation of private-practitioner data into the epidemiological surveillance system to be important.

In general, public officials perceived their own public health role as decreasing. An alternate, minority view was that they saw their role increasing, but limited to specific functions or client groups (such as the poor). This would obviously be in conflict with the proposed arrangements for the health care provider organizations, but it is currently hard to predict exactly how these will be implemented.

Possible forms of relationship

The following were mentioned as possible arrangements for public/private sector interaction in the delivery of public health services.

- Agreements for the exchange of information: this was a highly favoured way of identifying the “real coverage” of programmes. With the exception of sexually transmitted diseases, which obtain field information from the demographic and health surveys performed every four years since 1992, other programmes do not have such information.

- The government could offer the private sector access to logistical support and bulk purchasing (Expanded Programme on Immunization, family planning).

- The government could advertise private-sector services in exchange for support and information from the private sector.

- The government could offer funds for experimental testing of new modes of provision.

The director responsible for tuberculosis services rejected the idea of hiring private providers, because of the perceived high costs for the Ministry of Health.

Discussion

As mentioned in the introduction, it is legal for physicians to work at both public and private facilities. In a survey sponsored by the Peruvian College of Physicians in 1989 (Alarcón et al., 1989), only 7.5% of physicians doing their postgraduate training (“residents”) affirmed that they expected to have a private solo practice as their main job once they finished their training. Fifty
per cent wanted to work only for a public institution, and 42.5% wished both to work for a public institution and to have their own private practice. In fact, 30% of the sample had worked in private facilities before their residency. In another survey, Lip et al. (1990) found that the average number of jobs per physician was 1.9 (68% of them in the private sector): 28% of physicians said that private practice was their main source of income. In summary, therefore, we could say that private practitioners in Peru are generally both public and private practitioners. This means that most private practitioners are familiar with public-sector regulations and protocols about how to manage public health problems.

The health policy guidelines for 1995-2000 state as one of their objectives a change in the current relationship between the public and private sectors which will widen the latter’s participation in the provision of health care services (Ministry of Health, 1995a). This has been made official by the recent Law No. 26790 on Modernization of Social Insurance in Health (Congreso de la República Peruviana, 1997b), introducing the concept of the health care provider organization, which seeks to encourage the participation of the private sector in basic health care services. According to this model, the health care provider organization would be hired by the Peruvian Institute of Social Insurance or other enterprises to provide a minimum basic package of services, including public health activities. If, as the policy documents seem to indicate, the basic responsibility of the State is to ensure equity, social efficiency and quality of services received by the population, the private sector can and should participate as long as these general criteria are satisfied. A clear set of conditions for private-sector participation in public health activities has thus been established.

Not all aspects of private-sector participation are so strongly encouraged, however. The potential role of the private sector in facilitating information flows does not receive much attention. Documents laying out the details of major public health programmes pay little attention to the potential value of private-sector information. This is consistent with the failure to mention the possibility of a contractual relationship between the public and private sector, or even the specific denial of such a possibility.

In some cases, there are arguments that involving the private sector is inefficient (e.g. tuberculosis control) or efficient (e.g. family planning). Independent data suggest, however, that private participation is already substantial in several areas of public health interest. In the National Survey of Demography and Health 1992 (ENDES, 1992), private physicians accounted for 10% of the total supply of family planning services, mainly owing to their provision of intrauterine contraceptive devices (IUDs) (20.4%): in this area, they were the main provider at a national level, exceeding even the public hospitals. Four years later, in the same survey (ENDES, 1996), private physicians accounted for 9.1% of the total supply of family planning services,
mainly voluntary sterilization (17.4% of the national total), and IUDs (14.2%).
In the same survey, the percentage of unsatisfied needs for family planning
was 12.1% of women with a partner, 29% of this unsatisfied need being among
potential spacing users. In 2000, the private sector provided 19% of services,
including 22% of all IUDs (ENDES, 2000). This may explain the Ministry of
Health’s perception of a complementary role for the private sector, covering
some population groups which are small in proportion to the total
population.

Conclusions
From a macro, health-policy perspective, the opportunities for the private
sector in the provision of public health services seem to be well established.
The remaining, unchallenged role for the State is the financing of public
health services, along with quality and safety monitoring of those services
provided by the private sector. Possible mechanisms that have been
implemented elsewhere include contracting-out, information exchange and
voluntary accreditation programmes in exchange for publicity and
advertising. Taking advantage of economies of scale in the purchase of
contraceptives and drugs is another area where collaboration could be
explored.

Interviews with policy-makers and civil servants suggest, however, that
implementation of these principles is still weak. Those interviewed seemed
more likely to have a positive opinion about involvement of private providers
where:

- they believed that the private sector provided good quality service
- the private sector operated in market segments or activities where
  public providers were less active
- they believed in general that the role of government should be one of
  promotion and regulation, rather than provision
- public officers have had personal experience of working for the
  private sector (this “dual practice” is legally admitted and socially
  prestigious).

Executive director posts are usually allocated on the basis of personal trust
or political preference. Including private-sector experience as a criterion for
choice could facilitate mutual understanding and support.

It would appear that a set of policies favouring appropriate private-sector
involvement in public health activities is already in place in Peru. However,
the acceptance of these policies by civil servants, and the implementation of
programmes that incorporate such principles, are far less evident. It would
seem that limited and well designed trials and pilot programmes are now required to test the potential of private-sector providers and convince policymakers of their usefulness.

**Further reading**


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5. Improving the management of sexually transmitted infections in the private sector in South Africa
Duane Blaauw, Helen Schneider

Introduction

The control of sexually transmitted infections is an important public health problem in South Africa. These diseases are common and constitute an important preventable cause of morbidity, particularly in disadvantaged groups (Pham-Kanter et al., 1996). In addition, sexually transmitted infections significantly enhance the transmission of human immunodeficiency virus (HIV) (Laga et al., 1991; Grosskurth et al., 1995). The South African Department of Health has outlined a national strategy for controlling the epidemic which prioritizes the effective management of patients with sexually transmitted infections, using a syndromic approach (Department of Health, 1997). Recent evaluations suggest that the quality of care in public-sector facilities is improving, owing to interventions such as the development of national treatment guidelines, the training of staff in syndromic management and the provision of effective drugs (Edwards-Miller & Makhanya, 1998; Pick et al., 1998).

However, the management of sexually transmitted infections by the private sector is an important problem that has not yet been adequately addressed by national control efforts. The private sector is a significant component of the health care system in South Africa, and if STD patients continue to receive suboptimal treatment from private health care providers, this could seriously undermine public-sector control efforts.

The role of private providers in the delivery of public health services has only recently begun to receive attention in the literature (Bennett & Ngalande-Banda, 1994; Musgrove, 1996; Berman, 1996; Swan & Zwi, 1997; Bennett et al., 1997; Brugha & Zwi, 1998).

Public health services include:

- population-based services (e.g. the provision of water and sanitation or vector control)

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1 Correspondence to Helen Schneider.

2 Also referred to as “sexually transmitted diseases”, hence the acronym STD used here.
personal preventive services (e.g. immunization or family planning)
- personal curative services which affect broader public health by interrupting further disease transmission (e.g. treatment of tuberculosis or sexually transmitted infections) (Swan & Zwi, 1997).

Population-based services have generally been accepted as the responsibility of the State, and continue to be financed and provided by the public sector in most countries. However, in countries where the private sector is more developed, private providers are responding to the demand from patients, and are increasingly involved in the provision of personal preventive services (Atkinson & Cheyne, 1994; Balraj et al., 1993; Abu-Zeid & Dann, 1985; Gan & Yusof, 1993; Berman & Rose, 1994; Foreit, 1992), as well as the treatment of diseases which have broader public health significance (Berman & Rose, 1994; Langsten & Hill, 1995; Bhat, 1993; McCombie, 1996; Uplekar & Rangan, 1993; Aljunid, 1995).

Patients prefer using private providers for a variety of reasons, including accessibility, travel time, hours of service, waiting times, presence of physicians, availability of drugs, personal treatment and confidentiality (World Bank, 1993; Aljunid, 1995). Although more affluent patients use private providers more frequently, patients from low-income groups also make significant use of private providers (Gan & Yusof, 1993; Berman, 1996; Yesudian, 1994; Swan & Zwi, 1997). However, despite the preferences of patients, the technical quality and efficiency of public health services delivered in the private sector is often poor (Swan & Zwi, 1997). Studies have shown that private providers overprescribe antibiotics (Trostle, 1996; Langsten & Hill, 1995); use unnecessary injections (Ross-Degnan et al., 1992); fail to follow national treatment guidelines (Uplekar & Rangan, 1993); and seldom address important preventive and promotive aspects of patient management, such as record-keeping, partner notification, defaulter tracing, outcome evaluation and disease notification (Bennett & Ngalande-Banda, 1994; Uplekar & Rangan, 1993; Kirsch & Harvey, 1994).

This presents a significant dilemma for the State. On the one hand, shifting the responsibility for health care to the private sector and expanding the role of private providers may be a reasonable strategy to improve access to and coverage of public health services (Swan & Zwi, 1997). On the other hand, however, the delivery of health services with public health significance by the private sector may actually produce greater negative health effects and entrench current inequities in disease burden and health status.

One important priority is the identification and development of strategies to improve the quality and efficiency of public health services already being provided in the private sector (Swan & Zwi, 1997). However, the literature indicates that influencing the behaviour of private providers is a difficult task (Brugha & Zwi, 1998; Trostle, 1996). A number of interventions have been
proposed (Bennett & Ngalande-Banda, 1994; Uplekar & Rangan, 1993; Lomas et al., 1991; Rosen, 1989; Davis et al., 1995; Illife & Munro, 1993; Perez-Cuevas et al., 1996; Sackett et al., 1996; Bennett et al., 1994; Ross-Degnan et al., 1992; Reerink & Sauerborn, 1996; Harvey, 1996) but few of these have been rigorously evaluated, particularly in lower-income and middle-income countries (Brugha & Zwi, 1998). Recent reviews have suggested that strategies which address only the knowledge of private providers are rarely successful in influencing practice (Davis et al., 1995; Oxman et al., 1995; Paredes et al., 1996). Brugha and Zwi (1998) have argued that improving the quality of public health services delivered by the private sector will require multifaceted interventions which are sensitive to the local context and are based on an understanding of the range of factors which determine or influence the behaviour of private providers.

Influenced by these insights, we have been investigating the management of sexually transmitted infections by private general practitioners (GPs) in South Africa as a case-study to explore the role of private providers in the delivery of public health services. This work touches on a number of significant themes, including:

- influencing the behaviour of private providers
- involving private providers in national disease control programmes
- addressing the quality of care in the private sector
- providing incentives for preventive care
- developing public/private partnerships.

The next section of this paper summarizes the available evidence on the management of sexually transmitted infections by private practitioners in South Africa. This is followed by an analysis of the factors influencing the behaviour of private practitioners, with particular reference to the management of sexually transmitted infections. The final section suggests possible interventions for improving the quality of STD care by private practitioners.

This rapid appraisal constituted part of the first phase of our investigation and included a literature review, document analysis, key-informant interviews and in-depth interviews with selected general practitioners. The next phase of the study will utilize a quasi-experimental methodology to evaluate specific interventions which can be adopted at local level to improve the quality of STD management in the private sector.
Management of sexually transmitted infections in the private sector

The private sector is an important component of the health care system in South Africa, consuming approximately 55% of total national health expenditure (Söderlund et al., 1998). In 1998, 29% of hospital beds, 56% of medical practitioners and 77% of specialists were found in the private sector (van den Heever, 1998). Only 18% of the population are covered by health insurance¹, mainly in the form of not-for-profit medical schemes (Söderlund et al., 1998). However, out-of-pocket payments to private providers by the uninsured population are well documented (McIntyre et al., 1995; Söderlund et al., 1998). Table 1 shows that health insurance coverage increases with income quintile and is higher in urban areas, but also demonstrates that individuals in lower-income categories make significant use of private providers, despite their lack of health insurance cover.

<table>
<thead>
<tr>
<th>Income quintile*</th>
<th>Persons covered by health insurance</th>
<th>Households using private care as first choice</th>
<th>Persons using private care in last month</th>
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<td></td>
<td>Rural %</td>
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<td>16</td>
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*1 = lowest income quintile; 5 = highest income quintile.

The health care utilization patterns of uninsured individuals have not been extensively studied in South Africa and are probably fairly complex. Indigent patients presumably depend on the public sector for most of their care, whereas the less destitute appear to use private providers for some of their primary care, but will utilize the public sector for more expensive hospital services (McPake, 1997).

The type of illness is also a significant determinant of health-seeking behaviour. Sexually transmitted infections appear to be one set of conditions for which treatment is regularly sought in the private sector in South Africa, despite the fact that the majority of patients are from lower-income groups. A study of utilization patterns in Alexandra, a poor urban township in Gauteng province, found that 63% of all visits for sexually transmitted infections

¹The term “health insurance” is used here to cover both for-profit health insurers and not-for-profit medical schemes.
occurred in the private sector (Frame et al., 1991). In Hlabisa, a rural district in KwaZulu-Natal where public facilities have received extensive support to improve STD management, 48% of all STD patients still preferred to go to private practitioners (Wilkinson et al., 1998). A national survey estimated that private practitioners treat approximately five million cases of sexually transmitted infections each year in South Africa, possibly outnumbering cases seen in the public sector (Dartnall et al., 1997).

The relative privacy and anonymity of GP consulting rooms is a significant determinant in the choice made by STD patients but other factors, such as better access, longer hours of service, shorter waiting times, more personalized attention and being seen by a physician instead of a nurse are also important.

However, although the care offered by general practitioners is attractive to STD patients, the technical quality of STD management is poor. In the recent national survey of general practitioners (Dartnall et al., 1997), only 28.3% of general practitioners prescribed effective treatment for urethral discharge, 15.5% treated genital ulcers effectively and only 4.4% prescribed adequate treatment for pelvic inflammatory disease (Figure 1). In a similar study in Hlabisa, only 9% of GP prescriptions for sexually transmitted infections were considered adequate (Connolly et al., 1999).

The management of sexually transmitted infections by private practitioners in South Africa provides a good case-study for exploring the role of private providers in the provision of public health services. The findings summarized
here support the evidence from similar studies done elsewhere (Brugha & Zwi, 1998), in that:

- private providers play a significant role in the provision of public health services, but
- the quality of care provided is poor, which may seriously undermine national control efforts.

Factors influencing private-provider behaviour

General factors influencing the behaviour of general practitioners

The behaviour of private providers is determined by a complex and dynamic web of personal and environmental factors. Table 2 outlines a framework for exploring these issues and summarizes some of the general factors that influence GP behaviour in South Africa. It is similar to the model proposed by Brugha and Zwi (1998) but focuses on the actors in the GP environment, as well as their potential influence on private providers.
Table 2. General factors influencing GP behaviour in South Africa

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<th>Level</th>
<th>Sector</th>
<th>Actors/factors</th>
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<td>Individual</td>
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<td>Political orientation</td>
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<td>Immediate environment</td>
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<td>Consumer groups</td>
<td>Knowledge and educational level</td>
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<td>Economic climate</td>
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<td>Council of Medical Schemes</td>
<td>Regulation of competition</td>
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<td>Specialist societies</td>
<td>Accreditation</td>
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</table>

IPA: Independent Practitioner Association
HPCSA: Health Professions Council of South Africa
CPD: Continuing Professional Development
SAMA: South African Medical Association
CME: continuing medical education
SAQA: South Africa Qualifications Authority
BHF: Board of Healthcare Funders
The framework categorizes these factors into three levels of influence (Table 2). At a personal level, the behaviour of general practitioners is obviously determined by characteristics such as their attitudes, social background, gender, training and experience. They are also influenced by individuals and groups within their immediate operating environment. This includes the patients, funders, suppliers and other public and private providers with whom general practitioners interact on a regular basis. Lastly, GP behaviour is affected by more distal actors, primarily professional organizations and agencies of the State, that determine the broader policy, regulatory, financial, educational and professional environments in which general practitioners operate.

Factors influencing STD management by private practitioners

The various personal and environmental factors interact to influence clinical decision-making by general practitioners. There appear to be two main reasons for the poor quality of treatment of sexually transmitted infections by private providers:

- a lack of awareness and/or acceptance of newer approaches to STD management
- the relatively high cost of antibiotics for the treatment of sexually transmitted infections, and the general practitioner’s reluctance to dispense these to uninsured, cash-paying patients.

This basic analysis is summarized in the flowchart in Figure 2.
The few South African studies that have examined the quality of STD care in the private sector measured private providers’ knowledge, rather than their actual practice. However, in these studies, very few general practitioners were able even to describe effective treatment for common sexually transmitted infections (Dartnall et al., 1997). This indicates a significant deficit in the knowledge of general practitioners about current STD management (Connolly et al., 1999).

The fact that few general practitioners have heard of the syndromic approach to STD management also suggests that the problem is one of
knowledge rather than acceptance. However, some academics and clinicians have rejected syndromic management as being contrary to the principle of specific diagnosis and treatment (Brugha & Zwi, 1998). One difficulty with protocols such as syndromic management is that they “are perceived to be for nurses, not doctors” (key-informant interview—Family Medicine department).

Inadequate undergraduate training is one possible explanation for the poor standard of knowledge of general practitioners. However, a more likely reason is that general practitioners fail to keep up with medical advances after they qualify, or do not have access to high-quality information. For example, most general practitioners depend on information provided by drug companies, either through company representatives or sponsored continuing medical education (CME) sessions, in order to keep up-to-date. In 1998, the Health Professions Council of South Africa (HPCSA) passed regulations introducing mandatory recertification of medical practitioners, which could have a significant impact on the state of knowledge of general practitioners. Not only do all physicians now have to participate in a minimum of 250 hours of continuing professional development (CPD) activities every five years, but the requirement for accreditation of CPD providers should also improve the quality of information available to general practitioners.

There is often a significant gap between private providers’ knowledge and their practice (Brugha & Zwi, 1998). Even if general practitioners know about effective STD management, they may not actually employ it, or not for all their patients. Typically, it is the poorer, uninsured patients who receive low-quality care. Private practitioners can prescribe effective treatment for STD patients with health insurance, but providing more expensive antibiotics for patients without health insurance would result in much lower profit margins. One of the reasons for this is that cash-paying patients generally demand low-cost, all-inclusive packages of care, and there is sufficient competition between general practitioners in this sector of the market to ensure that profit margins are narrow (in-depth GP interview). General practitioners will try to compensate by minimizing their costs and increasing the number of patients seen, both of which result in lower quality of care for patients. Unfortunately, most STD patients do not have health insurance and, therefore, frequently receive ineffective treatment from private providers.

Medical schemes have some flexibility in determining the structure and content of their benefit packages. Benefits for certain conditions, such as HIV and sexually transmitted infections, are commonly excluded by medical schemes, making it difficult for general practitioners to provide optimal therapy for such patients. However, both general practitioners and medical-scheme administrators admit that these restrictions are easily (and frequently) bypassed in practice, at least in the case of STD patients (in-depth GP interview; key-informant interview—Medscheme).

For STD patients without medical aid, general practitioners essentially have
to choose between maximizing their profits or acting professionally and providing effective therapy, despite the loss in profits. A number of environmental factors may influence how general practitioners resolve this fundamental tension between their commercial interests and their professional ethics. In general, the pattern in South Africa is still similar to that of other developing countries, in that professionalization and regulation are relatively weak, and commercialization predominates (Bennett, 1997). However, changes are occurring in the GP environment. A number of new organizations, including provider networks, managed care organizations, the Health Professions Council and the South African Medical Association (SAMA), have begun to try and influence the practice of general practitioners.

The financing environment in South Africa reinforces the commercial orientation of general practitioners. The fee-for-service payment system provides little incentive to ensure that STD patients are treated effectively at the first visit, or to adopt preventive measures to reduce the spread of sexually transmitted infections. In addition, fee-for-service reimbursement seems particularly susceptible to abuse. The threat of litigation or censure by professional bodies should be a deterrent against unethical and fraudulent practices, but this does not seem to be the case in South Africa.

In the in-depth interviews with general practitioners, they frequently complained that GP practice has become much less lucrative in the last few years. Some of the reasons for this include:

- the relatively low increases in the scale of benefits for GP consultations
- the attempts by the State to restrict the dispensing of drugs
- the increased competition from specialists, private hospitals and nurse-based services.

These changes might influence general practitioners to overservice their medical aid patients and provide lower-quality care for cash-paying patients, including patients with sexually transmitted infections, in order to maintain their income.

Although general practitioners in South Africa are increasingly becoming subject to managed-care processes, such as pre-authorization of hospital admissions, pharmaceutical benefit management and utilization review, the standard fee-for-service model still predominates. In theory, managed care could provide positive incentives to improve the quality of care, but in practice in South Africa the focus has been more on reducing costs. It is encouraging that medical schemes and their administrators are finally beginning to scrutinize the activities and claims of providers, but unfortunately, it would appear that the current information systems and instruments of managed care are too crude to deal with specific issues such as the poor quality of STD care by private providers.
In response to the perceived threat from managed care, private providers have begun to join together in provider networks, such as independent practitioner associations (IPAs). The position of the associations in this debate has been rather ambivalent. They have mainly acted to protect the commercial interests of general practitioners through activities such as bulk-buying and contracts with funders, but, on the other hand, are also trying to implement professional controls such as peer review, continuing medical education and the use of standardized treatment protocols (key-informant interview – African Health Synergies). Clearly, not all associations are the same. Some of those we spoke to were quite interested in addressing quality-of-care issues, whereas others were only concerned with finding new ways to make money for their members.

Professional and regulatory bodies should obviously play an important role in trying to shift GP behaviour away from blatant commercialism and towards more professional and ethical standards of care. The Health Professions Council is the regulatory body for medical practitioners, and the South African Medical Association is the most important professional body in the country. The professional credibility of these bodies was compromised by their poor record during the apartheid years, but both organizations have undergone transformation recently and are beginning to exert more professional leverage over private practitioners. The implementation of the CPD policy has been a major achievement for the Health Professions Council, while the Medical Association has begun developing quality-of-care guidelines for private providers and is one of the main accrediting agencies for CPD. As yet, neither this nor the Medical Association guidelines have specifically addressed STD management by private providers, although both provide useful mechanisms for doing so.

One of the underlying reasons why the behaviour patterns of general practitioners continue unchecked is that patients are generally not able to judge the technical quality of the treatment they receive. Patients are poorly informed and poorly organized and, unfortunately, this seems unlikely to change in the near future. At present, there are few consumer organizations and civic bodies, and none that focus specifically on the health care sector.

An understanding of these influences will hopefully help in identifying the opportunities and constraints for improving the quality of STD care by private general practitioners.

**Improving the quality of private STD care**

Swan and Zwi (1997) propose that there are three possible strategies that government may adopt in dealing with the poor quality of public health services delivered by private providers, namely:
PUBLIC HEALTH ROLES FOR PRIVATE PROVIDERS

- a laissez-faire approach
- discouraging private providers from delivering health services with public health consequences
- trying to improve the quality of service currently provided.

The dominant neoliberal paradigm would appear to support a laissez-faire approach, arguing that the market mechanism will eventually lead to greater quality and efficiency than if the State were to interfere (Swan & Zwi, 1997). However, an alternative viewpoint is that government intervention is necessary, either to restrict the private sector from providing public health services or to improve the quality of the care being provided at present. Swan and Zwi (1997) argue that the third strategy is the only feasible option in the current climate. A laissez-faire attitude would not be appropriate, given the questionable quality and efficiency of current services provided by the private sector, whereas restricting private practitioners would be politically difficult, especially where public-sector public health services are also inadequate.

Even the World Bank has come to realize that State intervention is occasionally required, especially in the health care market (Swan & Zwi, 1997). The commonly accepted economic rationale for government intervention is to address market failures or to improve equity. The World Bank does caution, however, that intervention by the State does not guarantee a better outcome, since “government failure may be as common as market failure” (Swan & Zwi, 1997).

Treatment for sexually transmitted infections is not a public good in the economic sense, since it is neither non-rival nor non-excludable. Nevertheless, there are two important reasons why the market may fail to deliver good-quality and efficient STD care. Firstly, the effective management of sexually transmitted infections results in a positive externality, by preventing the further spread of sexually transmitted infections and HIV. Economic theory suggests that it will not be possible to establish a fully competitive market for services with positive externalities, because individual consumers will not be prepared to pay the full costs and will tend to underconsume, while profit-maximizing private providers will be unlikely to supply the services unless their expenses are reimbursed (Swan & Zwi, 1997). For this reason, subsidies are the standard economic mechanism for addressing positive externalities. A second problem is the asymmetry of information between patients and private providers (Swan & Zwi, 1997). Patients are not able to judge the technical quality of the STD treatment they receive, and therefore continue to make use of general practitioners providing substandard care.

These arguments suggest that the State should intervene to try and improve the quality of STD care currently provided by private general practitioners. However, the government will need to decide whether the relative marginal
returns justify the investment in private providers, rather than investment in improving public-sector services (Swan & Zwi, 1997). In addition, the State will need to develop interventions at a number of different levels. The national government, in partnership with the important national stakeholders, including the Health Professions Council, the South African Medical Association, funders and the medical schools, should intervene at the macro level in order to produce an environment that is more conducive to the provision of good-quality care by private providers. More importantly, district programmes and facilities must engage with local private practitioners and independent practitioner associations to implement appropriate local interventions to improve the quality of STD care by general practitioners.

**Interventions at the individual level**

Improving the knowledge and attitudes of general practitioners is an important intervention at the individual level. This could involve strategies such as the distribution of standard treatment guidelines, as well as continuing medical education workshops on STD management. There is limited experience in South Africa of more intensive practice activities, such as academic detailing and audit, but these are clearly more effective in influencing the behaviour of general practitioners and, therefore, warrant development. Different guidelines for STD treatment are currently used in the public and the private sectors, and an important priority would be to develop national guidelines that have the support of stakeholders in both sectors. The recent introduction of continuing professional development (the CPD policy) will make a significant contribution to ensuring that general practitioners keep up to date with medical knowledge. The only specified requirement in the current regulations is some training in medical ethics, but it could be argued that a core curriculum should include topics of public health significance, such as rational prescribing and STD management.

**Interventions in the immediate environment**

Increasing consumer knowledge and mobilization would enable patients to make more informed decisions about their choice of private provider. The accreditation of general practitioners who agree to adhere to standardized guidelines, or who have received appropriate training in STD management, would also help to address the problem of information asymmetry.

A more controversial intervention would be for the State to provide incentives to private providers to manage their uninsured STD patients more appropriately. Private providers could be remunerated for STD consultations, provided with drugs or allowed to refer patients to public dispensaries for drugs. The investment in private providers could be justified by the fact that the majority of STD patients are currently seen in the private sector. However,
such systems would require some capacity to control potential abuse by private providers (key-informant interview – National Department of Health).

**Interventions in the broader environment**

Increasing health insurance coverage would improve the quality of STD care by removing some of the financial obstacles to prescribing appropriate antibiotics for STD patients. In the short term, the State should continue to promote community rating within the financing environment and ensure that medical schemes do not exclude cover for STD treatment. The proposed social health insurance scheme is a longer-term strategy. At present, this only addresses a minimum package of essential hospital care but, presumably, it would be possible in theory to include important public health conditions, such as sexually transmitted infections, in a minimum package of care.

Another priority is to strengthen the professional orientation of organizations such as the Health Professions Council and the South African Medical Association, as well as supporting the fledgling attempts at peer review by the independent practitioner associations. Important areas for regulation include the health insurance market and dispensing of drugs by general practitioners. To overcome the public perception that the Health Professions Council exists to protect the interests of providers rather than patients, the Council needs to be seen to be acting against malpractice and unethical behaviour.

All of these approaches imply significant State capacity to engage with and regulate the private sector. Thus far, the government has had little direct interaction with private providers. The challenge will be to try and initiate a partnership between the government, professional associations and private providers in order to address poor quality of care in the private sector.

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PUBLIC HEALTH ROLES FOR PRIVATE PROVIDERS


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PUBLIC HEALTH ROLES FOR PRIVATE PROVIDERS


South Africa has a history of over 100 years of private health insurance arrangements, with little involvement by the government in the direct provision of insurance cover at any stage. Health insurance schemes have traditionally been called “medical schemes”, the first one being the De Beers Consolidated Mines Ltd Mines Benefit Society, established in 1889. By 1910, there were seven such schemes in existence and, by the beginning of the Second World War in 1939, a total of 48. It was only in 1967 that legislation was promulgated, in the form of the Medical Schemes Act, that recognized medical mutual insurers as distinct entities. The period from 1969 to the mid-1980s was characterized by strong government regulatory involvement in the medical schemes industry. Regulation was especially concerned with the relationship between medical schemes and the provider community, and both modes and rates of reimbursement were fixed by statute. Schemes were forbidden from charging differential premiums based on risk. In the 1989 amendment to the Act, rules disallowing risk-rating of premiums were removed from the statute books at the instigation of commercial life insurers keen to enter the health insurance market (van den Heever, 1997, 1998). Risk-rating of medical scheme premiums was allowed until the end of 1999, after which it again became illegal for schemes to charge premiums based on the risk of ill-health.

The structure of the industry circa 1999

By law, all medical schemes are non-profit mutual organizations, controlled by a board representing their members. Because of the complexity of the industry, however, all schemes employ professional administrators to handle the day-to-day processing of claims and collection of premiums. In some cases, administrators are in-house employees of the fund. In most cases, however, this work is contracted out to full-time, professional medical scheme administrators, which operate as for-profit companies. The medical scheme

1 Correspondence to Neil Söderlund.
The environment thus consists of a largely for-profit industry administering a set of distinct, mainly employment-based, non-profit risk pools. There are a number of reasons for the fact that medical schemes are employment-based. Firstly, in most countries, including South Africa, the workplace or industry of employment provided a natural aggregation of persons suitable for mutual welfare arrangements (Schulenburg, 1994; n/e/r/a, 1993; Normand & Weber, 1994). Secondly, the tax system in South Africa only allowed an employer to claim tax deductions for medical scheme contributions, not for individuals. Finally, because membership of most company schemes is offered at low or no cost to the employee, adverse selection is less of a problem, and there has thus historically been strong government support for linking medical scheme membership to employment.

The distinction between closed (employment-based) and open funds is an important one. Since membership of employment-based funds is often compulsory for employees earning above a certain level, and pensioners typically elect to remain a member of the scheme after retiring, a broad spectrum of risk types are accommodated within one fund, typically with little variation in premiums due to risk. Open funds, on the other hand, have little natural cohesion between members, and thus generally charged risk-rated premiums until the end of 1999. Although these are, by law, still non-profit organizations, their administrators typically have much more say in the scheme policy. It is generally acknowledged that most open funds operate effectively as for-profit organizations, with administrators claiming any underwriting surplus. Increasingly, open funds have sought to recruit younger members from the employment-based, closed-fund industry.

**Access to medical scheme cover**

Access to private health cover remains a good indicator of the distribution of health care resources in South Africa. In 1995, medical schemes spent more than four times as much as the State per head of the covered population (McIntyre et al., 1995). Table 1 shows data extracted from the 1995 October Household Survey on medical scheme membership in different provinces and income quintiles.
Medical scheme coverage was negligible for those in families with an average income per member per year of less than 5 000 South African rand, and only the top income quintile had more than 50% coverage. Table 2 gives a breakdown of medical scheme membership by age and population group. All population groups showed a distinct drop in membership in older age groups, suggesting that the elderly had difficulty obtaining affordable cover. Even amongst relatively privileged whites, only half of those over 75 years of age had medical scheme cover. Since the elderly generally have high care requirements, this implies a considerable burden on the State.

There has been a marked increase in the black African proportion of medical scheme membership, from 23% and 24% of medical scheme members in 1990 and 1991, respectively, to 36% in 1995. While much of this has been due to rapid upward job mobility in this group, this period has also seen the organized labour movement becoming prominent in setting up medical schemes for its members.

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**Table 1. Proportion of population with medical scheme cover, by province and income category**

<table>
<thead>
<tr>
<th>Population/income</th>
<th>% with medical scheme cover</th>
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<tr>
<td>Whole population</td>
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<tr>
<td>Family income quintile’</td>
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<tr>
<td>1 (&lt;R885 per annum)</td>
<td>2</td>
</tr>
<tr>
<td>2 (R885-2444 per annum)</td>
<td>3</td>
</tr>
<tr>
<td>3 (R2445-4776 per annum)</td>
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<tr>
<td>4 (R4777-11000 per annum)</td>
<td>20</td>
</tr>
<tr>
<td>5 (&gt;R11000 per annum)</td>
<td>60</td>
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* Refers to the average annual income per family member. R = rand Source: Söderlund et al., 1998.
Aims of this study

Significant regulatory changes have happened in the medical schemes industry over the last decade or so, beginning with the deregulation of medical scheme risk pooling in 1989, and ending in 2000 with the reintroduction of regulations to ensure risk pooling and the provision of essential hospital cover. This paper seeks to explore the membership dynamics of medical schemes during the period of deregulation, and draw some conclusions on the impact of deregulation. In particular, given the nature of regulatory changes, we were interested in assessing the extent to which adverse selection (on the part of potential enrollees) and risk selection (on the part of insurers) determined membership characteristics. A before-and-after assessment of the regulatory changes based on scheme-level analyses has already been reported (Söderlund & Hansl, 2000), and this work complements it by examining the behaviour of individuals in relation to medical scheme membership during the period when schemes were able to risk-rate their premiums.

If the private health insurance sector is to meet public health care objectives, it needs to enhance the efficiency of health care provision while providing fair and comprehensive cover. Generalized market failure in insurance markets with imperfect information suggests that this will be impossible without appropriate regulation. This paper explores whether there

Table 2. Medical scheme membership by age group and race (1995)

<table>
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<tr>
<th>Age group</th>
<th>Overall %</th>
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<th>Coloured %</th>
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<td>24</td>
<td>73</td>
</tr>
<tr>
<td>25-44</td>
<td>22</td>
<td>11</td>
<td>24</td>
<td>35</td>
<td>76</td>
</tr>
<tr>
<td>45-59</td>
<td>22</td>
<td>7</td>
<td>20</td>
<td>17</td>
<td>75</td>
</tr>
<tr>
<td>60-74</td>
<td>17</td>
<td>3</td>
<td>7</td>
<td>13</td>
<td>62</td>
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<tr>
<td>75+</td>
<td>19</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>47</td>
</tr>
</tbody>
</table>

Source: Söderlund et al., 1998.
is evidence in the South African health insurance market of the effectiveness of such regulation. The issue of efficiency of cover has been addressed in a separate paper (Söderlund & Hansl, 2000). This study has sought to determine the comprehensiveness and fairness of private health insurance coverage, specifically:

- the extent of risk-sharing in the South African private health insurance market between funds and over time, particularly in respect of risk selection (by insurers) and adverse selection (by enrollees)
- the impact of regulatory changes in the late 1980s and early 1990s on risk selection and adverse selection.

**Data sources and methods**

Two data sources were used for this study. The first is a population-based household survey conducted annually in South Africa, the October Household Survey. It samples approximately 140 000 individuals per year, and collects data on health status, use of health services and insurance coverage. The second data-set was a three-and-a-half year panel of claims and premium data for people enrolled in over 40 different medical schemes. It allowed analysis of levels of cover chosen and premiums paid in relation to actual claims patterns.

**October Household Survey**

Only data for 1995 were available at the time of conducting the study, and we examined the determinants of health insurance cover for a single cross-sectional sample only. Many of those surveyed were from households where income was so low as to make insurance cover a complete impossibility, so households with an average income of less than 2 000 rand (US$330) per member per year, or where there were no employed persons, were excluded from the analysis. This left a sample of 73 000 individuals. Our analysis was thus conducted at the level of individuals, rather than households, and variables were added to capture how an individual’s position within the household affected his/her insurance coverage.

The Household Survey states only whether an individual was a member of a medical scheme, and not what level of cover had been obtained, or at what cost. We were thus forced to formulate a discrete-choice model, whereby the probability of taking out insurance cover was hypothesized to be a function of individual, household and environmental characteristics

\[
\text{Prob} \{\text{insurance cover}\} = \alpha + \beta'X + \epsilon
\]

where \(X\) is the vector of independent variables, \(\alpha\) and \(\beta\) represent parameters to be estimated, and \(\epsilon\) is a normally distributed random error term.
All independent variables enter the model in categorical form, despite the fact that some, such as income and age, were available as continuous variables. This was done primarily to allow non-linear effects where no specific functional form was predicted by theory. Each of the independent variables is described below, together with its hypothesized relationship to insurance coverage.

**Age group:** If adverse selection predominates in the insurance market, we would expect relatively low levels of cover for young adults, and higher levels of cover as age and hence risk of illness increases, other factors being equal. If, on the other hand, risk selection by insurers is prominent, we would expect the opposite, with higher levels of cover for the young. (Although young children also have high costs, individuals from this age group would not be purchasing cover themselves.)

**Gender:** Gender biases in employment and compensation practices may ensure that men are offered insurance cover by employers, whereas women are expected to receive cover via their spouses. Alternatively, women and men may have differing levels of risk aversion, and hence insurance demand.

**Marital status:** We hypothesize that adult household members would be most likely to cover both themselves and their partners when in a stable marriage relationship.

**Household income:** Empirical evidence suggests that the demand for health care increases with increasing income, and we would thus predict increasing levels of health insurance coverage. Furthermore, the tax-exempt status of medical scheme premiums is a greater inducement for those in higher marginal tax bands.

**Discharged from hospital in the last month:** Hospital discharge within the last month is taken as an indicator of the prevalence of serious, but possibly predictable, ill-health. If this were associated with higher probability of cover, it could suggest adverse selection, assuming that hospital admission is not significantly affected by moral hazard.

**Illness in the last month:** Similarly, if higher levels of self-reported illness were associated with a greater probability of insurance cover, then this would indicate adverse selection, and the converse would imply risk selection on the part of insurers. Self-reported illness itself is unlikely to be influenced by the existence of insurance cover, and moral hazard would thus not explain this association.

**Injury in the last month:** Since injury is generally completely unpredictable, demand for health insurance should not be associated with injury, even if adverse selection or risk selection exist. If a positive association were found between both illness and injury, on the one hand, and probability of cover, on the other, then this would suggest that adverse selection is not the cause, and a third, missing variable is probably responsible.

**Permanent disability:** The same expectations as for illness and hospital
admission would apply, except that we would expect permanent disability to be more easily observed by insurers than probability of acute illness or hospital admission in an otherwise well person. Consequently, we would hypothesize that the risk-selection effect would override the adverse-selection effect for disabled persons, and we would thus expect an inverse relationship between disability and probability of cover.

**Relationship to head of household:** Many households include more than a single nuclear family. We hypothesize that those who are spouses or children of the head of the household will have a greater probability of being included in insurance cover than parents, grandparents, other relatives, or unrelated household members.

**Racial group:** Because of historic inequities, prejudice on the part of employers and lower levels of demand for western medical care, we would expect insurance cover to be more frequent amongst whites, other factors being equal.

**Distance to the nearest health facility:** We hypothesize that demand for health insurance will diminish as individuals have poorer access to health facilities from which they could expect health care services.

**Head of household present:** Where the head of a household is a migrant worker, absent for most of the year, we hypothesize that levels of cover for the household will be lower, because of the logistical difficulties involved in membership of a distant insurance fund.

**Student status:** Most medical schemes allow grown-up children to remain as dependent members of their parents’ fund for as long as they are studying, but once this has ended, they are required to join in their own right. We would thus expect a higher probability of cover for those studying.

**Employment status:** Health insurance cover in South Africa is primarily obtained through employment, and self-employed people would typically be charged a higher premium, or have difficulty obtaining cover at all (at least in part because of the greater likelihood of adverse selection). We would thus expect formally employed persons to have higher levels of cover than the self-employed.

The model was specified as a probit model, and used a maximum likelihood estimation procedure. The PROC CATMOD facility in the SAS statistical software system was used for computation (SAS Institute, 1994).

### Medical scheme enrollee data

The analysis examined medical scheme premiums paid at the family level, how these changed over time, their relationship to characteristics of the families concerned, and the underwriting practices of the fund. The data thus allowed analysis of the type of cover purchased (and hence willingness to pay for cover) across a range of possible explanatory characteristics. Data were obtained for
the period January 1995 to June 1998 for 42 medical plans administered by a single administrator. Most of these were closed funds.

It was hypothesized that the premium paid is a function of intrinsic family characteristics (age, income and race of the principal member, number of dependants), historic health care usage (from claims history), fund characteristics and the year of study. The premium paid per family member per month was regressed against the following set of explanatory variables.

**Benefits claimed per member per month:** We used actual claims to proxy ex ante expectation of claiming. We would expect the coefficient on this variable to have a positive sign, under the assumption that those with an expectation of higher claims costs will be willing to pay higher premiums for cover. This variable essentially captures the effect of adverse selection on demand for health insurance, and the coefficients on the remaining variables thus represent the determinants of pure risk aversion.

**Risk selection index:** If the risk of claiming were entirely predictable and could be incorporated into price, then the loss ratio (claims:premiums) would equal 1 for all families, administrative costs and insurer profits aside. As there is an increase in the proportion of random or unpredictable claims, adverse selection decreases, or an insurer puts less effort into underwriting, so the correlation between benefits and claims is likely to weaken for individual families. We have thus calculated a risk-selection index for each of the 42 plans studied for each year of study, using the bivariate Pearson correlation coefficient between total claims and total benefits at the family level for that fund. If we assume that the theoretical potential to predict claims is the same for all funds, then the correlation between claims and benefits is probably a good marker of the degree to which they practise risk selection, or are affected by adverse selection. Since historical information would be used for future risk selection, the strongest correlation should be between claims in year t and premiums in year t+1. Unfortunately, this approach eliminated one year from our already somewhat short panel of three and a half years, so contemporaneous data were used. Figure 1 shows the risk selection index for open and closed schemes for the four study years. The index increases for both open and closed schemes over the study period, but is consistently higher for open schemes (between two and seven percentage points), as would be expected.
If families are unwilling to pool risks, we would expect them to be willing to pay higher premiums for non-risk-pooled insurance than for pooled insurance, after adjustment for the risk status of the family concerned. This thus constitutes a further adjustment for adverse selection at the whole-fund level, rather than the individual level. The hypothesis is that individuals will be willing to pay more for cover in a fund where the fund as a whole requires less risk pooling (i.e. the risk-selection index is higher).

**Open versus closed schemes:** After adjusting for risk-selection and adverse-selection effects, we would expect lower premiums in the closed-fund market, primarily because of lower administrative and sales costs. Closed funds typically have minimal sales costs, and where there are purchasing decisions, these tend to be made by large companies with significant negotiating power. Closed funds also have minimal underwriting requirements, since premiums are typically community-rated, and lower administration costs, since their membership churns at a lower rate than that of open schemes.

**Year:** A year dummy adjusts for system-wide changes in demand for health insurance over the period studied. This might capture a variety of additional factors, such as changes in the relative preference for private as opposed to public health care, the (delayed) effect of regulatory changes, and changes in the employment market.

**Age of principal member:** We would hypothesize that the degree of risk aversion, and hence the demand for insurance, would differ for different age groups. We have no evidence to suggest the shape of this relationship, but suspect that demand would be greatest during a person’s economically active years because of the greater financial impact of ill-health at this stage.

**Income:** As income increases, we would expect demand to become less
elastic, as the relative importance of price of cover diminishes. There is also strong ecological evidence that societies spend a greater proportion of their income on health care as they become richer, and we would hypothesize that increasing income has a positive coefficient with regard to willingness to pay for insurance cover. The administrator from whom data was acquired did not provide information on the absolute levels of income per family, but we were able to allocate most families to one of 10 income bands, based on the salary of the principal member.

**Number of dependants/special dependants:** Demand for health insurance is likely to be greatest where there is least pre-insurance risk pooling, i.e. the single-person family. As families get larger, there is a greater likelihood that other family members will be able to support a sick family member, and hence obviate the need for insurance cover. Consequently, we would expect large families to have lower levels of cover.

**Race:** Historical and cultural factors are likely to have led to higher levels of demand for health insurance amongst white, advantaged groups than previously disenfranchised black, coloured and Asian racial groups. This is likely to be due to lower health care expectations amongst formerly disadvantaged groups, as well as relatively greater satisfaction with the alternative to private medical insurance, i.e. public-hospital-based care.

Since the dependent variable (premium paid) is adjusted for claims levels (both current and past), the model estimated pure demand for health insurance, purged of adverse-selection effects. It thus allows assessment of the relative willingness to pay for open or closed fund cover, as well as the relative appeal of funds with high and low levels of risk selection. Implicitly, a demand model of a system where costs = premiums also captures the cross-subsidies that occur within the closed system. Someone who values insurance highly is likely to pay more than the actuarially fair price, and someone for whom insurance is less valued will pay less, other factors being equal. Consequently, a cross-subsidy occurs from those with an inelastic demand for health care to those with an elastic one.

A simple linear model was estimated using SAS PROC GLM and an ordinary-least-squares (OLS) estimator.

**Results**

Partial regression coefficients for the population discrete choice cross-sectional model, using Household Survey data, are shown in Table 3 below. All explanatory variables are categorical. The coefficients should thus be interpreted as the difference in premium paid per person per month associated with a shift from the reference category to the category concerned.

---

1Special dependants are non-child dependants and are typically grandparents living within the same household.
## Table 3. Partial regression coefficients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Estimate</th>
<th>Std Err</th>
<th>Chi-Square</th>
<th>Pr&gt;Chi</th>
</tr>
</thead>
<tbody>
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<td>Intercept</td>
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<td>0.167</td>
<td>4.3</td>
<td>0.0377</td>
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<td>Age group</td>
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<td>0.093</td>
<td>224</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>1-4 years</td>
<td>1.351</td>
<td>0.083</td>
<td>265</td>
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</tr>
<tr>
<td></td>
<td>5-14 years</td>
<td>1.091</td>
<td>0.083</td>
<td>175</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>15-24 years</td>
<td>0.819</td>
<td>0.082</td>
<td>101</td>
<td>0.0001</td>
</tr>
<tr>
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<td>25-44 years</td>
<td>0.697</td>
<td>0.079</td>
<td>78</td>
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</tr>
<tr>
<td></td>
<td>45-59 years</td>
<td>0.532</td>
<td>0.079</td>
<td>46</td>
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</tr>
<tr>
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<td>60-74 years</td>
<td>0.172</td>
<td>0.080</td>
<td>5</td>
<td>0.0308</td>
</tr>
<tr>
<td></td>
<td>75+ years (reference)</td>
<td>0.000</td>
<td>0.000</td>
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<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>-0.021</td>
<td>0.014</td>
<td>373</td>
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</tr>
<tr>
<td></td>
<td>Female (reference)</td>
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<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
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<td>0.027</td>
<td>224</td>
<td>0.0001</td>
</tr>
<tr>
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<td>Cohabiting</td>
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<td>0.044</td>
<td>159</td>
<td>0.0001</td>
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<tr>
<td></td>
<td>Divorced</td>
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<td>0.043</td>
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<td>Widow/widower</td>
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<tr>
<td></td>
<td>Married (reference)</td>
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<td>0.000</td>
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<td></td>
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<tr>
<td>Income category*</td>
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<td>0.102</td>
<td>180</td>
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<tr>
<td></td>
<td>5 000-10 000</td>
<td>-0.779</td>
<td>0.102</td>
<td>58</td>
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<td></td>
<td>10 000-20 000</td>
<td>-0.275</td>
<td>0.102</td>
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<tr>
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<td>20 000-30 000</td>
<td>-0.010</td>
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<tr>
<td></td>
<td>30 000-50 000</td>
<td>0.080</td>
<td>0.103</td>
<td>1</td>
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<td>50 000-75 000</td>
<td>-0.058</td>
<td>0.109</td>
<td>0</td>
<td>0.5951</td>
</tr>
<tr>
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<td>75 000-100 000</td>
<td>-0.133</td>
<td>0.125</td>
<td>1</td>
<td>0.2857</td>
</tr>
<tr>
<td></td>
<td>100 000-200 000</td>
<td>-0.170</td>
<td>0.117</td>
<td>2</td>
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</tr>
<tr>
<td></td>
<td>&gt;200 000 (reference)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged from hospital in last month</td>
<td>Yes</td>
<td>0.169</td>
<td>0.046</td>
<td>14</td>
<td>0.0002</td>
</tr>
<tr>
<td>Illness in last month</td>
<td>Yes</td>
<td>0.191</td>
<td>0.021</td>
<td>85</td>
<td>0.0001</td>
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<tr>
<td>Injury in last month</td>
<td>Yes</td>
<td>-0.007</td>
<td>0.052</td>
<td>0</td>
<td>0.8977</td>
</tr>
<tr>
<td>Permanent disability</td>
<td>Yes</td>
<td>-0.115</td>
<td>0.032</td>
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</tr>
<tr>
<td>Relationship to head of household</td>
<td></td>
<td>654</td>
<td>0.000</td>
<td></td>
<td></td>
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<tr>
<td>Head</td>
<td></td>
<td>0.571</td>
<td>0.063</td>
<td>83</td>
<td>0.0001</td>
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<td>Partner of head</td>
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<td>0.567</td>
<td>0.065</td>
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<tr>
<td>Son/daughter</td>
<td></td>
<td>0.401</td>
<td>0.062</td>
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<tr>
<td>Parent</td>
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<td>0.405</td>
<td>0.089</td>
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<td>Grandparent</td>
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<td>0.410</td>
<td>0.148</td>
<td>8</td>
<td>0.0056</td>
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<td>Grandchild</td>
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<td>-0.187</td>
<td>0.068</td>
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<td>Brother/sister</td>
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<td>0.184</td>
<td>0.075</td>
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<td>0.0139</td>
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<tr>
<td>Other relative</td>
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<td>0.051</td>
<td>0.071</td>
<td>1</td>
<td>0.4681</td>
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<td>Unrelated person (reference)</td>
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<td>0.000</td>
<td>0.000</td>
<td></td>
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</tr>
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<td>Racial group</td>
<td>Black African</td>
<td>-0.917</td>
<td>0.018</td>
<td>2709</td>
<td>0.0001</td>
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<tr>
<td></td>
<td>Mixed race/coloured</td>
<td>-0.638</td>
<td>0.021</td>
<td>958</td>
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<tr>
<td></td>
<td>Asian</td>
<td>-0.798</td>
<td>0.025</td>
<td>997</td>
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<tr>
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<td>White (reference)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance to nearest health facility</td>
<td>&lt;1 km</td>
<td>0.233</td>
<td>0.015</td>
<td>235</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>1-5 km</td>
<td>0.220</td>
<td>0.014</td>
<td>248</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>&gt;5km (reference)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head of household present</td>
<td>Yes</td>
<td>-0.016</td>
<td>0.022</td>
<td>1</td>
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<td>Student status</td>
<td>Yes - full time</td>
<td>0.305</td>
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<td>176</td>
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<tr>
<td></td>
<td>Yes - part time</td>
<td>0.282</td>
<td>0.048</td>
<td>34</td>
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</tr>
<tr>
<td></td>
<td>No (reference)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>Unemployed</td>
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<td>0.075</td>
<td>0</td>
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<tr>
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<td>Formally employed</td>
<td>0.261</td>
<td>0.073</td>
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<td>0.0003</td>
</tr>
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<td>Self-employed</td>
<td>-0.553</td>
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<td>51</td>
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<tr>
<td></td>
<td>Both self-empl. &amp; formally empl. (reference)</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Income per household member/year in rand.
Probability of insurance cover decreased significantly with increasing age, indicating that older persons had poorer access to health insurance cover, other factors being equal. Given their higher likelihood of ill-health, this is unlikely to be a function of different preference, and is highly suggestive of risk selection by insurers against the elderly in the insurance market. All age effects were significantly greater ($p<0.05$) than the reference category (75+ years). No significant gender effect on health insurance cover was detected. Married people were significantly more likely to have cover than widowed, divorced, unmarried or cohabiting persons. In terms of household income, a distinct nonlinear effect was evident, with significant income elasticity of demand at lower income levels (2 000-20 000 rand per household member per year), but there was no significant income effect above this income level.

Discharge from hospital and self-reported illness in the last month were associated with significantly higher probabilities of insurance cover. Combined with the fact that the coefficient on the acute injury term (i.e. nonpredictable events) was nonsignificant, this suggests that adverse selection with regard to pre-existing or predictable illnesses does exist in the South African health insurance market. The negative coefficient on the permanent disability term indicates that with long-standing, permanent illnesses, risk selection on the part of insurers probably exists.

Within households, the head of the family and his/her spouse had the highest probability of insurance cover, followed by their children, parents and grandparents. Grandchildren, brothers and sisters, other relatives and persons unrelated to the head had low relative probability of insurance cover. Racial-group effects were very marked, even after adjustment for income, with Asian, coloured and black African respondents having significantly lower probability of cover than whites. Those living within five kilometres of the nearest health facility were also significantly more likely to have insurance cover. The presence or absence of the head of the household did not predict probability of cover, but both full-time and part-time students were more likely to have cover than their nonstudying counterparts. Formally employed persons had higher levels of cover, and self-employed persons lower levels of cover, than nonemployed persons or those with a mixture of formal and self-employment.

Table 4 shows the pure risk-aversion demand model estimated on medical scheme enrollee data.
As expected, both the risk-selection index and the open-scheme dummy variable had significantly positive signs, indicating an overall preference by consumers for non-risk-pooled cover. The relationship between premiums paid and benefits is also significantly positive, although substantially less than 1. This suggests that expectation of claims levels is likely to influence

<table>
<thead>
<tr>
<th>Table 4. Regression results for medical scheme insurance demand model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parameter</strong></td>
</tr>
<tr>
<td>Intercept</td>
</tr>
<tr>
<td>Risk-selection index</td>
</tr>
<tr>
<td>Open scheme</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Claims/person/month</td>
</tr>
<tr>
<td>Age of principal member</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dependants</td>
</tr>
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<td>Special dependants</td>
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<tr>
<td>Race</td>
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</table>

Model R-squared = 58.7%
Dependent variable — premium paid per family member per month.
willingness to pay for cover as well as the prices charged by insurers. When
the lagged value of benefits received is used as the regressor (not reported
here), the relationship becomes significantly stronger, indicating that
consumer demand and insurer pricing behaviour are influenced more by
(known) past claims experience than by future likely claims. This would
suggest a risk-selection/adverse-selection cause for the phenomenon, rather
than a moral-hazard one.

Willingness to pay for cover is highest in the 45-59-year age category for
principal members, and significantly lower for those over 75 and under 45.
Low levels of willingness to pay in the younger age groups may be simply
because this age-group is less risk-averse. For the elderly, this is unlikely to be
the case; it may instead represent the inaccessibility of cover where ex-
employers do not provide cover, and risk-rated open-scheme premiums are
unaffordable. In line with our initial hypothesis, willingness to pay for cover
appears to be higher where family size is smaller. By implication, there is likely
to be a cross-subsidy from small to large families within the fund environment.
Likewise, there is an expected positive income elasticity of demand, implying
that high-income families cross-subsidize low-income families. This is also
encouraged by the tax system, as the tax-exempt status of a portion of medical
scheme contributions will generally be larger for a higher-income earner. Even
after adjustment for utilization levels and income, whites appear significantly
more willing to pay for medical scheme cover than other racial groups. With
the exception of the final half-year studied, there appeared to be a steady
increase in the level of pure insurance demand with time. Much of this is
probably due to the perceived deterioration of free public hospital care over
the period studied.

Discussion

Many of the determinants of health insurance coverage found are consistent
with conventional insurance theory on risk pooling (Rothschild & Stiglitz,
1976), as well as the findings of similar studies in other countries (Acs, 1995,
Gertler & Sturm, 1997). There are a few exceptions, however. Acs (1995) found
that larger households were more likely to take out cover, other factors being
equal, and Gertler found nonconsistent, but generally increasing levels of cover
with increasing age. It is very difficult to make meaningful comparisons of this
sort across national boundaries, however, as regulatory changes and general
economic factors differ so much between settings.

Both analyses point to the importance of the employer role in ensuring
health cover. Closed, employer-based funds cover many people who would
probably not buy cover on the open market. They also manage to purchase
cover at significantly lower prices than would prevail in open schemes.
Evidence from another study (Söderlund & Hansl, 2000) shows that open schemes generally provide for less efficient health care spending than closed, employer schemes after adjusting for risk factors. Employer participation in medical scheme cover thus appears to increase coverage and improve equity of access and efficiency.

The relatively low levels of cover for the permanently disabled and the elderly in this study indicate that risk selection was operating with regard to “easily identifiable” risk factors, such as age and disability. At the same time, there were suggestions of adverse selection with regard to less easily identifiable medical risks. Relatively high numbers of middle-aged and elderly people who can afford an average medical scheme contribution appear not to have cover, and a large proportion of these must be forced to rely on the State in the event of serious illness. In the pure risk-aversion analysis, it is evident that medical-scheme members are willing to pay more for cover that requires less risk pooling, other factors being equal. Consequently, in shifting from community-rated to risk-rated funds, many enrollees have saved less than the difference between a pooled and actuarially fair premium, the difference generally going into more comprehensive benefits and/or higher fees to administrators (Söderlund & Hansl, 2000).

Deregulation of the medical schemes industry thus appears to have impaired health care access for high-risk individuals, as well as shifting a greater potential burden on to State health services. To reverse this, the State has, since January 2000, reregulated risk pooling via mandatory community rating and open enrolment rules. It remains to be seen how effective this will be in keeping high-risk individuals covered. Critics argue that this move will cause catastrophic adverse selection and a collapse of the medical schemes industry altogether (van der Linde, 1997). Given the fact that deregulation brought about only modest decreases in adverse selection anyway, this seems somewhat alarmist. Furthermore, studies from elsewhere suggest that severe and irreversible adverse-selection phenomena rarely, if ever happen in practice (Buchmueller & DiNardo, 1999).

Three possible solutions for adverse selection have been suggested for South Africa, the first two of which have been included in the 2000 revision of the South African Medical Schemes Act. Firstly, reforms might be introduced which allow insurers to penalize adverse selection without excluding members on the basis of health risk. These include late-age-joining penalties and waiting periods before benefits can be claimed. A second, relatively simple approach requires tax deductibility of medical scheme contributions to be extended to the self-employed, for whom coverage levels are low and adverse selection common. A third, more extensive reform would involve mandatory basic insurance cover for all of those earning above a certain level. The social health insurance (SHI) plan mooted by the Department of Health is such an intervention, where adverse selection is eliminated by removing the choice
whether or not to take out private health insurance (Department of Health, 1995, 1997).

This and other work has pointed to significant unravelling of insurance risk pools in South Africa during the 1990s, with consequent loss of cover for high-risk groups, cost escalation and an increasing burden on the State. While there have probably been a number of causes, deregulation of the industry in the late 1980s is likely to have been a major contributing factor. Deregulation appears to have decreased cover for the chronically ill, without significantly improving the problem of adverse selection. Recent regulatory reforms aim to improve access to cover for all, while also decreasing selective joining behaviour at time of illness. They are complex to administer, however, and require significant regulatory monitoring effort. Further study is needed to assess the effectiveness of the reforms introduced.

References


7. Mapping health insurance in Thailand - directions for reform

Viroj Tangcharoensathien¹, Siriwan Pitayarangsarit, Samrit Srithamrongswat

Introduction

A policy of charging for drugs and medical services in public-sector health facilities has been in place in the Thai health system since 1945. An informal exemption mechanism for the poor, at the discretion of the health worker, was implemented in parallel with user charges. Informal exemption has gradually evolved into a systematic means-tested exemption scheme. A low-income card has been issued every three years since 1981 to households living below a defined poverty line.

Government employees and their dependants (parents, spouse and children) have been quite generously provided with medical care coverage. A pre-existing Employer Liability/Workmen’s Compensation Scheme for work-related illness or injury and compensation on death was the foundation for the recent development of a tripartite social insurance scheme for formal-sector private employees covering non-work-related illness, maternity, disability and compensation on death. Finally, a voluntary community-based health insurance scheme has now evolved into a voluntary subsidized health card. Voluntary private insurance has long existed in Thailand to provide cover for the wealthy.

Different areas of social protection have thus developed at different paces, and the resulting health insurance schemes vary significantly in terms of benefit package, provider-payment methods, financing sources, level of government subsidy, efficiency and quality of care. However, by 1996, 37% of the population were still uninsured. Current policy discussions focus on increasing efficiency, reducing inequity within the insured population and extending coverage to the entire population.

This paper describes some important public insurance schemes, highlighting their salient characteristics and weaknesses. We address the public/private mix issue in terms of service provision for beneficiaries under different insurance schemes, notably the social insurance scheme, which

¹ Correspondence to Viroj Tangcharoensathien.
adopted the contract model for the purchase of care from both public and private health care providers. Valuable lessons have been drawn from the public and private providers’ behavioural responses to different payment methods, especially fee-for-service and capitation. This paper also explores the characteristics of the uninsured. On the basis of these analyses, we recommend reforms designed to achieve greater efficiency, equity and universal coverage.

Health insurance schemes

We classified various health insurance schemes into four groups by their nature and main objectives:

- Social Welfare Scheme (SWS) – this scheme provides free medical care for the poor, the elderly, children under 12 and the disabled.
- Civil Servant Medical Benefit Scheme (CSMBS) – provided as a fringe benefit for government employees and their dependants
- compulsory social insurance – Social Security Scheme (SSS) and Workmen’s Compensation Scheme (WCS)
- voluntary schemes – government Health Card Scheme (HCS) and private health insurance.

The basic characteristics of each scheme are summarized in Table 1. In 1996, 37% of the total population of 60 million people were not covered by any scheme, and almost 30% were covered by the Social Welfare Scheme (Table 2).
Table 1. Characteristics of health insurance and welfare schemes in Thailand, 1999

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Social Welfare Scheme</th>
<th>Civil Servant Medical Benefit Scheme</th>
<th>Social Security Scheme</th>
<th>Workmen's Compensation Scheme</th>
<th>Health Card Scheme</th>
<th>Private insurance</th>
<th>Uninsured persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scheme nature Model</td>
<td>Social welfare Public integrated model</td>
<td>Fringe benefit Public reimbursement model</td>
<td>Compulsory Public contracted model</td>
<td>Compulsory Public reimbursement model</td>
<td>Voluntary Voluntary integrated model</td>
<td>Voluntary Voluntary reimbursement model</td>
<td>Not applicable Voluntary out-of-pocket model</td>
</tr>
<tr>
<td>Population (millions)</td>
<td>17.7</td>
<td>7.62</td>
<td>3.30</td>
<td>Same population as SSS</td>
<td>7.92</td>
<td>0.72</td>
<td>22.08</td>
</tr>
<tr>
<td>% of total population in 1996</td>
<td>29.5% (poor 12.3%, elderly 3.5%, children under 12 13.7%)</td>
<td>12.7% (CSMBS 11.3%, State enterprise 1.4%)</td>
<td>5.5%</td>
<td>(5.5%)</td>
<td>13.2%</td>
<td>1.2%</td>
<td>36.8%</td>
</tr>
<tr>
<td>3. Benefit package</td>
<td>Ambulatory services</td>
<td>Only public designated</td>
<td>Public only</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public (MOPHI)</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Public only</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public (MOPHI)</td>
<td>Mainly private hospitals chosen free choice</td>
</tr>
<tr>
<td></td>
<td>Choice of provider</td>
<td>Referral line</td>
<td>Free</td>
<td>Contracted hospital or its network</td>
<td>Free</td>
<td>Referral line</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Cash benefit</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Conditions included</td>
<td>All</td>
<td>All</td>
<td>Non-work-related illness, injuries</td>
<td>All</td>
<td>Work-related illness, injuries</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Conditions excluded</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Maternity benefits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Annual physical check-up</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Prevention, health promotion Services not covered</td>
<td>Very limited</td>
<td>Yes</td>
<td>Health education, immunization</td>
<td>No</td>
<td>Possible</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private bed, special nurse, eyeglasses</td>
<td>Special nurse</td>
<td>Private bed, special nurse</td>
<td>No</td>
<td>Private bed</td>
<td>Depends on package</td>
</tr>
<tr>
<td>4. Financing</td>
<td>Source of funds</td>
<td>General taxation</td>
<td>General taxation</td>
<td>Tripartite (Government, employers, employees each pay in 1.5% of payroll)</td>
<td>Employer, 0.2-2% of payroll with experience rating</td>
<td>Household 500 baht + tax 500 baht</td>
<td>Household</td>
</tr>
<tr>
<td></td>
<td>Financing body</td>
<td>Ministry of Public Health Global budget</td>
<td>Ministry of Finance</td>
<td>SSO</td>
<td>Ministry of Public Health</td>
<td>Private insurance companies</td>
<td>Fee-for-service at point of service</td>
</tr>
<tr>
<td></td>
<td>Payment mechanism</td>
<td>Fee-for-service</td>
<td>Capitation</td>
<td>Fee-for-service</td>
<td>Limited fee-for-service</td>
<td>Fee-for-service with ceiling</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Copayment</td>
<td>No</td>
<td>Yes: IP at private hospitals</td>
<td>Maternity emergency services</td>
<td>Yes if beyond the ceiling of 30 000 baht</td>
<td>Yes if beyond the ceiling</td>
<td>Yes if beyond the ceiling</td>
</tr>
<tr>
<td></td>
<td>Expenditure per capita 1996 (baht)</td>
<td>&gt;280 + additional cross subsidy by public hospitals</td>
<td>1 778</td>
<td>1 428</td>
<td>182</td>
<td>534 + (additional subsidy by public hospitals)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Tax subsidy per capita (1996)</td>
<td>280</td>
<td>1 778</td>
<td>476</td>
<td>Admin cost of WCS office</td>
<td>125</td>
<td>0</td>
</tr>
</tbody>
</table>

The Organization for Economic Cooperation and Development has categorized the relationships between key players in health care (beneficiaries, health care purchasers and health care providers) into a useful seven-model framework (OECD, 1994). These are voluntary out-of-pocket, voluntary and compulsory (public) reimbursement model, voluntary and compulsory contract model, and voluntary and compulsory integrated model. Based on the seven OECD models, we have categorized the six insurance schemes in Thailand and the uninsured population into several models (Table 3). Our evidence concerning the strengths and weaknesses of each scheme was quite similar to the OECD analysis of the seven models.

The Organization for Economic Cooperation and Development has categorized the relationships between key players in health care (beneficiaries, health care purchasers and health care providers) into a useful seven-model framework (OECD, 1994). These are voluntary out-of-pocket, voluntary and compulsory (public) reimbursement model, voluntary and compulsory contract model, and voluntary and compulsory integrated model. Based on the seven OECD models, we have categorized the six insurance schemes in Thailand and the uninsured population into several models (Table 3). Our evidence concerning the strengths and weaknesses of each scheme was quite similar to the OECD analysis of the seven models.
Insured population

This section gives a brief description of each insurance scheme and its particular strengths and problems. A thorough understanding of these schemes will help in the design of a system of universal coverage. Private insurance was excluded from our analysis. It covers a small fraction of the population (1.2%) and operates by a conventional fee-for-service payment method. Administrative costs are high and insurers cannot effectively prevent fraud and overcharging by providers. Risk-rated premiums usually exclude high-risk enrollees, and private insurance is thus fundamentally at odds with the objectives of societal equity.

Social Welfare Scheme

Historical evolution

The Social Welfare Scheme, established in 1975, was intended to ensure access to health care for poor families. Initially, the government allocated a budget to public hospitals to provide free care for households whose monthly income was below 1 000 baht, at the staff’s discretion. The first official issue of the Low Income Card (LIC) was in 1981. A card was valid for three years and could be renewed after verification of income. Evaluation of the 1981 cards issued by district governors found that they were not properly targeted: the poor were not adequately covered, while some non-poor held cards. Though community participation helped to identify the real poor, the same problem was found for cards issued for the period 1987-90. In 1994, the government expanded the Social Welfare Scheme to cover other underprivileged groups: the elderly (aged over 60 years and not covered by any other scheme), children under 12 years, the disabled, army veterans and monks.

Population coverage

Coverage increased rapidly when the scheme was extended to cover the elderly and children under 12. By 1996, some 30% of the population was covered. The expansion of the scheme during the Seventh National Health Plan (1992-96) accounted for 71% of the increase in insurance coverage in the period 1991-95.

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1 The monthly household income of 1 000 baht (40 US$ at 25 baht/US$) was the threshold for the issuing of a free medical care card. The poverty-line figure at the time was 2 800 baht per month for a family or 2 000 for a single person.

2 By September 1999, the number of people registered under the scheme was approximately 20 million.
Benefit package and trends
The scheme provides free care at public facilities. All beneficiaries are required
to register at a Ministry of Public Health medical institution. A comprehensive
package of ambulatory services and hospital care is guaranteed by the scheme.
It excludes other services, e.g. private hospital room or special nursing, and a
referral letter is required for access to care outside registered facilities.
The following 15 conditions are excluded from the benefit package:

1. Cosmetic surgery
2. Dentures
3. Synthetic lenses and eyeglasses
4. Medical appliances unless deemed necessary
5. Infertility treatment
6. Artificial insemination
7. Sex-change operations
8. Organ transplantation
9. Experimental treatments without proven benefits
10. Preventive measures which the Ministry of Public Health
    Communicable Disease Control Department deems
    nonessential services
11. Haemodialysis for chronic end-stage renal disease
12. Self-inflicted injuries, e.g. criminal abortion or suicide
13. Specialized hospital care without a proper referral letter
14. Traffic accidents (paid for by insurance companies under the
    Traffic Accident Protection Act)
15. Nonclinical services for personal convenience, e.g. private room
    and board, air-conditioned accommodation.

Similar exclusion lists are used by the Social Security Scheme and the Health
Card Scheme. The rationale behind the list is to enforce the referral system
and ensure coverage for essential services, while avoiding the costs of
financially catastrophic cases, such as end-stage renal failure.

Sources of financing
The scheme is financed by general taxation through an annual global budget
allocation to hospitals and health centres. An agreement on unit costs between
the Ministry of Public Health and the Bureau of Budget was reached in 1997, but has not been revised since then. In 1996, the budget subsidy was 280 baht per capita per year. However, the total budget for the scheme increased steadily from 2 500 million baht in 1992 to 8 841 million baht in 1999 (Health Insurance Office, 1996, 1999). Significant increases were observed during the periods 1993-94 and 1997-99 because of the increasing numbers of beneficiaries. The per capita budget subsidy of 280 baht for the poor is significantly lower than for other schemes, such as the CSMBS and Social Security Scheme. Public hospitals thus have to cross-subsidize Social Welfare Scheme patients with revenue from other schemes, such as the CSMBS.

Payment methods

There are two levels of budget allocation. Firstly, funds are allocated from the Ministry to the provinces using a regression formula (throughputs in previous years in terms of numbers of outpatient visits and admissions and numbers of registered beneficiaries). Budget allocations to health centres and district and provincial hospitals within a province are decided by the Provincial Committee. However, the criteria for intraprovincial allocation are demand characteristics and utilization levels.

Utilization

Beneficiaries of the Social Welfare Scheme had higher rates of illness per capita and used more services in public facilities than others (National Statistical Office, 1996). They had almost the highest admission rates, and their health status was poorer than that of the general population (Table 4, Table 5).

Table 4. Illness rates and use of outpatient services (visits per capita per year), 1996

<table>
<thead>
<tr>
<th></th>
<th>Self-reported illness (episodes per capita per year)</th>
<th>Service utilization (visits per capita per year)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Perceived ill</td>
<td>Perceived ill with absence from work</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Social Welfare Scheme</td>
<td>6.9</td>
<td>2.5</td>
</tr>
<tr>
<td>CSMBS</td>
<td>3.7</td>
<td>1.0</td>
</tr>
<tr>
<td>State enterprises</td>
<td>3.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Social Security Scheme</td>
<td>2.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Health card</td>
<td>4.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Private insurance</td>
<td>3.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Total population</td>
<td>4.0</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Problems

Some significant problems were identified with the Social Welfare Scheme. Targeting the poor is difficult, owing to seasonal variations in income and underreporting of income by households. Non-card-holders who cannot afford their medical bills may be fully or partially exempted from payment on a sliding scale at the discretion of hospital social workers. The problem remained, although to a lesser extent, when the community participated in identifying poor households. The expansion of the programme to cover children and the elderly is controversial, since some members of these groups come from rich families where public subsidies are inappropriate. There are also the problems of underfinancing, inappropriate allocations to hospitals and the nature of the public integrated model, in which salaried public health workers are less responsive to patient needs. An opinion survey among card-holders showed no evidence of low consumer satisfaction, probably owing to lower expectations among the poor (Health Insurance Office, 2000).

Reform efforts

The Ministry of Finance and the Ministry of Public Health began to reform the social welfare system in 1998. Unfortunately, the reform focuses only on financial management of the scheme, such as improving accountability, decentralizing management of funds, increasing the transparency and equity of budget-setting and strengthening the primary care network. Two important problems still remain: targeting the poor and the weakness of the public integrated model.

Scheme management (means-testing and registration, fund allocation within the province) was decentralized from the Ministry of Public Health to the provincial committees, consisting of various stakeholders including the media and public representatives. The budget is allocated to provinces

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Table 5. Annual admission rate per capita per year by type of hospital and insurance coverage, 1996

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Admission rate (per capita per year)</th>
<th>District %</th>
<th>Provincial %</th>
<th>Private %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>0.04</td>
<td>31</td>
<td>46</td>
<td>22</td>
</tr>
<tr>
<td>Social Welfare Scheme</td>
<td>0.10</td>
<td>45</td>
<td>48</td>
<td>6</td>
</tr>
<tr>
<td>CSMBS</td>
<td>0.08</td>
<td>22</td>
<td>53</td>
<td>24</td>
</tr>
<tr>
<td>State enterprises</td>
<td>0.06</td>
<td>7</td>
<td>33</td>
<td>59</td>
</tr>
<tr>
<td>Social Security Scheme</td>
<td>0.05</td>
<td>9</td>
<td>42</td>
<td>48</td>
</tr>
<tr>
<td>Health card</td>
<td>0.08</td>
<td>43</td>
<td>49</td>
<td>6</td>
</tr>
<tr>
<td>Private insurance</td>
<td>0.15</td>
<td>9</td>
<td>19</td>
<td>72</td>
</tr>
<tr>
<td>Total population</td>
<td>0.06</td>
<td>33</td>
<td>47</td>
<td>19</td>
</tr>
</tbody>
</table>

according to the number of registered beneficiaries, adjusted by age. This replaces the current formulae of throughput and numbers of registry. A reinsurance premium of 2.5% of the budget is deducted from the total, held by the Ministry of Public Health and earmarked to pay for high-cost care and some special services (Srithamrongsawat, 1998).

**Civil Servant Medical Benefit Scheme**

**Historical evolution**

Government officers were the first group of formal-sector employees to obtain employment-based health insurance, long before the social insurance developments of the early 1990s. Historically, medical cover was granted as part of fringe benefits in compensation for a generally low salary scale. This ideology explains the noncontributory nature of the scheme. The first Royal Decree, promulgated in 1980, provided equal benefits for officers of all ranks, replacing previous rules and regulations whereby higher-rank officials got better benefits.

**Population coverage**

This fund generously covers current public-office holders and their dependants, including parents, spouses and up to three children under 20 years of age. It also covers retired employees and their dependants (medical insurance covering dependants has been one of the key incentives keeping people in low-paid public-sector jobs). Unlike other schemes, where beneficiary registration was well developed, there is no database of beneficiaries or identification card. The entitlement of a beneficiary is verified by responsible officers in each government agency. Expenditure increased at a very high rate, 14% in real terms per annum during the period 1988-97, even though the number of government employees had not increased and average household size had decreased slightly. The growth in expenditure was probably mainly due to increases in utilization and higher unit costs of care (Figure 1).

---

1The criterion for high-cost care is a patient with a diagnosis related group (DRG) weighting of more than 2.5.
Benefit package

The scheme covers both ambulatory and inpatient care quite generously. Only ambulatory care sought from public providers, not private clinics and hospitals, is reimbursed. Inpatient care provided by public hospitals is almost completely covered, with minor limitations on items such as private room and board at 600 baht (US$24 at 25 baht to 1 US$) and some medical appliances. A copayment of approximately 50% has been enforced for private inpatient care (Tangcharoensathien et al., 1993). In 1998, during the economic downturn, the scheme introduced a number of additional stringency measures; beneficiaries had to pay for nonessential drugs and private room and board for hospital stays over 13 days. Access to private inpatient care was terminated altogether, except for life-threatening accidents and emergencies (Pitayarangsarit et al., 1999).

Sources of financing and payment methods

The CSMBS is a noncontributory scheme totally financed by general tax revenue through the Comptroller-General’s Department of the Ministry of Finance. The scheme reimburses beneficiaries for outpatient care and private inpatient care, but pays public hospitals directly for inpatient care on a fee-for-service basis.

As a result of the fee-for-service payment method, and weak monitoring by the Ministry of Finance, underfinanced public hospitals have an incentive to overcharge in order to cross-subsidize the Low Income Scheme. When there are no copayments, beneficiaries are not cost-conscious. There is evidence that
they demand unnecessary and expensive brand-name drugs and stay longer in hospital than the general population (Tangcharoensathien et al., 1993). Private hospitals have abused the system by overcharging and false claims (e.g. reclassifying nonreimbursable ambulatory care as reimbursable inpatient care). These phenomena have resulted in a rapid increase in expenditure and the highest expenditure per capita to date, 2 200 baht in 1998.

Utilization

The admission rate among CSMBS beneficiaries was significantly higher than among the general population (Figure 2). In the 30-34 age group, the CSMBS admission rate, 0.142 per capita, was more than double that of the general population (0.066). The admission rate for children of CSMBS members aged 0-6 years was three times that of the general population (Tangcharoensathien et al., 1996).

When there was almost no charge for admission, the average length of stay was significantly longer, 13 days for current officials and 19 days for pensioners in public hospitals in 1992. When patients faced 50% copayments in private inpatient care, the average length of stay was 2-3 times shorter than in public hospitals, after controlling for diagnosis (Table 6). In addition, inefficient use of beds in public hospitals resulted in longer average stays (Tangcharoensathien et al., 1993).
Problems

Three major problems have been identified in the CSMBS: inefficiency, cost escalation and inequity. Inefficiency was reflected in unnecessarily longer stays, relaxation of clinical indications for admission into private hospitals (e.g. diarrhoea), and frivolous use of expensive brand-name drugs. Cost escalation was reflected in an average 14% real increase in expenditure per annum in the period 1988-97. The fact that the government provided a subsidy of 2 200 baht per capita for CSMBS and 280 baht for the Low Income Scheme posed obvious equity questions. All parties were equally responsible for the situation: public hospitals had incentives to overcharge in order to cross-subsidize their Social Welfare Scheme patients, for-profit private hospitals had profit motives and beneficiaries were not cost-conscious, since they did not have to pay the cost of their treatment. These problems were all compounded by the fact that the Comptroller-General’s Department was incapable of monitoring spending or of instituting reasonable policy interventions.

Reform efforts

Analysis of the above problems has led to a number of reforms. The Health Systems Research Institute, in collaboration with other stakeholders, such as the National Economy and Social Development Board, the Bureau of Budget, the Ministry of Finance, the Ministry of Public Health, etc., proposed a reform focusing on provider payment. A prospective contract model was proposed and adopted in a cabinet resolution in February 1998. An age-adjusted capitation formula for ambulatory care and a global budget based on a relative weighting of diagnosis related groups (DRG) for inpatient care have been planned, but not yet implemented at the time of writing. Under this contract model, public and private hospitals would compete for registered beneficiaries. A mixture of capitation and global budget arrangements was thought to offer the best potential for cost savings.

Table 6. Average length of stay in public and private hospitals, by diagnosis, CSMBS

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Public hospital</th>
<th>Private hospital</th>
<th>Public : private ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean day</td>
<td>SD</td>
<td>Mean day</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>6.42</td>
<td>6.11</td>
<td>2.33</td>
</tr>
<tr>
<td>Cataract</td>
<td>7.56</td>
<td>6.01</td>
<td>3.36</td>
</tr>
<tr>
<td>Normal childbirth</td>
<td>4.75</td>
<td>2.82</td>
<td>5.46</td>
</tr>
<tr>
<td>Diabetes</td>
<td>19.71</td>
<td>20.93</td>
<td>5.75</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>17.78</td>
<td>26.75</td>
<td>5.16</td>
</tr>
<tr>
<td>Hypertension</td>
<td>17.44</td>
<td>20.03</td>
<td>5.21</td>
</tr>
<tr>
<td>Heart disease</td>
<td>14.93</td>
<td>17.39</td>
<td>4.82</td>
</tr>
</tbody>
</table>

SD = standard deviation.
In the meantime, since the prospective contract model has not been implemented, the Ministry of Finance decided in a cabinet resolution of February 1998 to introduce copayments by beneficiaries for drugs not included in the national essential drug list, as well as fees for private room and board after 13 days’ occupancy. Assessments of the reform found significant cost savings of 8% over seven months of the interventions in 1998 (Table 7). In 1999, when the interventions took full effect, a cost saving of 21.7% was observed, mainly due to decreased inpatient expenditures. There was a 50% reduction in expenditure after the termination of private inpatient care (Pitayarangsarit et al., 1999).

Table 7. Actual and expected expenditure, CSMBS, 1995-99 (baht, 1997 prices)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual OP</td>
<td>4 163</td>
<td>4 992</td>
<td>5 625</td>
<td>5 413</td>
<td>5 477</td>
</tr>
<tr>
<td>Expected OP</td>
<td>4 141</td>
<td>5 053</td>
<td>5 586</td>
<td>5 965</td>
<td>6 259</td>
</tr>
<tr>
<td>Saving</td>
<td>-9.3%</td>
<td>-12.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual IP</td>
<td>7 531</td>
<td>9 070</td>
<td>9 878</td>
<td>9 757</td>
<td>8 041</td>
</tr>
<tr>
<td>Expected IP</td>
<td>7 545</td>
<td>9 032</td>
<td>9 902</td>
<td>10 519</td>
<td>10 998</td>
</tr>
<tr>
<td>Saving</td>
<td>-7.2%</td>
<td>-26.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total actual IP+OP</td>
<td>11 694</td>
<td>14 062</td>
<td>15 503</td>
<td>15 170</td>
<td>13 517</td>
</tr>
<tr>
<td>Expected total</td>
<td>11 685</td>
<td>14 084</td>
<td>15 488</td>
<td>16 484</td>
<td>17 256</td>
</tr>
<tr>
<td>Total saving</td>
<td>-8.0%</td>
<td>-21.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Cabinet resolution on copayments effective March 1998 (seven months of financial year 1998).
OP = outpatient, IP = inpatient.
Formulae for:
expected OP = 1 316.2Ln(yr-1994) + 4 140.5 (R² = 0.9947)
expected IP = 2 145.5Ln(yr-1994) + 7 544.8 (R² = 0.9992)
expected total = 3 461.7Ln(yr-1994) + 11 685 (R² = 0.9999).

Table 8 demonstrates the effects of copayments in an evaluation study. The average length of stay (ALOS) was significantly reduced from 6.55 days pre-intervention to 5.37 days and 4.78 days, respectively, for the first and second three-month periods post-intervention. The charge per admission in public hospitals was reduced by 28% in June-August 1998 compared with October 1997-February 1998. Reducing charges per admission and admission rates led to a reduction in total expenses (Pitayarangsarit et al., 1999).
### Table 8. Length of stay and charges (baht per admission) in public hospitals in Phitsanulok province, CSMBS, financial year 1998

<table>
<thead>
<tr>
<th></th>
<th>Public hospital</th>
<th>Private hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total IP among current officers</td>
<td>4 092</td>
<td>2 186</td>
</tr>
<tr>
<td>Admissions/month</td>
<td>818</td>
<td>729</td>
</tr>
<tr>
<td>Admissions rate per capita per year</td>
<td>0.08</td>
<td>0.07</td>
</tr>
<tr>
<td>ALOS, day</td>
<td>6.55**</td>
<td>5.37**</td>
</tr>
<tr>
<td>Charge per admission, baht</td>
<td>13 463**</td>
<td>10 907**</td>
</tr>
<tr>
<td>Total IP among pensioners</td>
<td>276</td>
<td>168</td>
</tr>
<tr>
<td>Admissions per month</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>Admission rate per capita/per year</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>ALOS, day</td>
<td>9.19</td>
<td>7.36</td>
</tr>
<tr>
<td>Charge per admission, baht</td>
<td>20 256</td>
<td>16 744</td>
</tr>
</tbody>
</table>

*Excluding private admissions.

**Statistically significant change P<0.05.

Note: Reforms have taken effect since March 1998.

### Social Security Scheme

**Historical evolution**

This scheme aims to provide health and income security for formal private-sector employees, especially for sickness, maternity, invalidity and death. In March 1991, the government, employers and employees started to contribute 1.5% of payroll each to the Social Security Fund (SSF). The scheme was phased in gradually. Four benefits were implemented in the initial phase in 1991:

- **non-work-related sickness benefits**, including cash benefits (for members with not less than three months’ contributions): there was a six-month extension for people who had lost their jobs

- **maternity benefits**, including cash benefits for members and spouses (seven-month qualifying period)

- **invalidity benefits** (three-month qualifying period)

- **funeral grant** (one-month qualifying period).

Child benefits and old-age pensions have subsequently been implemented. Unemployment benefit has yet to be introduced through a Royal Decree.

During the scheme’s inception in 1990, the Ministry of Public Health worked with the Medical Committee, evaluating the financial implications of different ways of paying for medical care. It had originally been planned that sickness benefit should cover only hospitalization and should be based on fee-for-service reimbursement, as in the Workmen’s Compensation Scheme. However, during the drafting of the Social Security Act in 1990, political pressure led to
the extension of sickness benefit to include ambulatory care, without changing the level of contributions. This, together with the Social Security Fund’s inability to cope with rising medical expenditure under fee-for-service arrangements, and lower administrative costs under capitation, led to the adoption of capitation by the fund (Tangcharoensathien & Walee-Ittikul, 1991). Single-rate capitation covers both ambulatory and inpatient services. Public and private providers were invited to provide services to registered workers. An initial 700 baht (US$28) capitation fee\(^1\) was applied to all contractor hospitals, both public and private.

**Population coverage, benefit package, sources of financing and payment methods**

In 1991, firms with more than 20 workers were required to participate in the Social Security Scheme. In 1994, the threshold was lowered to 10 employees. Compliance by both employers and employees is high, as there are fines and imprisonment for evasion. A worker’s annual contribution is income-tax deductible, and the cash benefits disbursed also enjoy a personal income-tax rebate to encourage employee compliance.

Workers are entitled to a comprehensive service package, including ambulatory and inpatient care. A similar exclusion list to that of the Social Welfare Scheme applies. Recently, workers have been given access to haemodialysis for end-stage renal failure.

According to the OECD classification, the Social Security Scheme is a “compulsory contract” model. It is the sole insurer, with compulsory, income-related, tripartite contributions; employer, employee and the government each contribute 1.5% of payroll to the Social Security Fund. Insured workers have the opportunity to change their provider once a year. There is no copayment at point of service. In this model, there is considerable potential for the achievement of microeconomic efficiency by a combination of consumer-led competition and the development of suitable incentives and regulations in the contracts between the Social Security Office and providers (Tangcharoensathien et al., 1999a). However, both are subject to information constraints (OECD, 1994).

**Utilization**

Probably owing to ignorance and a lower average education level among Social Security Scheme workers, utilization rates were low at first, but have slowly increased over time (Table 9). However, utilization rates have remained far lower than those for CSMBS beneficiaries.

\(^1\) Calculation based on three ambulatory visits and 0.5 hospitalization days per capita per year, and average costs of 150 baht per outpatient visit and 600 baht per hospital day (Tangcharoensathien & Walee-Ittikul, 1991).
Problems

The strength of the Social Security Scheme has been its capacity for cost-containment. However, the cost/quality tradeoff has subsequently become a significant problem, especially when workers have not exercised their right to choose the provider with which they register (Mills et al., 2000). When workers do choose a contractor hospital, they are unlikely to have full information about the clinical quality of care to aid their choice.

Insurance coverage is linked with employment and terminates when employment ceases. This problem became evident during the economic crisis in mid-1997, when many workers were laid off. The inability to carry over insurance cover is the main obstacle to sustainable universal coverage, even among formal-sector private employees.

Reform efforts

This scheme has the highest potential for extending the coverage of health benefits, especially to spouses and dependants, with a minimal additional contribution requirement. In addition, the scheme has the potential to extend coverage to the self-employed on a compulsory basis (voluntary membership suffers from significant adverse-selection problems). This would bring the uninsured into a cost-effective scheme and boost cost-containment in the long term.

Other reform initiatives recently introduced or planned include the improvement of the scheme’s quality-monitoring capacity and the provision of better information for workers in their choice of contractor hospitals. Hospital-based ambulatory care is traditionally provided in large, overcrowded outpatient departments with long queues, very short consultation times and low user satisfaction (Tangcharoensathien et al., 1999b). There is an opportunity for the Social Security Office to contract ambulatory care with primary care providers rather than hospitals. This will improve not only access to care, but also quality of service.

### Table 9. Outpatient and inpatient utilization rates at registered hospitals, Social Security Scheme, 1992-96

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OP utilization rate (visits per capita per year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>0.71</td>
<td>0.87</td>
<td>1.07</td>
<td>1.23</td>
<td>1.36</td>
</tr>
<tr>
<td>Private</td>
<td>1.01</td>
<td>1.13</td>
<td>1.25</td>
<td>1.41</td>
<td>1.48</td>
</tr>
<tr>
<td>IP utilization rate (admissions per capita per year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>0.033</td>
<td>0.038</td>
<td>0.039</td>
<td>0.024</td>
<td>0.031</td>
</tr>
<tr>
<td>Private</td>
<td>0.029</td>
<td>0.033</td>
<td>0.040</td>
<td>0.020</td>
<td>0.029</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>5.38</td>
<td>4.96</td>
<td>4.32</td>
<td>4.59</td>
<td>4.84</td>
</tr>
<tr>
<td>Private</td>
<td>6.65</td>
<td>6.63</td>
<td>5.18</td>
<td>5.60</td>
<td>5.86</td>
</tr>
</tbody>
</table>

Health Card Scheme

Historical evolution

The Health Card Scheme (HCS), initiated in 1983, has gone through several transformations. Initially, it was a community financing scheme linking curative care with other primary health care activities e.g. maternal and child health, immunization and essential drugs. Households voluntarily contributed to the Village Health Fund, which supported primary health care activities and guaranteed access to free care at health centres and district hospitals.

This small-scale project was upgraded to a national project in 1984 (Singkaew, 1993). Later, it was reoriented from community financing towards a government-subsidized voluntary health insurance fund, whereby each household contributed 500 baht to cover care for four members for a year. The government provided a subsidy of a further 500 baht from general tax revenue. However, the underlying policy objectives were generally unclear, as none of the three successive health secretaries spelled out the Ministry of Public Health’s agenda with regard to the scheme (Kiranandana et al., 1990). The scheme was initially perceived as a promising start in the campaign to achieve universal coverage. Subsequent evidence showed that its potential for expansion was limited and its financial viability questionable, particularly because of adverse selection. Currently, there is risk pooling at the central level to facilitate portability of cover and risk sharing among provincial funds. In 1994, free health cards were given to community leaders and village health volunteers in acknowledgement of their contribution to the community.

Population coverage

The coverage of the health card scheme has been strongly cyclical. After the first expansion target had been set, health cards covered 4.7% of the population in 1987. Coverage went down between 1988 and 1992, owing to unclear policy direction by the Ministry of Public Health. It then increased again between 1993 and 1995 as a result of some of the reforms described above and the particular interest of the Minister of Health. Peak coverage was observed in 1995, despite the fact that the figures exclude some 750 000 cards issued free to community leaders and village health volunteers (Figure 3).
Benefit package and trends

During the initial phase linked to primary health care, the benefit package was strictly limited, e.g. not more than six visits per annum or 2,000 baht per episode, and a strict referral system operated from lower to higher levels of care. Programme evaluation found that these limitations hindered access to care, however, so a more generous and comprehensive package of ambulatory services and hospital care was introduced. An exclusion list of 15 conditions, similar to that in the Social Welfare Scheme, has recently been introduced. The referral system is still enforced, but the first contact may be with either the health centre or the district hospital, and all previous limits have been removed. Portability of coverage is guaranteed by means of a “cross-boundary card” especially for temporary migrant workers.

Sources of financing and payment methods

Initially, the scheme was completely financed by household contributions, and the Health Card Fund was managed at village level. Following the 1994 reform aimed at publicly subsidized voluntary insurance, management was centralized at the provincial level. The scheme required the government to match community contributions one-to-one. The provincial Health Card Fund earmarked 7.5% for administration (2.5% as an incentive for the card seller, 2.5% for central administration and 2.5% for provincial administrative expenses). Most of the rest (90%) was intended as compensation for health care providers for basic services, referrals and accident and emergency services. An earmarked 2.5% was diverted for re-insurance of high-cost cases and cross-boundary payments\(^1\) (Health Insurance Office, 1995). The Health Card Scheme would fit into the “voluntary integrated” model of coverage in the OECD classification.

\(^1\) This policy was changed in 1998, with responsibility for payment being shifted to provincial funds, since it was found that some provinces had been issuing cross-boundary cards instead of referring patients in order to save money.
Utilization

A trend of increasing utilization, especially for outpatient visits, has been observed in the Health Card Scheme. Reported figures showed that utilization was 2-4 times higher among health card holders than among Social Security Scheme enrollees. Higher utilization rates among health card holders might be explained by adverse selection as a result of the voluntary nature of membership, and the fact that there are no prescreening procedures. On the other hand, the relatively lower utilization rates by Social Security Scheme members might also be partly due to poorer access to care and the “healthy worker” effect (Table 10).

Community leader and health volunteer card holders had 1.2 and 1.4 outpatient visits/person/year respectively. They also used health centres to a greater extent than other health card holders. They were admitted 0.03 times/person/year. Utilization rates for cross-boundary card holders could not be estimated because there was no measurable and appropriate denominator. However, these groups used the higher levels of care more than other groups. This probably implies that the cross-boundary card holders generally moved to work in urban areas, rather than to rural areas (Srithamrongsawat, 1996).

Table 10. Utilization rates by health card holders and other schemes

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health card OP/person/year</td>
<td>1.0688</td>
<td>0.88</td>
<td>0.93</td>
<td>2.11</td>
<td>3.03</td>
<td>2.04</td>
<td>2.48</td>
<td>2.30</td>
</tr>
<tr>
<td>Health card IP/person/year</td>
<td>0.0456</td>
<td>0.08</td>
<td>0.09</td>
<td>0.07</td>
<td>0.11</td>
<td>0.09</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td>Health card IP days/admission</td>
<td>3.48</td>
<td>3.99</td>
<td>4.33</td>
<td>4.34</td>
<td>4.34</td>
<td>6.2</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>SSS OP/person/year</td>
<td>0.32</td>
<td>0.22</td>
<td>1.07</td>
<td>1.23</td>
<td>1.34</td>
<td>1.52</td>
<td>1.46</td>
<td></td>
</tr>
<tr>
<td>SSS IP/person/year</td>
<td>0.02</td>
<td>0.01</td>
<td>0.04</td>
<td>0.02</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>SSS IP days/admission</td>
<td>4.23</td>
<td>3.74</td>
<td>4.32</td>
<td>4.59</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>General pop. OP/person/year</td>
<td>0.53</td>
<td>3.74</td>
<td>4.32</td>
<td>4.59</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>General pop. IP/person/year</td>
<td>0.07</td>
<td>0.06</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>General pop. IP days/admission</td>
<td>3.94</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

OP = outpatient; IP = inpatient; SSS = Social Security Scheme; N/A = not applicable.

Sources:

- Adapted from Pannarunothai (1997).
Problems
Because the health card scheme is voluntary, adverse selection was a feature, with the sick and potentially sick over-represented in its membership. This led to an escalation in average costs per person and made the fund financially unviable. Average cost per card (we used charges, since no real cost data existed) in 1997 was over 2 100 baht, but providers were reimbursed only 900 baht, since the remaining 10 per cent of the 1 000 baht per card were allocated for administration of the scheme (Table 11). Half of the costs incurred were outside the district health system. If the benefit package covered only district health services and excluded services provided outside the home district, the 1 000 baht revenue would be almost enough to cover all costs (Srithamrongsawat, 1996).

Table 11. Charges for services provided, Health Card Scheme, baht per card in 1997

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OP visit/ card</td>
<td>5.64</td>
<td>3.44</td>
<td>1.08</td>
<td>0.19</td>
<td>0.07</td>
<td>0.05</td>
<td>10.47</td>
</tr>
<tr>
<td>Charges per visit</td>
<td>39</td>
<td>128</td>
<td>191</td>
<td>290</td>
<td>320</td>
<td>507</td>
<td>92*</td>
</tr>
<tr>
<td>OP charges per card</td>
<td>221</td>
<td>440</td>
<td>206</td>
<td>54</td>
<td>21</td>
<td>23</td>
<td>966</td>
</tr>
<tr>
<td>Admissions /card</td>
<td>0.24</td>
<td>0.15</td>
<td>0.02</td>
<td>0.02</td>
<td>0.01</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Charges per case</td>
<td>1 497</td>
<td>3 500</td>
<td>5 436</td>
<td>3 722</td>
<td>7 906</td>
<td>2 625*</td>
<td></td>
</tr>
<tr>
<td>IP charges per card</td>
<td>366</td>
<td>514</td>
<td>126</td>
<td>76</td>
<td>90</td>
<td>1 171</td>
<td></td>
</tr>
<tr>
<td>Charges per card</td>
<td>221</td>
<td>806</td>
<td>720</td>
<td>180</td>
<td>97</td>
<td>113</td>
<td>2 137</td>
</tr>
<tr>
<td>Percentage</td>
<td>10%</td>
<td>38%</td>
<td>34%</td>
<td>8%</td>
<td>5%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

OP = outpatient; IP = inpatient.
* Calculated by dividing total charges by total of visits to all types of health facility.

After the economic crisis in 1997, with the help of an Asian Development Bank loan, the government increased its subsidy from 500 to 1 000 baht per card. This posed an equity problem, since members of the Social Welfare Scheme received a subsidy of only 280 baht, compared with 1 000 baht per family (around 250 baht per capita) for non-poor Health Card members.

Reform efforts
There have been minor changes since the reform in 1994. The Ministry of Public Health improved targeting by removing eligibility from patients who preferred to use private room and board. To combat adverse selection, the qualifying period before eligibility for services was extended from 15 to 30 days. In addition, reimbursement for cross-boundary care became the responsibility of the provincial fund, in order to prevent misuse of the cross-boundary card.

The scheme has been thoroughly studied with support from the Asian
Development Bank (Donaldson et al., 1999; Pannarunothai et al., 1997). Their recommendations, which we endorse, include:

- raising the price of the card to cover costs (2,000 baht for Bangkok and 1,500 baht elsewhere)
- encouraging a significant qualifying period to reduce adverse selection
- allowing applications for health card membership all year round
- enforcing referral rules (district-to-provincial) or else applying a higher copayment for provincial level care
- decentralizing card sales to local government and requiring local support for this activity.

The uninsured

According to the provincial health survey conducted by the Ministry of Public Health in 1996 (National Statistical Office, 1996), 37% of the Thai population were uninsured (Table 2). Between 26% and 31% of households in each income bracket were uninsured: 28% of the poorest households (with a monthly income less than 2,000 baht) should have been covered by the Social Welfare Scheme, but were not registered. Of the 16,659 uninsured persons sampled by the survey, 27% were in the lowest income bracket of less than 2,000 baht per month (Table 12).

Table 12. Monthly household income of insured and uninsured people, 1996

<table>
<thead>
<tr>
<th>Monthly income (baht)</th>
<th>Uninsured</th>
<th>Insured</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
<td></td>
</tr>
<tr>
<td>1. 2,000</td>
<td>4,451 27</td>
<td>11,672 32</td>
<td>16,123 30</td>
<td>28</td>
</tr>
<tr>
<td>2. 2,001-8,000</td>
<td>9,847 59</td>
<td>18,446 51</td>
<td>28,293 53</td>
<td>35</td>
</tr>
<tr>
<td>3. 8,001-15,000</td>
<td>1,333 8</td>
<td>3,693 10</td>
<td>5,026 9</td>
<td>27</td>
</tr>
<tr>
<td>4. 15,001-20,000</td>
<td>197 1</td>
<td>565 2</td>
<td>762 1</td>
<td>26</td>
</tr>
<tr>
<td>5. 20,001 +</td>
<td>340 2</td>
<td>859 2</td>
<td>1,199 2</td>
<td>28</td>
</tr>
<tr>
<td>6. unknown</td>
<td>491 3</td>
<td>1,093 3</td>
<td>1,584 3</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>16,659 100</td>
<td>36,328 100</td>
<td>52,987 100</td>
<td>31</td>
</tr>
</tbody>
</table>


Of the 16,659 uninsured persons, 80% of heads of household were educated only to primary-school level (Table 13). Only 13% of university graduates were uninsured, compared with one-third of those educated to primary-school level.
Table 13. Insurance coverage by educational level of head of household, 1996

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Number uninsured</th>
<th>Number insured</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary</td>
<td>13 332</td>
<td>27 336</td>
<td>40 668</td>
<td>77 33</td>
</tr>
<tr>
<td>2. Secondary</td>
<td>1 644</td>
<td>3 666</td>
<td>5 310</td>
<td>10 31</td>
</tr>
<tr>
<td>3. Vocational</td>
<td>403</td>
<td>1 324</td>
<td>1 727</td>
<td>3 23</td>
</tr>
<tr>
<td>4. University</td>
<td>203</td>
<td>1 301</td>
<td>1 504</td>
<td>3 13</td>
</tr>
<tr>
<td>5. Uneducated</td>
<td>958</td>
<td>2 415</td>
<td>3 373</td>
<td>6 28</td>
</tr>
<tr>
<td>6. Unknown</td>
<td>119</td>
<td>196</td>
<td>315</td>
<td>1 38</td>
</tr>
<tr>
<td>Total</td>
<td>16 659</td>
<td>36 238</td>
<td>52 897</td>
<td>100 31</td>
</tr>
</tbody>
</table>

Table 14 gives a breakdown of the uninsured population by occupation of the head of household. The highest percentage of uninsured persons occurred among farmers. Civil servants were least likely to be uninsured (5% of that group), whereas taxi drivers and merchants were most likely to be uninsured (44% of each group).

Table 14. Occupation of head of household for uninsured and insured, 1996.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Uninsured</th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of total uninsured</td>
</tr>
<tr>
<td>1. Farmer</td>
<td>7 896</td>
<td>49</td>
</tr>
<tr>
<td>2. Civil servant</td>
<td>198</td>
<td>1</td>
</tr>
<tr>
<td>3. Transport operator</td>
<td>564</td>
<td>3</td>
</tr>
<tr>
<td>4. Worker</td>
<td>904</td>
<td>6</td>
</tr>
<tr>
<td>5. Merchant</td>
<td>2 849</td>
<td>18</td>
</tr>
<tr>
<td>6. Other</td>
<td>3 063</td>
<td>19</td>
</tr>
<tr>
<td>7. Unemployed</td>
<td>613</td>
<td>4</td>
</tr>
<tr>
<td>8. Unknown</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>16 120</td>
<td>100</td>
</tr>
</tbody>
</table>

The uninsured are required to pay all medical bills in full in both public and private hospitals. In public hospitals, an exemption mechanism through social workers is available when the uninsured are unable to pay. Sujariyakul and Chongsuvivatwong (1999) reported an average bill of 7 622 baht per admission among people uninsured because of affordability constraints. This accounts for 18.6% of the average annual household income among this group.

The uninsured typically pay the bill by borrowing either inside or outside their family network. A high-cost medical bill, especially for a hospital admission, may be a major reason why uninsured people fall into the debt
Poverty and lack of insurance cover are the major factors affecting access to antenatal care (Tangcharoensathien et al., 2000) (Table 15).

### Table 15. Insurance status and maternal and child health profiles

<table>
<thead>
<tr>
<th>Monthly income</th>
<th>Urban Uninsured</th>
<th>Urban Insured</th>
<th>Rural Uninsured</th>
<th>Rural Insured</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor Non-poor</td>
<td>Poor Non-poor</td>
<td>Poor Non-poor</td>
<td>Poor Non-poor</td>
<td></td>
</tr>
<tr>
<td>1. % without ANC</td>
<td>9 4 1 1</td>
<td>3 0 1 1</td>
<td>3 0 1 1</td>
<td>1 1 1 1</td>
<td></td>
</tr>
<tr>
<td>2. % &lt; 4 ANC visits</td>
<td>43 28 12 13</td>
<td>41 34 18 17</td>
<td>40 33 16 16</td>
<td>21 21 21 21</td>
<td></td>
</tr>
<tr>
<td>3. % at prenatal risk</td>
<td>34 23 29 27</td>
<td>34 24 25 24</td>
<td>34 24 25 24</td>
<td>20 20 20 20</td>
<td></td>
</tr>
<tr>
<td>4. % low birth weight</td>
<td>14 10 14 8</td>
<td>14 11 9 9</td>
<td>14 10 9 9</td>
<td>9 9 9 9</td>
<td></td>
</tr>
<tr>
<td>n =</td>
<td>68 208 149 499</td>
<td>125 253 377 564</td>
<td>2240</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Wongkongkathep, 2000. ANC = antenatal care.

### Summary of problems

An analysis of the four main insurance schemes and the uninsured population sheds light on the strengths and weaknesses of health insurance cover in Thailand, which are summarized below.

The poor are more or less protected through the Social Welfare Scheme. Targeting problems have been partly resolved in recent years, but still exist. The marginally poor are not entitled to free health cards, but would generally be partially or totally exempt from large inpatient bills in public hospitals. However, they could easily get into debt by borrowing before they applied to social workers to claim the exemption, especially in the case of catastrophic illness.

The CSMBS consumed more resources than any other health fund per person covered, and also received the highest State subsidy. With its fee-for-service reimbursement model, neither CSMBS beneficiaries nor public or private providers are concerned with cost or efficiency. Thailand’s compulsory employment-based Social Security Scheme, with its universal capitated payment system, has contained costs admirably, but quality of care has suffered in the process. The Social Security Scheme has generally failed to monitor quality adequately, or punish contractor hospitals with poor standards, and levels of consumer satisfaction are therefore low. Importantly, however, the Scheme has substantial potential for extending coverage to dependants, nonformal workers and the self-employed. Although the Voluntary Health Card Scheme looked like a promising approach to coverage extension some years ago, it is now faced with major adverse-selection problems, and high utilization rates and costs, and as currently structured it is not financially viable.
Reform efforts

The Health Systems Research Institute (HSRI) is intimately involved with current health reform in Thailand. Two important policy contexts influencing the observed policy direction have come to our attention and are worth mentioning. Firstly, the general reform of the public sector aimed at good governance, decentralization, “lean government” and privatization has increased the role of the private sector and the community in a number of social contexts. For example, all 26 public universities were due to become autonomous entities by 2002. Medical cover for employees in autonomous universities is likely to be provided through voluntary private for-profit insurance in place of the CSMBS. Although the CSMBS proposal for the reform of payment methods was adopted by cabinet resolution, the current Ministry of Finance is more in favour of increasing the role of uncoordinated private for-profit insurance. Cream-skimming and premium increases are foreseeable under this scenario, together with lower efficiency and equity outcomes.

Secondly, health reformers have advocated universal coverage through legislation for the uninsured population. There is some degree of consensus that Thailand will have two main public schemes in the future. The first would be the social insurance scheme covering public and private formal-sector employees (e.g. a scheme integrating the current CSMBS and Social Security Scheme). The rest of the population would be covered by a national health insurance scheme, covering members of the current Social Welfare Scheme and Health Card Scheme and the uninsured. This integration would be enforced by legislation. The future public schemes (social insurance and national health insurance) would share a similar core package of services, provider-payment methods (notably the closed end expenditure contract model, whereby providers receive payments from purchasers with a limit on the total amount, usually according to the numbers registered) and level of government subsidies. By July 2001, universal health care coverage had been introduced in 21 pilot provinces, and the scheme was due to expand to 76 provinces throughout the country by April 2002.

National health insurance is financed through compulsory contributions and general tax subsidies for the poor. Private insurance, if not allowed to provide a basic package, could play the role of providing additional benefits. Copayments could help to combat moral hazard by sending a signal to the insured population that consumption in all schemes must be efficient. The capacity for premium collection, the creation of a beneficiary database and the development of organizational management capacity should be developed in parallel.

The fee-for-service reimbursement model must be avoided. A contract model and closed end payments, such as risk-adjusted or age-adjusted capitation and global budgets, are advocated for both schemes.
In the meantime, the immediate reform agenda includes efficiency improvements, especially through CSMBS payment reform, coverage extension by the social security scheme, proper targeting of the poor, and cost-recovery in the Health Card Scheme.

Acknowledgements

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8. Health-seeking behaviour for common illnesses in a low-income population in Kampala, Uganda
Frank Lule, Shane Allwright

Introduction

The recent change in government policy in Uganda in favour of privatization in all sectors has led to a rapid expansion in private-sector initiatives in many areas, including the health sector. Increasing restrictions in the national health budget and the high proportion of qualified doctors working in the private sector, especially the for-profit sector (Giusti et al., 1997), have increased the pressure for greater privatization. There has also been growing pressure from the donor agencies to promote privatization as a strategy for mobilizing resources and utilizing them efficiently for the provision of social services.

Recognizing that the private health sector is growing rapidly, particularly in urban areas, the Ministry of Health is considering a strategy to integrate the private health sector into its national health programme. However, little is known about the population served and the factors that affect the patterns of service delivery, especially in the for-profit sector.

This rapid growth in the private sector is occurring in many developing countries. In Zimbabwe, 66% of doctors are employed in the private sector (Bennett et al., 1997). In Malawi, 40% of health care is provided by the private sector (Banda & Simukonda, 1994), which is similar to the proportion in Uganda. The percentage of practitioners in South Africa grew from 47% in 1979 to 58% in 1987 (Price, 1994). In India, private provision of health care has increased considerably, with 70% of hospitals and 50% of hospital beds in the private-for-profit and not-for-profit sectors, employing more than 70% of qualified doctors (Bhat, 1996). Tesfahun (1997), in his household study of an urban area in Ethiopia, found that more than half the population had used private providers for their health care in the previous month.

Services provided by the private sector

Curative services are the main focus of most of the players in the private sector, especially the for-profit sector. The other important service is delivery of
pharmaceuticals; there is a multiplicity of private pharmacies in urban areas, selling a wide range of products, usually at high prices. Vogel and Stephens (1989) have observed that in West African countries like Liberia, Senegal and Côte d’Ivoire, the customers at these for-profit retail pharmaceutical outlets come from various social and economic backgrounds.

The findings of studies on the structure, size and scope of private-for-profit facilities in Uganda are mixed. According to Okello and Konde-Lule (1997), many of the clinics registered met community standards in terms of physical facilities, personnel and cleanliness. However, Asiimwe and Lule (1992) have observed that many of the clinics were poorly equipped and often in unhealthy settings.

**Health-seeking behaviour**

A simple definition of health-seeking behaviour is “when and where families seek help for an illness”. Choices include: home care without drugs, home care after seeking advice from a relative or neighbour, home medication with purchased drugs, home treatment using traditional remedies, visiting a traditional healer, seeking advice and/or prescribed treatment from a pharmacist, and seeking advice and/or prescribed treatment from a health worker in government or private practice.

Decisions are constrained not only by the level of resources at the person’s disposal for health expenditure, but also by factors such as distance from health care providers and availability of medicines for use in the home. People are further guided by their own health beliefs and experiences and the severity of the illness. In her work in the highlands of Rwanda, Csete (1993) identified four factors as principal determinants of initial treatment choice. These are the seriousness of the illness as perceived by the person seeking health care, knowledge (i.e. the careseeker’s) of the illness and its remedy, degree of confidence in folk remedies for the illness, and expenses associated with the health care alternatives.

Previous surveys on the utilization of private services have been carried out in dispensaries or outpatient departments, so they give no information about the health-seeking behaviour of people who never reach these facilities. Household surveys are needed to identify which groups are using, or not using, which health facilities, and also to support the new government policy of decentralization.

It is widely assumed that private-sector services are mainly utilized by populations of higher socioeconomic status who have the ability to pay, leaving the public services to the poorer sections of society. The public perception is that public facilities are usually overcrowded, inefficient, understaffed and short of drugs, while private-care facilities are thought to be
well-stocked with drugs, open at convenient hours and providing good quality
care. These assumptions are not necessarily correct.

A cross-sectional household survey was set up to investigate some of these
issues. An urban environment was selected to ensure sufficient numbers of
both public and private health care facilities, as well as variation in
socioeconomic groups. Two acute diseases which are common in Uganda were
examined: diarrhoea and acute respiratory infection (ARI). The aim of the
study was to ascertain the treatment-seeking behaviour of low-income
communities with a view to assessing the role of the private sector in the
delivery of health services in Kampala, Uganda. The objectives were:

- to determine the prevalence of ARI and diarrhoeal disease in the study
  population
- to establish the proportion of patients with ARI and/or diarrhoeal disease
  who are treated by the private sector rather than public health services
- to identify factors which influence these choices.

**Methods**

The survey was conducted in Bukesa Parish, Central Division, Kampala
District, Uganda. This is a high-density, low-income neighbourhood, with
crowded housing ranging from permanent structures, through semi-
permanent structures, to temporary structures with mud walls and papyrus
thatching. The study area is near several educational institutions, including
the national university. The public health care facilities close to the parish
(within 2 km) include a health centre, the national referral and teaching
hospital (Mulago Hospital), and University Hospital (accessible only to
students and staff, some of whom live in the study area). There are three
tertiary mission hospitals within 5 km of the study area, and many private
clinics and drug shops are distributed throughout the parish.

Judging by the proportion of users of private health services in Uganda
(40%) (Giusti et al., 1997), it was estimated that a sample of 330 households
was required. The seven administrative zones (local councils) of Bukesa Parish
were divided into 73 clusters of approximately 50 households each. Thirty
clusters were selected at random and eleven houses picked from each cluster
of 50 households. The first house in each selected cluster was chosen by
locating the centre of the cluster; the direction to be taken was determined
by spinning a bottle and then the first 11 houses in that direction were selected.

The interviews were conducted in June 1998 by six interviewers (including
one of the authors, FL). All had post-secondary education and previous survey
experience. The questionnaire was developed from questionnaires used in
similar studies in Vietnam and Ethiopia. Part A of the questionnaire elicited sociodemographic information (occupation, religion, educational status, average monthly income and number of people in the household) and asked whether any members of the household had had diarrhoea or ARI in the previous two weeks. The operational definition of diarrhoea was an episode of passing frequent, watery stools. The definition of ARI was cough, with or without difficult breathing. The head of the household or the primary caregiver answered these questions. Part B of the questionnaire was filled in only if household members had had diarrhoea and/or a respiratory infection. The respondent for Part B was the “patient” (if present at the time of interview and over 15 years of age), or the primary caregiver. The patient’s gender and age were recorded, as well as information on treatment-seeking practices (choices made, reasons for choices, treatment received, cost of treatment and symptoms that prompted seeking of care).

Statistical analysis was carried out using the JMP IN statistical package (SAS Institute Inc., 1997). Pearson chi square and Fisher’s exact tests were used to compare proportions in independent groups of categorical data, and the Wilcoxon rank sum test was used to compare medians. Table totals vary, as not all respondents answered all questions.

Results

Interviews were completed for 297 of the 330 households, a response rate of 90%.

Sociodemographic characteristics of respondents

Table 1 shows sociodemographic characteristics of the 297 respondents and their households. Just over half the respondents were women (58%), most (73%) were Christian, just over one-third (37%) either did not have a regular job or had no job. All except 22 (8%) had attained at least primary-level education or in any case could read and write. This is compatible with the 80% literacy rate reported for urban Uganda in the 1991 census (Ministry of Finance, Planning and Economic Development, 1991).

There were 1,553 individuals in the 297 households. The mean household size was 4.4 persons and 70% of households had three or more family members. Only 128 households (48%) had one or more children under five years of age.
Prevalence of diarrhoea and ARI

Of the 297 households, 29 individuals reported having diarrhoea and 188 reported ARI in the two weeks prior to interview; 20 individuals reported both diarrhoea and ARI. The crude attack rates for diarrhoea and ARI were 1.9% and 12.1% respectively (Table 2). About half the cases of both diarrhoea and ARI were male (48% for both diseases). Forty-one per cent (12/29) of the diarrhoea cases and 28% (51/184) of the ARI cases were in children aged five years or less.

Table 1. Sociodemographic characteristics of respondents and their households

<table>
<thead>
<tr>
<th>Respondent’s gender</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>120</td>
<td>41.7</td>
</tr>
<tr>
<td>Female</td>
<td>175</td>
<td>58.3</td>
</tr>
<tr>
<td>Total</td>
<td>295</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent’s religion</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>215</td>
<td>72.6</td>
</tr>
<tr>
<td>Other religions</td>
<td>81</td>
<td>27.4</td>
</tr>
<tr>
<td>Total</td>
<td>296</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent’s occupation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade</td>
<td>81</td>
<td>27.3</td>
</tr>
<tr>
<td>Government/NGO</td>
<td>106</td>
<td>35.7</td>
</tr>
<tr>
<td>Unemployed</td>
<td>110</td>
<td>37.0</td>
</tr>
<tr>
<td>Total</td>
<td>297</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent’s education</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>22</td>
<td>7.5</td>
</tr>
<tr>
<td>Primary level</td>
<td>121</td>
<td>41.0</td>
</tr>
<tr>
<td>Secondary level and above</td>
<td>152</td>
<td>51.5</td>
</tr>
<tr>
<td>Total</td>
<td>295</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent’s income (Ugandan shillings)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 30 000</td>
<td>91</td>
<td>40.3</td>
</tr>
<tr>
<td>30 001 – 100 000</td>
<td>84</td>
<td>37.2</td>
</tr>
<tr>
<td>&gt; 100 000</td>
<td>51</td>
<td>22.6</td>
</tr>
<tr>
<td>Total</td>
<td>226</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household size</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>90</td>
<td>30.4</td>
</tr>
<tr>
<td>3-5</td>
<td>133</td>
<td>44.9</td>
</tr>
<tr>
<td>&gt; 5</td>
<td>73</td>
<td>24.7</td>
</tr>
<tr>
<td>Total</td>
<td>296</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Households with children &lt; 5 years</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>128</td>
<td>47.9</td>
</tr>
<tr>
<td>No</td>
<td>139</td>
<td>52.1</td>
</tr>
<tr>
<td>Total</td>
<td>267</td>
<td>100</td>
</tr>
</tbody>
</table>
Health-care-seeking characteristics

Three diarrhoea patients (14%) received only home care for the current episode of diarrhoea. These individuals were similar to the 18 patients who sought help. Of the 18 who reported seeking help, only two consulted the public sector as their initial point of assistance; a few (5) went on to consult an additional source of care (Table 3).

Table 2. Prevalence of diarrhoea and acute respiratory infection in the study population

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of people with disease</th>
<th>No. of people in sample households</th>
<th>Attack rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
<td>29</td>
<td>1 553</td>
<td>1.9</td>
</tr>
<tr>
<td>ARI</td>
<td>188</td>
<td>1 553</td>
<td>12.1</td>
</tr>
</tbody>
</table>

Table 3. Health-care-seeking behaviour of patients with diarrhoea and ARI

<table>
<thead>
<tr>
<th></th>
<th>Diarrhoea</th>
<th>ARI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Outside help sought</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>85.7</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td><strong>Initial help</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private provider</td>
<td>16</td>
<td>88.9</td>
</tr>
<tr>
<td>Public provider</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td><strong>Subsequent help</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private provider</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Public provider</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Nowhere</td>
<td>13</td>
<td>72.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td><strong>First reason for choice made</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>Accessible</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Good care</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td><strong>Reason for not seeking treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not important</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>Could treat at home</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>Expensive</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

A higher proportion of ARI patients (21%) received home care only. The 39 ARI patients who did not seek help were older (Fisher's exact test, p = 0.003), from smaller households, ($\chi^2 = 8.08$, p = 0.01), and less likely to be in full-time employment, ($\chi^2 = 6.25$, p = 0.04) than the 149 ARI patients who did seek help. ARI patients who received home care and those who went for outside help did not differ significantly with respect to respondent’s religion, education level
and income, or sex of the patients. A quarter of those who sought outside help (37/144) went to a public provider as their initial point of assistance; only 16 went on to consult an additional source of care in either sector.

Reasons for choice of care were grouped into three categories: affordability (cheap), accessibility (near, less waiting time, and open at convenient hours) and good care (appropriate care, confidentiality and good attitude of staff) as perceived by the patients. In the case of diarrhoea, seven patients gave affordability as a first reason, five gave accessibility and six gave good care as the most important factor influencing their choice of care (Table 3). For ARI, good care was cited by 53 patients (37%), accessibility by 48 (34%) and affordability by 41 (29%) as the most important reason for choice of provider.

Table 4 shows that most of the ARI patients who utilized public services went there because of the good care (68%), whereas private providers were chosen because they were perceived to be accessible (42%), and affordable (31%). Almost all of those who cited affordability or accessibility as their primary reason for choosing a particular type of health care chose private health care, whereas among those whose primary reason was good care, there were similar numbers choosing private and public health care. The proportions were significantly different ($p < 0.0001$). Choice of provider (private or public) did not differ by occupation, education, average monthly income or religion of the respondent.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Public health care</th>
<th>Private health care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable</td>
<td>8</td>
<td>33</td>
<td>41</td>
</tr>
<tr>
<td>Accessible</td>
<td>4</td>
<td>44</td>
<td>48</td>
</tr>
<tr>
<td>Good care</td>
<td>25</td>
<td>28</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>105</td>
<td>142</td>
</tr>
</tbody>
</table>

$\chi^2 = 21, df = 2, p < 0.0001$.

Our comparison of the reasons for choosing public or private care for diarrhoea was limited by the small numbers of diarrhoea cases. However, both of the diarrhoea patients who used public services cited good-quality care as the reason.

**Cost of care**

Treatment costs were separated into consultation, drugs and transport costs (Table 5).

The three cost items were similar for both diarrhoea and ARI, irrespective of type of provider. The median total cost of care was 3 000 Ugandan shillings
for both diarrhoea and ARI. The majority of both the diarrhoea and ARI respondents (63% and 57% respectively) said the cost of care was either low or reasonable. Just over one-third of diarrhoea patients (38%) and two-thirds of ARI patients (66%) used cash savings to pay for their care.

Table 5. Cost of care by public and private providers, diarrhoea and acute respiratory infection (Ugandan shillings)

<table>
<thead>
<tr>
<th></th>
<th>Diarrhoea</th>
<th></th>
<th>ARI</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Cost of consultation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤500 shillings</td>
<td>14</td>
<td>82.4</td>
<td>88</td>
<td>80.7</td>
</tr>
<tr>
<td>&gt; 500 shillings</td>
<td>3</td>
<td>17.6</td>
<td>21</td>
<td>19.3</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
<td>109</td>
<td>100</td>
</tr>
<tr>
<td><strong>Cost of drugs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤2 000 shillings</td>
<td>8</td>
<td>47.1</td>
<td>60</td>
<td>49.2</td>
</tr>
<tr>
<td>&gt; 2 000 shillings</td>
<td>9</td>
<td>52.9</td>
<td>62</td>
<td>50.8</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
<td>122</td>
<td>100</td>
</tr>
<tr>
<td><strong>Cost of transport</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>70.6</td>
<td>85</td>
<td>78.3</td>
</tr>
<tr>
<td>Paid for transport</td>
<td>5</td>
<td>29.4</td>
<td>23</td>
<td>21.3</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
<td>108</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤2 000 shillings</td>
<td>7</td>
<td>38.9</td>
<td>56</td>
<td>40.9</td>
</tr>
<tr>
<td>2 001–5 000 shillings</td>
<td>5</td>
<td>27.8</td>
<td>43</td>
<td>31.4</td>
</tr>
<tr>
<td>&gt; 5 000 shillings</td>
<td>6</td>
<td>33.3</td>
<td>38</td>
<td>27.7</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
<td>137</td>
<td>100</td>
</tr>
<tr>
<td><strong>Price</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasonable or low</td>
<td>10</td>
<td>62.5</td>
<td>74</td>
<td>56.5</td>
</tr>
<tr>
<td>Excessive</td>
<td>6</td>
<td>37.5</td>
<td>57</td>
<td>43.5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
<td>131</td>
<td>100</td>
</tr>
<tr>
<td><strong>Mode of payment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash savings</td>
<td>6</td>
<td>37.5</td>
<td>87</td>
<td>65.4</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>62.5</td>
<td>46</td>
<td>34.6</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
<td>133</td>
<td>100</td>
</tr>
</tbody>
</table>

As only two diarrhoea patients sought private care, meaningful comparison of costs for public and private care was not possible. Table 6 shows that the total care costs of ARI cases using public providers were comparable with the costs of those who went to private providers. The median total cost of care from public providers was 1 700 shillings (interquartile range 200-6000 shillings); this was not significantly different from the median total cost of care from private providers, 3 300 shillings (interquartile range 1 500-5 750 shillings) (p > 0.12). There were no significant differences between cost of care and respondent’s occupation, average monthly income or education.
In most respects, the study area was typical of low-income urban Kampala. However, the proportion of households with children under five years (48%) was considerably lower than the average of 70% for developing countries. This may be due to the presence in the study area of adult migrant workers who have left their families behind in the villages, or of students from the nearby university renting accommodation in the area.

Prevalence of diarrhoea and ARI

The two-week crude attack rate of 1.9% was lower than in other studies (Wamai, 1992). This may be due to seasonal differences, as diarrhoea is usually more common in the dry season and this study was done during a rainy period. The fact that there were few children under five years of age may also be a factor.

The two-week crude attack rate of 12% for ARI was high. There were more ARI cases in the low-income groups, in children and in large households. These findings are consistent with other community-based studies in Uganda and other developing countries (WHO, 1995; Kiboneka, 1989). Many of the respondents were unemployed, and 40% were below the absolute poverty level. Not unexpectedly, rates of diarrhoea and ARI were higher in these households. In low-income households, particularly those with large families, a significant percentage of earnings must be used to pay for health care.

Health-care-seeking behaviour of respondents

Outside help was sought by more patients than anticipated, given that many cases of diarrhoea and ARI are self-limiting. However, the high utilization rates were similar to those found in other studies in low-income urban areas (Mwabu, 1986). Given the high cost of health care to individual households and to the government, health education has a role to play in helping people to discriminate between appropriate and inappropriate use of health services.
Choice of care

Three-quarters of the ARI cases and all except two people with diarrhoea consulted private providers. The population in this study area clearly preferred private services. This is consistent with reports from Uganda and other developing countries (Garner & Thaver, 1993) which indicate that people patronize private health care facilities for several reasons, including availability of services, convenience and a quick response. In this survey, accessibility was the reason given by most respondents for choosing private care. There were many private clinics in the study area, and virtually all shops and kiosks had stocks of some form of drugs, including chloroquine, analgesics such as aspirin, and cough syrups.

Public health facilities are meant to be free, whereas this survey, surprisingly, indicated that the second most common reason for choosing private providers was affordability. The cost of private care for ARI patients was not significantly different from the cost of public care. This implies that public facilities were not free as stated by the government, even before the full implementation of user fees in all facilities, as recommended in the new draft health policy document (Ministry of Health, 1997). The longer waiting times in public facilities contribute to higher indirect costs and may explain why users of private providers thought they were cheaper. The similarity in consultation costs was not anticipated, but may be partially explained by the fact that drugs can be purchased from drug shops and pharmacies without a consultation fee. The payments reported by those who used public facilities may be unofficial, as there were no official user fees. This practice has been reported in Uganda by several authors as a coping mechanism used by government staff to supplement their very poor salaries (Phillips, 1990; WHO, 1998).

Patients tend to evaluate quality in terms of perceived efficacy or appropriateness of treatment. The fact that good-quality care was the most important reason given for seeking care from public facilities suggests that these facilities still offer the best care and raises questions about the quality of treatment received from private providers. The depressing state of private care facilities has been documented, especially for-profit facilities in low-income areas (Yesudian, 1994). The problems cited ranged from poor infrastructure to the doubtful competence of the staff, as well as inappropriate and unsafe treatment. Standards are ignored, and consultations are sometimes very brief to ensure a high turnover of patients.

The fact that sociodemographic factors were not significantly associated with choice of health care provider suggests that the received wisdom that private practitioners are the exclusive preserve of the rich may be incorrect.
Conclusions

The study has shown that the provision (by private providers) and financing (by households) of health care by the private sector in urban areas is well entrenched. The majority of patients sought private care. Good quality care was the main reason for going to a public provider. The costs of private and public care were similar.

Private care, especially for-profit, evolved largely as a coping mechanism for both providers and consumers as a result of the collapse of the health system during the war in Uganda. Thanks to donors, the public system is now reviving. The government still has the obligation to cater for the public welfare, but this should entail collaboration and integration of all players, hence the public/private mix. The goal here should be to improve the standard of health care, not just to increase private provision. Regulation of the private sector will be an important step towards this goal. The way the question of the public/private mix is handled will largely determine the shape of health care in Uganda in the new millennium.

Acknowledgements

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9. Contracting in long-term psychiatric care - a comparative study of six hospitals in South Africa
Kim Porteus

Background
The past decade has been marked by increased pressure on developing nations to adopt market-driven strategies in order to address perceived inefficiencies within public-sector health provision. This period has also been marked by challenges to the institutional nature of mental health care services. A largely Western model of institutional care for the mentally ill was exported to many colonized nations in the late 1800s, and continued as the dominant model of public-financed care in the 1900s (Foster & Swartz, 1997). In South Africa, the philosophy of institutionalized custodial care for the mentally ill married well with apartheid, which not only served to institutionalize white hegemony, but also sought to solve social problems through physical separation. During the latter half of the 20th century, the institutional model of custodial care was criticized internationally and increasingly replaced by a more “developmental” and “community-based” paradigm. The critique was fuelled by advances in psychotropic medication and concern about the high cost and low quality of psychiatric hospital care, especially as quality increasingly became viewed from a human rights perspective. This shift occurred during the period of independence in Africa, when many previously colonized nations found themselves inheriting a mental health care system rooted within large chronic psychiatric institutions.

In 1994, the new South African government inherited a mental health service divided by race and modelled on large custodial institutions. The pressure to transform these institutions coincided with growing pressure to reform health services through privatization and other managed market strategies.

Contracting experience
South Africa began to contract out the delivery of hospital services in the early 1960s in areas of low government priority or capacity. Contracts were negotiated with a single private for-profit company on the basis of a fee per patient day. The contracts included tuberculosis hospitals, general district hospitals and long-term psychiatric hospitals. A thorough investigation of this
contracting experience, with reference to general district hospitals, was undertaken by Broomberg et al. (1997). The study concluded that contractor hospitals were able to produce more or less equivalent quality of care at lower cost. This did not generally result in lower fees to the State, however, which bore most of the risk in the contractual arrangements. The majority of the contracted hospitals were long-term psychiatric hospitals. In 1994, South Africa had 29 specialized chronic psychiatric hospitals. Twenty of these (9 000 psychiatric beds) were managed by the public sector. Nine hospitals (10 000 beds) were contracted out to the abovementioned private provider.

Throughout the 1980s and 1990s, several studies (WHO, 1977; American Association of Psychiatrists, 1979; Royal College of Psychiatrists, 1990; Mental Health and Substance Abuse Committee, 1996) strongly condemned the quality of care in both public and contracted institutions, but did not undertake a cost analysis of the institutions. The studies prior to 1990 were unable to obtain consistent access to public facilities and could thus not compare the public and contracted hospitals. The Mental Health and Substance Abuse Committee adopted a rapid assessment technique, and campaigned strongly for a more thorough investigation of quality within both public and contracted institutions.

This chapter reports the results of a detailed comparison of the cost and quality of care in public and contracted chronic psychiatric hospitals, in the light of the changing paradigm of mental health service provision. The chapter aims to contribute evidence from an empirical experience of private contracting to the wider health reform debate.

Methods

Our study attempted to describe and compare six large chronic psychiatric hospitals. One public hospital and one contracted hospital in each of three provinces were selected on the basis of a large population of chronic psychiatric patients (Table 1). Five of the six hospitals had cared only for black patients pre-1990 (CON-1, CON-2, CON-3, PUB-1, PUB-2), while the sixth hospital had been historically segregated into black and white wards (PUB-3). PUB-3 was thus atypical because of its position of historical racial privilege. While matched according to province and chronic patient population, nurses in all the hospitals suggest that the patient population in contracted hospitals was more stable (i.e. less acute and aggressive) than the patient population in public-sector hospitals, given the nature of transfers between public and contracted hospitals.

One week was spent at each hospital by a team of five researchers1 between

1 An economist, a social scientist, a social worker, a psychologist and a psychiatric nurse.
August 1996 and March 1997 to gather cost and quality data according to set protocols.

**Table 1. Hospital characteristics**

<table>
<thead>
<tr>
<th>Variables</th>
<th>CON-1</th>
<th>CON-2</th>
<th>CON-3</th>
<th>PUB-1</th>
<th>PUB-2</th>
<th>PUB-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector</td>
<td>CON</td>
<td>CON</td>
<td>CON</td>
<td>PUB</td>
<td>PUB</td>
<td>PUB</td>
</tr>
<tr>
<td>Province</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Historical patient population</td>
<td>HB</td>
<td>HB</td>
<td>HB</td>
<td>HB</td>
<td>HB</td>
<td>HW</td>
</tr>
<tr>
<td>Hospital inpatient population</td>
<td>1 799</td>
<td>1 284</td>
<td>490</td>
<td>311</td>
<td>668</td>
<td>1 177</td>
</tr>
<tr>
<td>Target inpatient population</td>
<td>1 799</td>
<td>1 057</td>
<td>343</td>
<td>181</td>
<td>601</td>
<td>505</td>
</tr>
</tbody>
</table>

CON = contracted; PUB = public-sector. HB = historically black; HW = historically white.

**Costs**

The recurrent operating costs of each hospital were calculated using a step-down cost analysis (financial year 1995/96) with costs allocated to the chronic adult inpatient case mix (excluding acute and paediatric patients). The analysis included personnel, pharmaceutical costs, infrastructure, transport, food/catering and laundry. Other cost items (including centralized administration, electricity, water, maintenance costs and replacement of minor cost items (e.g. crockery and cutlery) were excluded, owing to the lack of reliable data across all hospitals. A sensitivity analysis was conducted to explore the impact of the excluded costs on total costs.

**Quality of care**

A framework ("hierarchy of objectives") for assessing quality of care was developed, consisting of four “levels” of care – custodial care, psychiatric treatment, patient development and family/community services. Quality indicators (reflecting structure, process and outcome) were selected for each level of care. Examples of indicators at each level of the hierarchy are shown in Table 2.

The measurement tools included a patient record review (n = 1201), a nursing staff questionnaire (n = 365), a senior ward nurse interview (n = 50), a patient interview (n = 49), departmental and management interviews (n = 47), discussion groups and structured observation. The patient record review collected data on patient diagnoses and medications. Patient files were serially selected. The data were analysed by an independent psychiatrist who identified cases of concern (e.g. queries concerning dosages, polypharmacy and the consistency between diagnosis and medication). The nursing staff questionnaire was a true/false questionnaire administered to all on-duty nurses during the site visit. Questions covered a range of quality variables,
including patients’ daily lives, rights, cleanliness, staff satisfaction and management. The discussion groups and interviews were open-ended qualitative questions probing issues of institutional quality. The structured ward observation allowed researchers to rate aspects of ward quality independently, on the basis of a pre-defined Lickert scale.

Qualitative data were evaluated for common and divergent themes across hospitals. Descriptive statistics were calculated for all quantitative data. A multivariate analysis was performed on the three tools which had relatively large sample sizes (patient record abstraction, nursing staff questionnaire and observer evaluation). A factor analysis was conducted to identify variable clusters. A regression analysis was used to determine the extent to which sector\(^1\), hospital or ward-based variables (e.g. patient gender, functional level, staff-patient ratios, etc.) accounted for observed differences in quality across institutions.

A full description of the methods used can be found elsewhere (Porteus et al., 1998).

### Table 2. Hierarchy of objectives: sample indicators

<table>
<thead>
<tr>
<th>Level</th>
<th>Structure</th>
<th>Process/Programme</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and community services</td>
<td>Community-oriented staff</td>
<td>Facilitation of family involvement and change</td>
<td>Family involvement</td>
</tr>
<tr>
<td>Patient development for discharge</td>
<td>Developmental supplies Developmental staff</td>
<td>Patient rehabilitation services Patient discharge orientation</td>
<td>Independent functioning Patient discharge</td>
</tr>
<tr>
<td>Psychiatric treatment</td>
<td>Medication Trained psychiatric staff</td>
<td>Counselling Medical treatment services</td>
<td>Mortality</td>
</tr>
<tr>
<td>Custodial care</td>
<td>Ward size Care staff</td>
<td>Patient care routines Staff-patient relationship Personal freedom</td>
<td>Patient activity/ energy Patient cleanliness</td>
</tr>
</tbody>
</table>

### Limitations of this study

There were several limitations in this method of evaluation. First, while there was an attempt to match public and privately contracted hospitals, the extent to which these six hospitals represent the public and contracted sectors in general is limited. A second significant limitation of the study method was the lack of an external validation study with reference to the newly developed quality-of-care instruments. The cost findings are limited by the difficulty of accurately estimating the contribution of excluded costs to total costs.

\(^1\) “Sector” means the public sector vs. contracted sector.
Findings

An extensive set of quantitative and qualitative results were generated by this study, which are reported elsewhere (Porteus et al., 1998). This paper outlines a few of the key findings.

Sector vs. hospital differences

Differences between individual hospitals cannot be fully explained by sectoral (public vs. contracted) differences alone. Individual hospitals reflected a combination of variables independent of their sector— including local history and management. The differences between the public and contracted sectors must be understood within, and limited by, the context of individual hospital differences.

Quality of care

A wide-range of qualitative and quantitative measures of quality were recorded during the course of each site visit. A few of the important findings are reviewed here. While qualitative vignettes run the danger of sensationalizing poor quality, we have begun by depicting a few images from various hospitals to underscore the low quality of care in all hospitals. We then review quantitative comparisons using discharge rates and summarized quality indicators from each level of the hierarchy of objectives.

Qualitative impressions

The following images are selected from both public and contracted hospitals.

A man lies in his bed and asks to be taken outside. Having extra time, we take him outside on the one usable wheelchair in the hospital. He squeals with joy. It is the first time he has been outside since arriving three years ago...

It is “washing” time in a geriatric ward at another hospital. Men line up naked outside, waiting to be washed in mass routine...

In another hospital, a patient attacks another patient with a rake; the staff have been drinking and do not intervene in the fight...

Activity time at another hospital means patients are grouped outside and forced to sit in pre-designated formation. Nurses spend their time chasing after patients who do not sit down. These “activity” groups contain up to 80 patients each, with a junior nurse responsible for group “facilitation”.

Female patients in another hospital are permanently locked into their ward for fear of sexual abuse by male patients. Sex still occurs through gaps in the fences around the ward...
Discharge rates

The annual discharge rate for the period 1995-96 ranged between 0% and 10% (Table 3). The mean duration of stay ranged between 6.8 and 13.2 years. The mean duration of stay across the contracted hospitals was longer than the mean duration of stay across the public hospitals. The rates were calculated on the basis of the most recent date of admission (including temporary discharge and patients who absconded).

Table 3. Discharge rates and length of stay across hospitals

<table>
<thead>
<tr>
<th></th>
<th>CON-1</th>
<th>CON-2</th>
<th>CON-3</th>
<th>PUB-1</th>
<th>PUB-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge rates</td>
<td>2%</td>
<td>1%</td>
<td>10%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Median duration of stay</td>
<td>11.59</td>
<td>11.36</td>
<td>8.33</td>
<td>10.06</td>
<td>4.38</td>
</tr>
<tr>
<td>Mean duration of stay</td>
<td>13.16</td>
<td>13.16</td>
<td>6.76</td>
<td>9.54</td>
<td>8.43</td>
</tr>
<tr>
<td>Standard deviation (duration of stay)</td>
<td>0.56</td>
<td>0.69</td>
<td>0.40</td>
<td>0.56</td>
<td>0.69</td>
</tr>
</tbody>
</table>

Summarized quality scores

Hierarchy of objectives level 1 – family and community services: There was no evidence of ward-based services or programmes designed to facilitate family contact at any hospital. Family contact came exclusively within the mandate of the social worker. Social worker services were severely understaffed (Table 4). One public hospital had a “community worker” programme making limited home and community visits. The other public hospital had regular “community outings” for the “high-functioning” inpatients. The contracted hospitals, by comparison, had no community or effective family orientation. Both public and contracted hospitals failed with reference to family and community services – the contracted hospitals were relatively more isolated from adjoining communities than the public hospitals.

Table 4. Patients per allocated staff member across hospitals

<table>
<thead>
<tr>
<th></th>
<th>CON-1</th>
<th>CON-2</th>
<th>CON-3</th>
<th>PUB-1</th>
<th>PUB-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients per medical practitioner</td>
<td>590</td>
<td>711</td>
<td>1 355</td>
<td>2 580</td>
<td>696</td>
</tr>
<tr>
<td>Patients per psychologist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3 300</td>
</tr>
<tr>
<td>Patients per social worker/community worker</td>
<td>1 769</td>
<td>639</td>
<td>-</td>
<td>-</td>
<td>1 345</td>
</tr>
<tr>
<td>Patients per occupational therapist/OTA</td>
<td>126</td>
<td>182</td>
<td>83</td>
<td>52</td>
<td>197</td>
</tr>
</tbody>
</table>

Hierarchy of objectives level 2 – patient development services: Both public and contracted hospitals failed to achieve developmental programming. There were no developmental programmes implemented in practice at the ward
level. Contracted hospitals organized patients into “groups” where they would sit or sleep. Patients in public hospitals were not relegated to sitting groups, and largely sat or wandered the hospital grounds. A small centralized occupational therapy programme catered for between 0% and 20% of the patients. This focused for the most part on repetitive craft-type activities, targeting self-motivated, relatively high-functioning patients who could tolerate repetitive work. There were no discharge-planning procedures or support programmes at either the public or contracted hospitals.

**Hierarchy of objectives level 3 - psychiatric treatment:** Only the most minimal of psychiatric treatment objectives were achieved at either public or contracted hospitals. Psychiatric treatment was reviewed within the following indices – personnel, counselling/therapy services, management of psychotrophic medication, and mortality.

The primary providers of psychiatric services in the hospitals were the nurses. The public hospitals employed significantly more nurses per patient than the contracted hospitals, especially in the professional nurse categories (Figure 1). There were few medical practitioners in any of the hospitals, particularly in the most rural province (Table 4).

None of the hospitals provided systematic counselling or therapy services. Four of the five hospitals had no trained psychologists. They neither employed

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**Figure 1. Nursing staff per patient across hospitals**

![Figure 1](image)

None of the hospitals provided systematic counselling or therapy services. Four of the five hospitals had no trained psychologists. They neither employed

---

1 One psychiatrist served all mental health facilities within the Northern Province. The psychiatrist was scheduled to visit periodically during the month, but these visits often do not happen in reality.
traditional healers nor established relationships with community-based traditional healers. While, theoretically, nurses have a counselling role, there was no evidence of nurses conducting group or individual counselling in any of the hospitals.

The proportion of patient medication records queried by the study psychiatrist (on the basis of dosage, level of polypharmacy and appropriateness of drug combinations used, and the relationship between medication and diagnosis) ranged between 23% and 41% (Figure 2). There was some suggestion that there were fewer queries in contracted hospitals (p < 0.05), although this may reflect the more stable patient population in these hospitals. Most queries related to the relationship between diagnosis and medication, with particular reference to diagnoses of “mental handicap”. A positive finding across all hospitals was a low frequency of queries about dosage, polypharmacy and combination of medications. The low frequency of dosage queries was supported by a more detailed dosage analysis.

<table>
<thead>
<tr>
<th>Query type</th>
<th>PR1</th>
<th>PR2</th>
<th>PR3</th>
<th>PUB1</th>
<th>PUB2</th>
<th>PUBH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mismatch between diagnosis and drugs</td>
<td>14.7</td>
<td>7.1</td>
<td>7.7</td>
<td>11.4</td>
<td>10.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Mismatch between MH &amp; drug</td>
<td>5.1</td>
<td>11.4</td>
<td>19.7</td>
<td>21.5</td>
<td>18.2</td>
<td>13.4</td>
</tr>
<tr>
<td>Drug combination</td>
<td>0.4</td>
<td>0.8</td>
<td>5.6</td>
<td>0</td>
<td>4.8</td>
<td>6.9</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>1.7</td>
<td>1.3</td>
<td>1.4</td>
<td>3.1</td>
<td>0.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Drug dosage</td>
<td>1.2</td>
<td>1.7</td>
<td>1.4</td>
<td>2.5</td>
<td>0.5</td>
<td>1</td>
</tr>
</tbody>
</table>

Mortality rates ranged between 5% and 10% across hospitals during the 12 months prior to the site visit (Table 5). A large number of deaths occurred
under the age of 35 – up to 60% in one hospital. Over 60% of those who died were patients under the age of 55. (PUB-1 had the greatest proportion of patients over 65 (25%); CON-3 had the smallest number of older patients at 8%). Infectious diseases were the most frequently reported cause of death. The highest mortality rate (at CON-2) resulted from a Shigella outbreak. There were no reported suicides.

Table 5. Patient mortality rates per institution

<table>
<thead>
<tr>
<th></th>
<th>CON-1</th>
<th>CON-2</th>
<th>CON-3</th>
<th>PUB-1</th>
<th>PUB-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>96</td>
<td>122</td>
<td>31</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>Deaths/ patient/ year</td>
<td>0.05</td>
<td>0.10</td>
<td>0.07</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>% deaths &lt; age 35</td>
<td>7% (7/96)</td>
<td>35% (43/122)</td>
<td>61% (19/31)</td>
<td>not available</td>
<td>41% (12/29)</td>
</tr>
<tr>
<td>% deaths &lt; age 55</td>
<td>39% (37/96)</td>
<td>70% (85/122)</td>
<td>81% (25/31)</td>
<td>not available</td>
<td>62% (18/29)</td>
</tr>
</tbody>
</table>

Hierarchy of objectives level 4 - custodial care: The hospitals achieved only rudimentary quality standards with regard to custodial objectives. All hospitals were designed as institutional hostels, with open-plan wards filled with beds in rows and minimal ablution facilities. Recreational facilities were limited or non-existent. There were no protected outdoor facilities. Wards were larger in the contracted hospitals than the public hospitals. Public hospital wards averaged 47 patients per ward unit, whereas contract hospital wards averaged over 160. Ablution facilities were few, often dysfunctional, overflowing, and unhygienic. The lack of hygiene in ablution facilities was presumably a contributing factor to the previous year's Shigella outbreak in CON-2, leading to the death of 10% of the patient population. A comparison of structural indicators of custodial care is provided in Table 6.

Table 6. Structural indicators of custodial care

<table>
<thead>
<tr>
<th>Level</th>
<th>Public-sector</th>
<th>Privately contracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>Centralized, bureaucratic, non-responsive</td>
<td>36 patients to 1 professional nurse</td>
</tr>
<tr>
<td>Staff complement</td>
<td>8 patients to 1 professional nurse</td>
<td>8 patients to 1 non-professional nurse</td>
</tr>
<tr>
<td></td>
<td>5 patients to 1 non-professional nurse</td>
<td></td>
</tr>
<tr>
<td>Staff performance</td>
<td>Basic custodial care requirements achieved</td>
<td>Low Hostel design</td>
</tr>
<tr>
<td>Staff satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure density</td>
<td>Average 209 patients per ward</td>
<td>Average 44.5 patients per ward</td>
</tr>
<tr>
<td></td>
<td>Average 16 patients per ward unit</td>
<td>Average 53 patients per bedroom unit</td>
</tr>
<tr>
<td>Supplies</td>
<td>Lacking/minimal custodial care requirements</td>
<td></td>
</tr>
</tbody>
</table>
A limited degree of individualized care was achieved within hospitals where wards were smaller than 50 patients (CON-3, PUB-1, PUB-2). Nurses were less likely to provide any individualized care, or even know all of the patients’ names, in the contracted hospitals where care was conducted via mass routines.

Time between basic care routines in the contracted hospitals is spent in “groups”, where patients mostly sit or sleep. While very self-motivated patients in the public hospitals may be active during the day, the majority of patients spend the days largely unsupervised, and sit or sleep.

Contracted hospitals demonstrated better ward-based administration (including organization of patient files) and more frequent patient treatment routines (including physical screening). A comparison of custodial care process indicators is summarized in Table 7.

Table 7. Custodial care: comparison of process indicators in the public and private sectors

<table>
<thead>
<tr>
<th>Process</th>
<th>Public sector</th>
<th>Privately contracted sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic care routines</td>
<td>Achieved, more individually</td>
<td>Achieved in mass, more depersonalized routines</td>
</tr>
<tr>
<td>Time between basic care routines</td>
<td>Unstructured – patients lie, sit and wander around</td>
<td>Patients organized into sitting groups</td>
</tr>
<tr>
<td>Staff-patient relationship</td>
<td>Kind and warm, short of actively affectionate</td>
<td>Kind and warm, short of actively affectionate. Rated less positively by nursing staff than in public sector</td>
</tr>
<tr>
<td>Ward-based patient administration</td>
<td>Lower-quality patient files</td>
<td>Higher-quality patient files</td>
</tr>
</tbody>
</table>

Summary of quality-of-care findings: Both public and privately contracted hospitals were characterized by fundamental quality deficiencies. Contracted hospitals demonstrated a slightly higher-quality service in ward-based administration (patient files, medical screening routines). The differences in quality which favoured the public sector lay in the “style” of care, with contracted hospitals adopting a less personalized approach. Contracted hospitals had, on average, less than half as many staff per patient as public hospitals, wards were larger, and care was organized into large and depersonalized group routines. Compared with this “group-routine” approach to care, the public hospitals’ approach to care was somewhat more individualized.
Cost of hospital treatment

The three contracted hospitals cost approximately 34 South African rand\(^1\) per patient per day and the two public hospitals cost approximately 78 rand per patient per day, excluding central administration and management functions. A sensitivity analysis was conducted to explore the contribution of excluded costs. Using the highest estimate for excluded costs of 8%, they were on average 35 rand and 84 rand, respectively. The contract prices charged across the three contracted hospitals ranged between 35 rand and 65 rand per patient day, with an average of 48 rand. In terms of cost per patient day to the public sector, public hospitals cost on average 1.6 times the average price of the contracted hospitals. The average difference between revenue and production costs in the contracted hospitals (i.e. their profit margin) was between 23% and 29%, assuming that excluded cost items accounted for up to 8% of production costs\(^2\).

Personnel is the largest cost item, representing between 70% and 80% of total costs across hospitals\(^3\). The remaining cost items (food, infrastructure,  

\(^1\) At the time of conducting this study 1 US dollar = approx 5 South African rand.  
\(^2\) We have considered the average across the three hospitals, since the hospitals are not operated as individual profit centres, but are part of a centralized corporate management structure.  
\(^3\) Assuming that costs excluded in this study account for approximately 8% of the total budget, these figures represent between 66% and 74% of total costs. The private company managing three of the hospitals calculates this figure to be approximately 65% for its hospitals.
transport, pharmaceuticals and laundry) represent on average 12%, 4.5%, 3%, 3% and 2%, respectively.

Cost differences between hospitals are explained almost entirely by expenditure on personnel. Public-sector hospitals had more nursing staff per patient across all nursing staff ranks, and proportionately more highly trained nurses (Figure 1).

Table 8 further demonstrates that cost differentials are consistent with differences in expenditure on personnel, and reflect the number of staff per patient rather than large differences in the salary scale.

**Table 8. Comparing sectors: personnel costs vs. overall costs**

<table>
<thead>
<tr>
<th></th>
<th>Cost/ patient/day (rand)</th>
<th>Personnel cost/ patient/day (rand)</th>
<th>Patients/ nurse</th>
<th>% of budget</th>
<th>Average annual nursing staff salaries (rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privately contracted (CON)</td>
<td>34</td>
<td>25.2</td>
<td>6.4</td>
<td>74</td>
<td>56 970</td>
</tr>
<tr>
<td>Public (PUB)</td>
<td>78</td>
<td>61.1</td>
<td>3.1</td>
<td>78</td>
<td>62 204</td>
</tr>
<tr>
<td>CON/PUB</td>
<td>0.44</td>
<td>0.41</td>
<td>2.1</td>
<td>.95</td>
<td>.92</td>
</tr>
</tbody>
</table>

Note: This table uses the costs calculated for each hospital, assuming that excluded costs are negligible.

**Contract design**

The design of the contracts placed the risk disproportionately on the public sector and the patient population, with little risk residing with the service provider. The contracts with each of the privately contracted providers were long-term contracts (signed for at least 20 years), negotiated noncompetitively with a preselected contractor on the basis of cost per patient day. The contract price increased annually, independent of performance. There were few quality specifications, and those that did exist were vague and related only to custodial care objectives. No penalties were stipulated for nonperformance. The absence of clear performance or monitoring guidelines linked to payment methods and of any recognition of investment in quality improvements provided no incentive to improve quality of patient care. In two out of three of the contracts, all infrastructure and maintenance had to be met by the contractor. One contract allowed contractors to refuse to pay for medication that was more expensive than had been anticipated, but allowed them to retain savings if medication costs were less than expected.

The contracts included a minimum occupancy clause specifying that, should hospital occupancy fall below 90% for more than two weeks, the Department of Health would be responsible for a per diem rate at an assumed bed occupancy of 90%. Consequently, virtually all the risk associated with decreased demand for services was borne by the State.
Discussion

This study was, in fact, an investigation of the contracting experience within a context of institutional neglect on the part of both the public sector and private providers. The experience suggests that, in the context of neglect (or in a context where monitoring capacity is not developed), both public and contracted care yield poor quality outcomes. In the context of post-1994 mental health policy (Department of Health, 1997), psychiatric hospitals should seek to minimize the duration of stay of long-term patients by preparing patients, families and communities for the patients’ discharge. While the contractor hospitals had significantly lower costs than the public hospitals, neither was producing the desired institutional result.

The number of personnel, staff mix and ability to allocate personnel on the basis of patient load are the three characteristics which seem to explain the cost differences between sectors. Higher average personnel costs in public hospitals are primarily a reflection of greater staff availability across all cadres in these hospitals, as well as proportionately more highly trained staff in the overall staff mix. The lower costs in contracted hospitals not only reflect lower numbers of staff and proportionately fewer highly trained staff, but also reflect the fact that staff in the contracted hospitals are more efficiently allocated on the basis of patient load across hospitals.

There was little evidence of systematic or sustained differences in quality of care between the public and contracted hospitals. The most discernible difference lay in a cluster of personnel numbers, ward size and approach to daily living, with contracted hospitals having fewer nursing staff, larger wards and a more depersonalized approach to daily care routines. There was little relationship between differences in cost and quality of care among these hospitals. While the contract price varied widely, the production costs and quality-of-care outcomes were virtually identical.

Whether or not contracting is “working” in this context depends upon the value system of the public sector. If the core value of the public sector is to minimize costs without specific reference to quality, then contracting out services is “working”. If the core value is to provide high quality of care, then the present practice is questionable, as contracted care suffers from the same quality deficiencies as public-sector care, and often worse. Assuming the public sector is motivated by the provision of relatively high-quality care, the question then becomes: how can the public sector transform either itself or the contracting partner to produce higher-quality outcomes?

Broomberg (1994) suggests that the answer lies largely in the ability of the public sector to negotiate balanced contracts, and monitor those contracts effectively. This study supports the conclusion that current contracts are not structured to produce quality outcomes. The contracts for the three contracted hospitals in this study were not designed to promote quality or efficiency. The
design of the contracts placed risk disproportionately on the public sector and the patient population, with little-to-minimal risk residing with the service provider.

The study suggests, however, that improving quality in these hospitals may go beyond contract design and monitoring mechanisms alone. It suggests that hospitals are currently not structured – in terms of personnel, programme or budget – to achieve objectives beyond minimal custodial care and psychiatric treatment. The personnel budget across hospitals, for example, is oriented toward the provision of custodial care, with less than 7% of the overall budget dedicated to psychiatric treatment or patient/family development services. The institutions, whether public or contracted, require profound organizational change in order to meet these objectives. Such a transformation will depend upon intersectoral collaboration with primarily public sector services, largely on the basis of shared “core values” (Collins & Porras, 1994) between local management and other public-sector services.

Furthermore, this study suggests that there are important intangible aspects of “quality” in the context of psychiatric services, which may be referred to as a sense of “organizational humanity”. This requirement may suggest different types of private partnerships (e.g. nongovernmental organizations, churches) which are already more explicitly driven by the more intangible aspects of quality – the building blocks of a deeper “organizational humanity”.

While this study investigates the contracting experience in the context of institutional neglect, the analysis has a number of implications with respect to quality improvement within psychiatric services in low-income and middle-income nations. Firstly, the custodial care legacy of the colonial era largely defines the organizational function and form of psychiatric hospitals in the current era. The first step toward quality improvement is a rigorous and inclusive debate about the function and form of quality in a postcustodial care paradigm. The definition of norms and standards for patients with “severe psychiatric morbidity” by Flisher et al. (1998) represents a first step in this direction for South Africa. The outcomes of this process must determine the nature of both the managing relationships and the contracts. Given both the magnitude of organizational change required and the importance of the more intangible aspects of care, quality will be improved not only through more technically efficient contracts (penalties for nonperformance, incentives for performance, joint monitoring mechanisms) but through the choice and development of the managing partner and monitoring relationships – whether public or privately contracted.
Acknowledgements

This chapter emerges from a long-term research project conducted by the Centre for Health Policy at the University of the Witwatersrand, designed to give a better understanding of cost and quality of care in chronic psychiatric hospitals in South Africa. The project team included Tennyson Lee, Makhosazana Sibeko, Neil Søderlund, Lucy Gilson and Enoch Peprah. Melvyn Freeman, Director for Mental Health, National Department of Health, initially conceived the idea for the study. The author would also like to acknowledge the contributions and support of Elizabeth Dartnall, Francesca Clews, Dr Rudolf Moos, Dr Marilyn Winkelby, Dr Helena Kramer, Dr Ruth Zwi, Dr Allison Beattie and Dr Ann Porteus. Many of those who have contributed the most time and insight to this study, the patients and staff at the six hospitals, must remain nameless for the purposes of confidentiality.

Further reading


References


Mental Health and Substance Abuse Committee, South Africa. Human rights violations and alleged malpractices in psychiatric institutions (paper presented to the National Department of Health). Pretoria, 1996.


10. Private health care in Uganda - the poverty cycle explained

Delius Asiimwe

Introduction

The political and economic instability in Uganda which continued throughout the 1970s and 1980s left a fractured economy that severely weakened the public health sector. There was a general lack of resources to run public health facilities and inadequate management skills among health workers that led to poor delivery of health services (Asiimwe et al., 1997). Despite over 10 years of relative peace and stability in most parts of the country, the legacy of these past developments in the form of poorly motivated health workers and poor accountability of public health-sector resources still persists. The public health workers’ practice of informal user charges and health worker absenteeism caused by parallel working by public health workers in the private health sector continue to have a tremendous impact on health service delivery in both the private and the public health sectors in Uganda (McPake et al., 1998). This forces many patients to seek services in the private health sector, the main reasons being greater ease of access, availability of staff and drugs and shorter waiting periods (Brugha & Zwi, 1998).

The past few years have also witnessed a shift in government policy in favour of privatization in all sectors. In the health sector in particular, the pressure for greater privatization has been prompted by the need to find alternative sources of funding for the health sector because of the growing limitations of the national health budget (Owor, 1987; Kaheru, 1990; Kiyonga, 1997). With the government intending to provide ready access to good-quality basic health care for all citizens according to need, regardless of their socioeconomic situation, and specifically to provide mechanisms and provisions to protect the poor, the most vulnerable and the disadvantaged, there was a need to develop closer coordination and integration between the public sector, independent voluntary (religious) providers, private for-profit providers and nongovernmental organizations (NGOs).

It was thus necessary to assess the nature and extent of current private-sector involvement in health; institute effective means of promoting private-
sector partnership; and establish appropriate instruments to facilitate and regulate the private sector in line with existing national laws and regulations (Ministry of Health, 1998). However, only a small amount of official data are available for a small number of registered private health facilities, mainly in urban areas. Little is known about the majority of unregistered and unrecognized facilities (Health Planning Department, 1996), leading some authorities to conclude that the potential of the private health sector had not been fully realized. It also makes it difficult for the government to formulate appropriate health policies (Asiimwe & Lule, 1992; Munishi et al., 1994; Okello et al., 1997).

In response to this information gap, a research project designed to determine the nature and role of the apparently rapidly growing private health sector was undertaken, beginning in December 1996. The study carried out an inventory of private health facilities in Kampala City, to establish the size, composition and characteristics of the private health sector, and undertook a qualitative assessment of the experiences and perceptions of private providers in a number of areas such as business operations, socioeconomic environment, regulations and private and public relationships. Finally, it examined the extent to which these factors affect private health-sector businesses in order to develop a deeper and wider understanding of the present private health sector.

A historical perspective on the emergence of private providers
The salaries of public health workers decreased significantly during the 1980s owing to the internal strife and associated socioeconomic mismanagement arising from political upheavals. There was a slight improvement in the early 1990s, but still salaries were not enough to enable workers to meet their monthly expenses without additional income earned inside or outside a public health facility. Health workers thus developed various means of survival, including informal charging for health services at the public facility which had hitherto been free, theft of user charges or drugs, home-based private practice, ownership of private facilities and salaried work in private health facilities (Jitta & van der Hiejden, 1993; Asiimwe et al., 1997). A large number of public health workers joined the private health sector, either by setting up private health facilities of various types or as employees in pre-existing facilities. This led to two major developments in Uganda’s health system, namely:

- the establishment of a wide range of private health facilities in urban and rural areas
- an increase in the number of public health workers doing part-time private work to earn additional income (Asiimwe et al., 1997).
Methods

The study employed both quantitative and qualitative research methods, with the researchers spending three-and-a-half months in the field. It combined an inventory of facilities as well as an in-depth interview with a number of providers to collect a considerable volume of data. The inventory part of the study was based in eleven parishes constituting 15% (116 136) of the total population (774 241) of Kampala district (Ministry of Finance, Planning and Economic Development, 1991). The actual parishes selected varied in terms of population density (high, medium or low) and nature (commercial/residential)\(^1\) so that the sample would be relatively representative of Kampala City as a whole.

Initially, a questionnaire was administered in each private health facility in the Local Council 1 zone (village). With the guidance of local leaders, the researchers tried to identify the location, size, type and characteristics of the private health facilities. The exact number of questionnaires administered depended on the number of health facilities available in each Local Council 1 (LC1) zone. The interviews were conducted with an individual or individuals working at the facility, irrespective of the person’s status. Where the respondent was not able to give all the required information, the researcher asked to speak with someone more conversant with facility activities and a call-back appointment was arranged. In cases where a facility was found to be closed, a call-back appointment would be arranged to meet the respondent. At least three call-backs were made before a particular respondent from a facility was declared as not available during the study period.

For those who totally refused to cooperate, a few observable items of information were collected. In particular, data on the location, type of facility and level of infrastructure present were recorded for the inventory.

From this inventory of private health facilities, a sample of 41 (10%) was taken for phase II of the study. They were stratified by parish, category and reported registration status in order to ensure fair representation. An in-depth interview was carried out with selected key informants in phase II, using a structured interview guide. The factors discussed included:

- the causes of the movement of private providers between the public and the private sector
- knowledge of, use of and problems associated with existing regulations
- the day-to-day operation of private health care businesses
- current market dynamics in the private sector.

\(^1\) For the purposes of this study, a “commercial” area was defined as one with 20 shops close together, or 10 plus a market. A “residential” area was one without these facilities.
The units of analysis for the quantitative data were the private facilities and the personnel working in these facilities. Information was derived from these about numbers of facilities, location, type, infrastructure, economic profile, services available, ownership and management, and about number and qualifications of personnel, their specialization and changes in their employment status and sectors over time.

**Results**

The study combined both quantitative and qualitative information from the inventory and testimonies from clinical attendants. Evidence from each phase of the study (inventory and in-depth interview) is used to support the other. More details can be obtained from the study report (Asiimwe, 1999). The private health facilities captured by the inventory phase are shown in Table 1.

**Table 1. Types of private health facility surveyed, by administrative division**

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Nakawa</th>
<th>Rubaga</th>
<th>Makindye</th>
<th>Central</th>
<th>Kawempe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Health centre</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dispensary</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Maternity/ nursing home</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Clinic</td>
<td>20</td>
<td>34</td>
<td>28</td>
<td>18</td>
<td>30</td>
<td>130</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>4</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Drug shop</td>
<td>26</td>
<td>28</td>
<td>17</td>
<td>14</td>
<td>18</td>
<td>103</td>
</tr>
<tr>
<td>Esabo/Duwa</td>
<td>24</td>
<td>32</td>
<td>36</td>
<td>11</td>
<td>31</td>
<td>134</td>
</tr>
<tr>
<td>TBA/herbalist</td>
<td>11</td>
<td>5</td>
<td>11</td>
<td>3</td>
<td>11</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>113</td>
<td>96</td>
<td>52</td>
<td>102</td>
<td>449</td>
</tr>
<tr>
<td>%</td>
<td>19.1</td>
<td>25.2</td>
<td>21.4</td>
<td>11.6</td>
<td>22.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The various establishments are defined as follows.

**Hospital:** a health facility with inpatient and outpatient departments, maternity services and facilities for various surgical operations.

**Health centre:** inpatient and outpatient departments, sometimes limited maternity services, but no surgery.

**Dispensary:** like a health centre but on a very small scale.

**Maternity and nursing homes:** health facilities specializing in maternity services (antenatal, perinatal and postnatal care). In our study these also included domiciliaries, i.e. health facilities offering nursing services to expectant mothers but not postnatal care.

**Clinic:** a health facility strictly limited to outpatient diagnosis and treatment.
**Pharmacy:** an authorized wholesale or retail establishment where drugs of all classes are sold to patients with prescriptions from qualified and registered medical personnel.

**Drugshop:** an authorized retail establishment selling only Class “C” drugs.

**Esabo:** a Kiganda name for the traditional healer’s facility, irrespective of its level or size, diseases treated, equipment used or qualifications of the doctor.

**Duwa** (local name): similar, but exclusively owned and run by Muslims, who generally use and read the Qur’an as a way of diagnosing ailments.

**Traditional birth attendant (TBA)/herbalist:** generally a provider using his/her own house as a facility to deliver mothers and offer limited postnatal care using local herbs and locally acquired skills. Herbalists mainly concentrate on treatment of reported diseases using local herbs.

From the inventory phase, and from previous studies, a number of factors were isolated which were likely to be important for the detailed survey (phase II). These include:

- **provider factors** (income needs, employment opportunities for providers and the breakdown of the public health system)
- **socioeconomic conditions** (stagnating economic growth, household poverty, poor health education)
- **the ease of private-sector work for public-sector workers** (regulatory climate, cost of entry, back-up income through work in the public sector)
- **the overall Government policy climate** (public service rationalization, decentralization, liberalization of the economy).

This chapter explores in detail aspects of each of the first three factors. The results refer to the private health sector in one of the prime districts of Uganda: Kampala. The district was chosen because it allowed an in-depth account to be given of the various characteristics of the private sector.

**Setting up private practice - sources of capital**

The major source of capital for private health care businesses was reported as personal savings. These savings are probably small, as they are derived from either the salaries of health workers working in the public health sector, where remuneration is very poor, or from current employment and small-scale business carried out by providers for survival. Other sources included loans from local companies or associations or from friends and relatives, secured on an informal basis. Such sources of initial funding determined the type, level of investment and operation of business by the private health worker. The evidence from the inventory reveals that the majority of the private facilities
were small business ventures. Fifty-two per cent were small clinics and drug shops practising and supplying Western medicine, while 38% were traditional healing facilities.

“The initial capital was one million five hundred thousand (1.5 million) Ugandan shillings. The capital was raised from my friends on mutual understanding and partly my own money as savings from my salary from a public hospital.” (Medical assistant in anaesthesia owning a clinic and working in a public hospital)

“I began with over 2 million Ugandan shillings. My relatives are the ones who gave me the money. I borrowed the money from them and I told them I would give them some interest. Even when I was working with city council for 10 years, I bought equipment like a trolley, and instruments for delivery slowly by slowly.” (Midwife and owner of maternity facility)

Even when health workers do have access to capital, they often choose not to invest in dilapidated facilities, using the capital instead to buy land for farming, commercial buildings or residential houses. This economic behaviour points to the uncertainty among providers, who should be investing in the private health sector.

During the inventory, the majority of facilities did not have the basic diagnostic equipment needed for their operations. In particular, they lacked thermometers, stethoscopes, blood-pressure-measuring equipment and sterilizers, as shown in Table 2. Available evidence from other surveys indicate that the availability of basic diagnostic equipment in public health facilities is much greater than in the private ones (Asiimwe et al., 1997; Okello et al., 1997).

**Table 2. Type of private health facility and available diagnostic equipment**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health centre</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Dispensary</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Maternity/nursing</td>
<td>22</td>
<td>18</td>
<td>5</td>
<td>20</td>
<td>1</td>
<td>5</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Clinic</td>
<td>112</td>
<td>104</td>
<td>61</td>
<td>98</td>
<td>16</td>
<td>59</td>
<td>105</td>
<td>36</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Drug shop</td>
<td>60</td>
<td>19</td>
<td>2</td>
<td>18</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Esabo/Duwa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TBA/herbal</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Type of facility: Th. = thermometer; Stet. = stethoscope; M/sc = microscope; BP = blood-pressure-measuring equipment; D/ch = dentist’s chair; Ster. = sterilizer; Exam. chair = examination chair; W/s = weighing scales. Facilities recorded: 406.
Apart from requirements for premises and equipment, a major start-up cost of establishing a new private facility is registration. It appeared from the survey that many facilities did not register themselves, even though they were legally required to do so (Table 3). This emphasizes the barrier imposed by regulatory conditions, and also calls into question government statistics on private-sector development, which are based on registration data.

### Table 3. Reported and actual registration status of private health facilities

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Reported registered</th>
<th>Reported not registered</th>
<th>Not known</th>
<th>Registration confirmed</th>
<th>Registration not confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Health centre</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Dispensary</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Maternity /nursing</td>
<td>16</td>
<td>6</td>
<td>-</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Clinic</td>
<td>93</td>
<td>20</td>
<td>6</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12</td>
<td>1</td>
<td>-</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Drug shop</td>
<td>69</td>
<td>26</td>
<td>3</td>
<td>31</td>
<td>38</td>
</tr>
<tr>
<td>Esabo/ Duwa</td>
<td>75</td>
<td>51</td>
<td>-</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>TBA/ herbalist</td>
<td>11</td>
<td>27</td>
<td>-</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Total (420)</td>
<td>279</td>
<td>132</td>
<td>9</td>
<td>137</td>
<td>142</td>
</tr>
<tr>
<td>%</td>
<td>66.4</td>
<td>31.4</td>
<td>2.2</td>
<td>49*</td>
<td>51*</td>
</tr>
</tbody>
</table>

* % of those reporting that they were registered (n = 279).

### Size and operation of facilities

The physical characteristics of health facilities were recorded by observation. Of the 413 facilities whose rooms were counted, 255 (61.7%) facilities occupied one room each and only 18 (4.4%) had five or more rooms. The size of facilities used by private providers was determined partly by their patient numbers and by the number of personnel employed at the facility. Ideally, for a facility like a clinic, the standard size requirement would be two rooms with five compartments to provide for examinations, injections, dispensing, a laboratory and a rest area.

Many of the facilities recorded (285 out of 406) were operating in rented premises. The rental for two rooms was reported to be around 70 000 Ugandan shillings (approx. US$60) per month in most suburbs of Kampala City. Most providers interviewed considered the level of rental charges too expensive, and opted for smaller premises. The preference for smaller health premises was further influenced by high government taxes and poor access to capital.

Operating in small rooms undermines patients’ privacy, since patients seated inside are likely to hear what the health care provider is discussing with another patient. It could also spread contagious diseases such as influenza or tuberculosis, thereby compromising the quality of care at the facility. Furthermore, individual health care providers might use their time inefficiently
because they are continually switching between examining, treating and injecting patients and acting as a storekeeper. Where doctors did employ nurses, much of the treatment was reported as being left to nurses, who do not examine patients or carry out laboratory tests. Ultimately, the quality of services rendered turned out to be no better than in public-sector facilities, which have a relatively adequate infrastructure, but likewise do not carry out adequate examinations or make proper diagnoses and do not have enough well-qualified health workers.

Parallel working arrangements

While a good number of public health workers may leave the public sector completely to join the private health sector, others choose to engage in private work while still working simultaneously in the public sector. Out of the total of 281 private-sector health workers who reported previously working in the public sector, 149 (53.0%) still retained a public job, while 130 (47.0%) had left the public sector altogether (excluding those working in the hospital, who totalled 96 and are considered separately in this paper – see below). On the other hand, five out of the 110 (4.5%) who reported having previously worked in the private health sector were currently employed in the public sector. This means that the public sector continued to employ new personnel from the private sector even if they retained their private jobs, although the numbers involved are small. Table 4(a) shows the previous places of employment of those currently working in the private health sector (excluding Kibuli hospital), and Table 4(b) gives the same information, but specifically for those working at the private hospital.

<table>
<thead>
<tr>
<th>Previous place of employment</th>
<th>Public sector*</th>
<th>Private health sector</th>
<th>Other private sector</th>
<th>None</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector*</td>
<td>149</td>
<td>18</td>
<td>3</td>
<td>109</td>
<td>2</td>
</tr>
<tr>
<td>Private health sector</td>
<td>5</td>
<td>32</td>
<td>1</td>
<td>71</td>
<td>1</td>
</tr>
<tr>
<td>Other private sector</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>14</td>
<td>13</td>
<td>3</td>
<td>368</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td>42</td>
<td>14</td>
<td>1</td>
<td>43</td>
<td>25</td>
</tr>
<tr>
<td>Total (926)</td>
<td>10</td>
<td>77</td>
<td>9</td>
<td>600</td>
<td>30</td>
</tr>
<tr>
<td>%</td>
<td>22.7</td>
<td>8.3</td>
<td>1.0</td>
<td>64.8</td>
<td>3.2</td>
</tr>
</tbody>
</table>

* The public sector here refers to all publicly owned organizations.
Kibuli private hospital

Kibuli Hospital is the only hospital in the list of private health facilities. It is owned and run by a local religious nongovernmental organization (NGO). It is a not-for-profit facility that registered in 1983 as a nursing home and became a hospital in 1993.

It is the newest and smallest of all the NGO hospitals in Kampala. There are two other NGO hospitals, owned and run by the Catholic and Protestant churches, respectively. The hospital offers a wide range of the usual hospital services and has the necessary equipment, but on a very small scale. The hospital employs a total of 96 health workers (including casual labourers). It also benefits from the services of 35 consultants on a part-time basis from the only government referral hospital in Kampala.

The data on the personnel from the hospital is presented separately here, the reason being that one single facility with a large number of staff would adversely affect the analysis of the smaller ones. A deliberate effort was made to use this information on Kibuli Hospital to support and compare the findings from the majority of smaller units.

Income of health workers in the private health sector

There was scanty information on the private providers’ income: only a few individuals remembered the figures, and they were only willing to divulge their income on a daily or monthly basis. The majority do not keep accounts, and their income could not be calculated on the basis of the number of patients or types of ailment treated at the facility, since there are no standard rates. The charges for the service vary greatly according to the patient’s ailment and the individual seeking treatment at a particular facility. For those involved in the sale of drugs, the estimated profits are based on their cost and the expected sale price. The problem with this estimation is that the sales are not all made at the same time. However, all facilities reported that their main source of

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Table 4b. Private health care providers’ previous employment and other current places of employment (private-hospital employees)

<table>
<thead>
<tr>
<th>Previous place of employment</th>
<th>Public sector*</th>
<th>Private health sector</th>
<th>None</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector*</td>
<td>1</td>
<td>4</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Private health sector</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Other private sector</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>-</td>
<td>2</td>
<td>47</td>
<td>-</td>
</tr>
<tr>
<td>Not known</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Total (96)</td>
<td>1</td>
<td>6</td>
<td>77</td>
<td>12</td>
</tr>
<tr>
<td>%</td>
<td>1.0</td>
<td>6.3</td>
<td>80.2</td>
<td>12.5</td>
</tr>
</tbody>
</table>

* The public sector here refers to all publicly owned organizations.
income remained consultation and procedure fees, with the hospital reporting that it accounted for about 95% of the hospital’s total annual revenue.

The majority of private providers admitted making a profit from their business, although it was a minimal one in many cases. Exceptions were the hospital, which reported running a deficit, and traditional birth attendants, who said they were not earning anything owing to poor demand for their services. In general, respondents claimed that poor and irregular demand for their services, high recurrent costs and government taxes all combined to make the income and profit of private health workers inadequate. The low and uncertain income levels in much of the private health sector compare closely with the low incomes of public health workers.

“It [income] is not specific. It depends on the conditions of patients and their affordability ... We collect 20 000 shillings to 25 000 shillings a day.” (Medical doctor, owning a private clinic and working with the Ministry of Health)

“When I know I have bought a tin, let me say of Aspirin, at 4 500 shillings and I am to sell each aspirin at 10 shillings then I expect to get 5 500 shillings. But the money does not come so fast from that tin, I sell it for long. When I subtract what I used to buy the tin (4 500 shillings), then I know what profit I have got.” (Enrolled nurse owning a drug shop)

**Dual employment inefficiencies**

During the qualitative fieldwork, some private providers were found to be regularly working in the public sector as well (Table 4). Although a few providers we interviewed think that parallel working expands the health system, evidence from similar studies indicates that health care providers often use public resources, including drugs, sundries and time, for private purposes (Asinirwe et al., 1997). Many resources may be lost to health care altogether, however, because of the inefficient organization of the private sector, with qualified health workers being unable to render services effectively in either public or private facilities. Providers are often not accessible to their patients because they are working elsewhere. Part-time working arrangements often mean that cases are not followed up. Some facilities, especially those owned by lower-level health workers, such as nurses and paramedics who work shifts, are not opened up until late in the evening.

“The practice of moving between government and private makes the health workers inefficient for either way, but more in the public sector. Patients in the public [sector] are left unattended [with health care providers] devoting much of the attention to their private patients ... It does not mean that during those hours when they are not there patients do not get sick.” (Registered nurse owning a clinic)
Conflicts of interest also affected the quality and acceptability of care offered:

“A woman was prescribed drugs at a public health facility and told where to buy them, but instead she bought them elsewhere. When she brought the drugs to the health providers to administer, they refused and the patient had to go back and buy another dose from where she was specifically directed.”

(Traditional healer – herbal)

**Consumer characteristics**

**Affordability:** The incomes of the patients who seek health services greatly affect the operation of private health facilities. Respondents reported relatively few patients (clients) seeking consultation services, with the majority coming to buy drugs without seeing the health worker, since this was considered expensive. For example, a patient may buy the drugs for 500 shillings (approx. US$0.3), while seeing the doctor may cost 3 000 shillings (US$2). It was reported that between 40% and 70% of patients bargained for cheaper treatment prices. In other cases, treatment was purchased in instalments. Instead of receiving four injections, the patient requests one, waits to recover slightly and then goes to find money to fund the completion of the course of treatment.

**Patients’ health-care-seeking behaviour:** The low incomes of patients combined with their health knowledge and the expectations of private providers also inhibited the quality of care. The majority of patients came to private providers wanting the drugs they thought would treat their ailments, while trying to avoid the cost of a medical consultation. Patients also try to purchase less than the recommended dose. In cases where underdosing occurs, and drug resistance builds up, the blame is often put on the providers who carried out the treatment. As the cost of treatment for complications escalates, private health services become unaffordable and patients turn to public health facilities, which are often unable to offer the required treatment either. Others seek out traditional healers, which is sometimes more costly and may involve undesirable acts such as the sacrifice of animals or even children.

“The low turn-up of patients and self-medication which is rampant in the area is partly attributed to affordability of poor patients ... The damage it causes is lamentable and when they try to rectify it, the costs are high and expensive. Patients come when they tried either underdose or otherwise cheap drugs, such that when you explore the history you find all the first-line drugs have been misused and have to recommend strong ones which in most cases are expensive, making affordability to majority of the patients difficult.”

(Medical doctor owning a clinic)

**Nonpayment of medical bills:** A good number of patients receiving treatment do not pay their full medical bills in the private health facilities.
Smaller providers like clinics, drug shops, Esabo/Duwa and traditional birth attendants often allow payment to be negotiated. Where negotiations occur, the patients may be given half the drugs immediately and the balance when they return to pay. In other cases, presumably where there is some mutual trust, a patient receives full treatment and pays later. One NGO hospital required patients receiving treatment on credit to leave possessions (e.g. a mattress or radio) as collateral in order to ensure that they would pay. However, not all patients whose property was retained were able to come back and pay. In another NGO hospital in Kampala, a “retainee ward” was set aside to detain patients who had been treated but had not fully paid their medical bills until they were able to pay. Unpaid debts of three months or more are common and, as a result, some facilities are unable to replenish their drug stocks. This, in turn, leads to poorer quality of service, and the demand for private health services is undermined. Compared with the public health sector, whose services are of equally low quality, the private sector is mainly affected by the demand side rather than the supply side.

“Poverty in the population is a problem. All the drugs you see in these places have standardized doses. Like ampicillin: the standard dose is 40 capsules, when you cost it, it’s about 1,000-2,000 shillings, but you see in Uganda there is a problem of poverty. You get a poor patient who has 200 shillings. Ethically, if you are to sell him/her the drugs it’s not good. What we do, we give half a dose, and when the patient gets money he/she comes for the remaining ones. So it’s a problem from poverty.” (Private pharmacist owning a pharmacy and working in a public hospital)

Conclusions

Uganda’s government can no longer adequately support free medical services, and this has led to inadequate salaries for public health workers, insufficient drug stocks at health facilities and failure to maintain the public health sector infrastructure. Various attempts in the past to rehabilitate the public health facilities by means of donor support and the introduction of user fees did not yield substantial results in terms of better health care delivery. The government’s policy of liberalizing the economy, including the health sector, sought to attract private investment in health facilities and provide a higher-quality, more acceptable service for those who could not afford to pay. This

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1 A news item on Lighthouse Television (LTV), Uganda (9.30 p.m., 14 April 1999) showed patients in a “retainee ward” at an NGO hospital in Kampala. They included men, women and children, some of whom had been there for several months. Some were paying off their bill in instalments, but others had little hope of ever getting out of the hospital.
study suggests that the private health sector is not vibrant and flourishing. It is small, undercapitalized, underdeveloped and fragmented in its operations. Where demand for private services exists, ability to pay is often insufficient to cover medically necessary services.

Private provision is dominated by traditional healers, clinics and drug shops, in that order, spread over all geographical areas. These very small, individually-run private health facilities offer mainly “first aid” services to low-income users in what must be a fairly competitive market.

The multiplicity of providers increases access and choice for patients, and in the case of emergencies a good number of lives are said to have been saved. However, the duplication of underfunded facilities has probably decreased the efficiency and standard of services. Most private providers have resorted to treating minor ailments which are common in the area, and sell drugs of the type and in quantities that patients can afford. These practices promote undertreatment and irrational drug use and in many cases, ultimately increase the cost of services to patients.

Funding was reported as a major constraint on the development of the private health sector. The major sources of initial finance were personal savings and support from friends and relatives. The lack of access to larger, formal loans considerably limits the expansion of individual facilities. The increasing numbers of patients seeking health services in the private sector nevertheless suggests that well organized investment which facilitated improvements in efficiency, quality and administration might be money well spent.

This calls for a more organized private health sector to deal with primary health care delivery, possibly through organized associations to facilitate supervision and monitoring. Nongovernmental organizations and private individuals should provide initial funding. Government might also provide some finance, and streamline policy and regulations governing the private health sector. Ultimately, however, investments in this area will only be worthwhile if community incomes improve.

Thus the cycle of poverty in the Ugandan health sector continues. The low incomes of public health workers which force them to set up private facilities, the uncertain gains from private practice because of inconsistent demand for services, and the poverty of consumers/patients are essential ingredients of an ill-functioning health care system. Over time, they have developed an integrated relationship, just as the veins in a plant leaf carrying food, water and other minerals sustain and affect each other.

There remain a number of positive features of the private health sector, however. Private health facilities are more geographically accessible, and open for long hours, sometimes up to 10 p.m. They offer a range of commonly required services – dental, maternity, postnatal, outpatient, inpatient, health education, laboratory and traditional healing services. Moreover, problems are said to be solved more quickly in the private health facilities. Although expense
is a barrier, many people travel long distances to visit a specific, highly desired private provider. By comparison, there are few public health facilities such as hospitals, and they are often far away from where people live. They also have long waiting times for examination, laboratory results and drugs.

Despite its shortcomings, the private sector relieves government of the burden of providing everything for the population. As such, the private health sector is a service rather than a business venture. Though the government openly recognizes and appreciates the private sector's contribution to Uganda's health system, it interacts with private health-sector operations purely as a business venture. Its main concerns thus surround issues of taxation, drug supply and licensing. The limited explicit government support for the private health sector has significant policy implications. The proposed partnership between the public and private sectors may not work simply because the private health sector cannot meet the minimum organizational standards needed to cooperate effectively. If they were to cooperate, there would need to be a clear delineation of roles between the two, support from the government in funding sustainable facilities, and clear regulatory guidelines covering joint employment, minimum standards and adherence to registration requirements.

Acknowledgements

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However, the views expressed here are those of the author and do not reflect those of any organization.

References


11. Contracts for primary care in South Africa’s part-time district surgeon system

Natasha Palmer

Background and rationale

Walsh et al. (1997) observe that an interesting side-effect of global change lies in the exchange of ideas and experience that has taken place between countries. This is also true between high-income and low-income countries, and one aspect of it is an enthusiasm for exporting types of public-sector reform to the rather different setting in most low-income and middle-income countries (LMICs). For example, the contracting-out of health services to the private sector and/or performance agreements between different levels of government are now common components of public-sector reform packages promoted by bilateral and multilateral agencies for low-income and middle-income countries (England, 1997; Mills, 1998; World Bank, 1997a; World Bank, 1993; WHO, 1999; World Bank, 1997b). This enthusiasm does not, however, appear to be based on much evidence specific to the functioning of contracts in low-income and middle-income countries. Although existing contractual relationships in developing-country health systems are attracting increased attention and evaluation (Broomberg et al., 1997; McPake & Banda, 1994; Perrot et al., 1997; Broomberg, 1997; Mills, 1998; Abramson, 1999; Soeters & Griffiths, 2003), evidence relating to their advantages and disadvantages is still very scarce. The applicability of private-sector management theory to the public sector is also disputed, especially in the context of low-income and middle-income countries (Bennett, 1997; Bennett et al., 1996; Broomberg, 1997; Broomberg, 1994; Ferlie et al., 1996; Hood, 1991). Furthermore, little attention has been paid to the nature of contracts required for health services, features of their design and implementation including pricing methods, and what capacities governments require in order to put contracting mechanisms in place (Mills, 1998).

Dunleavy and Hood refer to the dangers of inappropriate cloning of policies (Walsh et al., 1997). The increased popularity of contracts as a prescription for reform in low-income and middle-income countries highlights the need to understand their nature and the manner in which they are likely to operate in a developing-country context. Some of the problems highlighted by evaluations of contracting in well-resourced organizations such as the National
Health Service in the United Kingdom are likely to be exacerbated in an LMIC setting. Characteristics common to many low-income and middle-income countries must be recognized, such as poorly developed institutional capacity, a shortage of administrative and contract-writing skills and poorly developed markets. The capacity of markets to behave competitively and transparently, or of government to support the creation of such markets, is likely to be limited in many low-income and middle-income countries (Schick, 1998). This chapter explores some of these issues, drawing on preliminary evidence from a case-study of one type of well-established contract for primary care in South Africa.

**Contracting for primary care in South Africa**

South African health policy has not escaped the trend for new public-sector reforms, such as contracting out services to the private sector. With the end of apartheid and South Africa’s first democratic elections in 1994, the new government inherited a fragmented health system in which resource distribution was highly skewed. In addition, there was a long-established split between the delivery of curative and preventive primary care services. Initial discussions about the transformation of primary care emphasized the private sector as a resource which could be drawn upon by contracting it to deliver services. The Committee of Inquiry into a National Health Insurance System for South Africa, which reported in 1995 (Department of Health, 1995), paid considerable attention to the role of the private sector in delivering primary care on behalf of the State. The influence of “quasi-market” or new public management ideas, such as those embodied by the internal market in the United Kingdom National Health Service, can be clearly seen in these recommendations. They included competitively awarded contracts with private practitioner groups. They also described a role for newly established district health authorities as “public purchasers”, which would buy care from varying combinations of competing public and private providers.

These ideas have, in fact, been very slow to materialize. Nevertheless, South Africa does have a rare example of the State (in the form of each of its nine provinces), contracting with general practitioners as “part-time district surgeons” (PDS) to deliver curative primary care services on their behalf. This arrangement has been in place since the 1950s. The contractual relationship and the factors influencing it are described here to highlight issues of relevance to a broader discussion of contracts with the private sector for primary care, both in South Africa and elsewhere. The district-surgeon contract is interesting because, although it predates the present “fashion” for contracts and cannot be taken as an example of an ideal contract design, at the time of the research it was widespread and well-established and clearly raises relevant issues about the strengths and weaknesses of contracts in controlling private practitioner behaviour in an LMIC setting.
Part-time district surgeon system

District surgeons are doctors contracted by provincial health authorities. They fall into four categories: full-time, part-time, sessional and hospital-based. The main component of district-surgeon work (80-90%) (De Villiers, 1995) is curative primary care, but district surgeons are also required to provide certain forensic functions (e.g. the examination of victims of sexual and common assault, examination of drunken drivers, performance of post-mortems) and ex-officio functions (e.g. examination of persons applying for State disability grants and prisoners in jail). Until recently, the separation of responsibility for preventive and curative services in South Africa gave the provinces the responsibility for curative care and local government the responsibility for preventive services. In some towns, the district surgeon was the province's concession to the need for curative primary care services, with the rest of the health budget concentrated on hospital care.

Part-time district surgeons (PDS) are private general practitioners (GPs) who have a contract to treat State patients¹ in addition to their private practice. They usually have a separate, considerably inferior, set of rooms in their private practice in which they see State patients. The system arose as a convenient way to provide the services of a doctor in areas where doctors are unwilling to work full-time in the public sector, and where the volume of State work is manageable for a doctor alongside a private practice. Rural general practitioners in private practice in South Africa make their money from a combination of privately insured patients and those who pay a flat rate per consultation, and the dispensing of drugs at a marked-up price. In addition, many of them rely on some form of public-sector work, either as a part-time district surgeon or at the local hospital, to supplement their income. They may also work in the provincial hospital on a sessional basis in order to be permitted to use its facilities for their private patients. The numbers of State patients seen by district surgeons vary considerably – district-surgeon work could occupy between 20% and 90% of their time. This appears to be determined by a combination of the amount of private practice that they have, and whether the province where they are working has made any attempt to control either the number of patients that they can see or the total fees that they can charge in a given period of time.

The district surgeon's contract is standard and reimbursement is on a fee-per-service basis. District surgeons are paid a flat fee for every patient they see, with some variation according to the type of service, and an additional flat fee for medicines dispensed to the patient. The district surgeon is required to be available 24 hours a day for emergency cover. Traditionally, provinces have controlled the price of the contract, but not the volume. In effect, they

¹ State patients are those using Government-funded primary health care services, which have been free at point of use to all citizens since 1996.
have had an open-ended financial commitment to pay district surgeons for all services that they choose to render, but prices were fixed much lower than the equivalent income from a private patient (about 20% of the standard consultation fee reimbursed by medical insurance). Nevertheless, since primary health care services were made free to all South African citizens in 1996, provincial spending on district-surgeon services has increased sharply. In some provinces, the need for a referral from the primary health care clinic has been introduced, in an attempt both to stop patients visiting the district surgeon unnecessarily and to stop district surgeons encouraging unnecessary consultations in order to boost their income. Controlling access to the district surgeon remains problematic, however, as out-of-hours cases may not be able to wait for the clinic to open for a referral. District-surgeon services therefore continue to consume a sizeable portion of provincial health budgets.

There is a stigma attached to district surgeons as a result not only of their role in the apartheid health system (one district surgeon “overlooked” political activist Steve Biko’s injuries just prior to his death in 1977 (Bizos, 1998)) but also their current manner of service delivery. “Front door” service delivery for private patients and “back door” services for State patients still represent a largely racial distinction. District surgeons complain that the stigma of being the “State doctor” damages their private practice.

Since 1994, provinces have chosen to address these problems with the district-surgeon system in different ways. Several have attempted to move their district surgeons on to salaried appointments as part-time (sessional) public-sector doctors, although they have lost many rural general practitioners in the process. In the two provinces examined in this study, the district surgeons continued operating under the same contract as before, partly because the provinces concerned feared losing all their rural general practitioners. Despite what appears to be a mutual dislike of the arrangement, the fact that it has persisted may be evidence of the type of mutual dependence that arises in contracting out clinical services in a rural low-income or middle-income country setting.

Description of the research

As part of a larger research project evaluating alternative models of public/private contracts for primary health care in South Africa, 11 district-surgeon practices in two provinces of South Africa (Western and Eastern Cape) were evaluated. This chapter draws on some parts of an evaluation of the nature of the contractual relationship between the province and these district surgeons. The principal methods used for this part of the research were interviews with purchasers (provincial health managers) and providers (district surgeons) and a review of the contract documentation. A fuller account of this case-study
and the theoretical aspects of contracts is contained in Palmer and Mills (in press). Specific objectives relevant to the findings discussed here were:

- to identify and describe factors external to the contracting process which might influence the nature of the contractual relationship
- to describe and analyse the contracts in terms of their award process, design and specification.

In the discussion below, factors external to the contracting process which are likely to affect the nature of the contractual relationship are described (e.g. degree of market competition, nature of providers), followed by those which are part of the contracting process (e.g. contract award process, contract design). The influence of these two groups of factors on the contractual relationship are then discussed, alongside the relevance of this example to the introduction of new types of contracts into a similar rural LMIC setting.

External factors

External factors likely to shape the nature of the contract and contractual relationship were found to include the following.

Nature of service

The services which each provincial authority required from the district surgeon were not easily specified. One district surgeon summed up the nature of the work he was expected to do:

“Anything which is in the medical field has to be serviced by me, it has to be done, it doesn't matter what it is. Even if the ambulance isn't available, you have to make a plan. If there isn't a health care worker or the clinic sister has left, then it's your responsibility”.

Primary health care services are generally broad and overlap, but this was further complicated by the district surgeon not being contracted to provide all primary health care services (e.g. not usually preventive care), or only primary health care services (e.g. also emergency services). The package of services to be provided by each district surgeon was different and dictated by the specific circumstances of health care delivery in each town. To specify this accurately would mean writing a different contract for each district surgeon, and even then circumstances were likely to arise which were unforeseen. In this situation, it appeared that the contract for PDS services would always be incomplete.

1 “New purchaser-provider relationships in primary health care in South Africa”, funded by the UK Department for International Development.
Nature of market

District-surgeon services are most important to health care in small rural towns. Such towns rarely support more than one doctor or one private practice. Of the 11 towns visited, five had other practices working in the town, but they might not be willing to take on the district-surgeon work. The market for district-surgeon services was rarely competitive from the point of view of the purchaser. On the doctor’s side, the PDS income supplemented the income from private practice and might make the difference between staying in that town and having to move. Many general practitioners were dependent on being a district surgeon to remain in practice where they were. Doctors might have other ways of supplementing their incomes, such as doing sessions at the local hospital, but such opportunities are likely to be dependent on a good relationship being maintained with the province.

One regional health manager described the nature of the market as follows:

“One big problem is whether you have only one doctor in the town. That’s a big factor. The presence or absence of a hospital is another ... The big issue is that you have got no market competition and there is not enough private work to keep the doctor. So the doctor in X (town) would not be there for private reasons. So we have got to compensate for that type of situation. And if we press him too hard and he leaves, that is the end of medical care in that town”.

Barriers to entry into and exit from this market were also high, in that in most cases they would imply a change of location for the doctor. There were few possible substitutes for the district-surgeon service as a whole (e.g. 24-hour emergency cover). Public-sector clinics were able to offer an alternative primary health care service, but it could rarely operate 24 hours a day or provide access to a doctor. The community was unlikely to consider the clinic as a substitute. In most towns, both purchaser and provider therefore enjoyed a high degree of monopoly power. The idea of competition being a factor in these types of contract is highly questionable.

Capacity of purchaser to write and manage contracts

The two provinces studied represent the two ends of the spectrum of government capacity in South Africa, but both ends were weak. Part of South Africa’s negotiated settlement, which led to elections in 1994, was that nine new provincial structures should be established, and this has meant that South Africa’s public sector has undergone massive upheaval and
transformation. Government capacity is overstretched, particularly in certain provinces.

In the case of the Eastern Cape, sections of the former Cape Province have been amalgamated with the two former so-called “homelands” of the Ciskei and Transkei. Such unification of previous administrations into a single bureaucracy has been a daunting task (Gilson et al., 1999). The Eastern Cape was faced with forming an administration out of the rump of several previously unattached bureaucracies. One Eastern Cape manager commented:

“I am the only one left who knows anything about or who is managing the district surgeons ... The Eastern Cape, forming a new province, didn't have any infrastructure to fall back onto to manage it, whereas in the Western Cape they could still use their expertise from the previous time”.

Neither province had particular contracting expertise in its health department.

Initial motivation of the contracting parties

The initial motivation1 of the contracting parties was important in determining the way in which they would approach the negotiation and operation of the contract. On the side of the province (the purchaser), the principal motivation appeared to be to fill a gap in service delivery. Public-sector facilities in rural towns were poorly equipped and staffed, and the district-surgeon system was historically a way of supplementing this poor capacity in the public sector, using the resources of the private sector. Until public-sector capacity improved, some provinces with few public-sector doctors in rural areas felt little choice but to continue with the system.

The motivation of the district surgeons was perhaps more complex. In most cases, there was a significant financial component. Most rural towns did not provide a rich enough seam of paying patients to keep a practice solvent, and doctors used the district-surgeon work as a vital supplement to their income.

In response to questions about why they did the work, some district surgeons emphasized this financial aspect:

“It’s an income that we are dependent on”

“It’s a sure income every month that you don’t have many overheads on”

“I must have that income”.

1 “Initial motivation” here refers to the reasons which made the contracting parties enter into the contract originally, and does not include the effect on motivation of the incentives contained in the contract.
Another aspect of their motivation was a remarkable consistency in stressing a sense of obligation to the community in the town in which they were practising:

“Call it a sense of decency, if we didn’t do it, nobody would do it”

“It’s part of the work in a small town to provide services to the indigent patients”

“We have always accepted that we have to do all the doctor work, because there is nobody else available”.

Some expressed the view that, even if they were no longer the district surgeon, they would still have to do the work, so they might as well continue to be the district surgeon and get paid for the work they did.

**Negotiation and design of contracts**

The second set of factors influencing the contractual relationship arose from the way that the contract was awarded and written. These were themselves influenced by the external factors described above, in particular the lack of competition in the market for district services and the lack of capacity on the part of the purchaser. As a result, the awarding of the contracts differed from the manner assumed for competitive settings. Most contracts were not awarded competitively, there was very little negotiation about the form of the contract, and some more recently appointed district surgeons were operating entirely without a written contract. Each of these factors will be described in more detail below.

**Awarding of contracts**

Four district surgeons had been asked by the province to apply for the position in writing. The others had either been approached directly by the province to take on the role, or had simply taken over the work from a departing partner. Two of the four doctors who had applied for the position in writing knew that the position had also been advertised. Only one knew that someone else had applied for the job. In no case had there been any negotiation over the terms of the contract.

**Form of contract**

All district surgeons were employed under the same contract. Contracts had been awarded between 1973 and 1998. Since 1993, no written contracts had been provided by the province. Four district surgeons were therefore operating without a written contract.

The contract under which district surgeons were working was both out-of-date and vaguely worded. This reflects factors described in the previous section, in particular poor administrative capacity at provincial level, poor contract-writing skills, and the difficulty of specifying what services the district surgeon must deliver, and when and how they should be delivered. In addition,
in some cases district surgeons were operating under verbal agreements which directly contradicted the terms of the written contract. For instance, the contract stated that it remained in effect until the doctor’s 65th birthday, but some were told verbally that they were employed on a month-to-month basis.

District surgeons’ duties were specified broadly in the contract, divided into five sections of “clinical duties”, “ex-officio work”, “medical forensic work”, “emergency services” and “other duties”. Clinical duties are described as “the rendering of medical and obstetric services required for State patients” and “the rendering of surgical service which may reasonably be expected of a GP”. The contract requires the district surgeon to be available 24 hours a day and “to give preference to his official duties, except where serious emergencies occur in his private practice”, and finally “to render any other professional duties required of him by the Deputy Director General, Hospital Services”.

Whilst all of the district surgeons interviewed were working under the same contract, it is interesting to note a variety in their opinions about how well it was specified. It was also clear that they did not see the written contract as an important determinant of what they should do – believing that this was more appropriately left to their discretion. They sometimes referred to the contract as if they were humouring the province by continuing to work under a document which had so little current relevance. Comments included:

“Those old contracts are irrelevant for the present situation. The nature of the practice has changed so much ... Is that really a contract?”

“We haven’t got a very fixed contract, we have the contract that I signed 14 years ago ... It’s a very basic and very loose type of contract. It’s not binding any of the parties, it just sort of asks the practitioner to give a decent service ... Services to be delivered aren’t spelt out in any clear way”

“You have to give a service to the extent that there won’t be any complaints”.

Some expressed greater frustration at the vagueness of the situation:

“My contract is one line long. It says ‘you are hereby appointed district surgeon for the month of February’ and that was three years back! So basically there is no contract”.

Discussion

At the beginning of this chapter, we described the enthusiasm for contracting with private providers in low-income and middle-income countries like South Africa. Some factors influencing how one system is already operating have been presented. What can this tell us about the way that other contracts with
private providers for primary care in low-income and middle-income countries are likely to operate?

Firstly, the weaknesses of the case study must be acknowledged. The district-surgeon system is an old – some would say moribund – arrangement carried over from a health system which did not pay much attention to primary care or the welfare of State patients. It was not established with the benefits of contracting in mind, and is far from an example of “best practice”. However, its relevance is that it is well-established and that many of the constraints described which are external to the contracting process are highly typical of settings in which contracts with private providers could be introduced.

In the short-to-medium term, these constraints are unlikely to change, even if there is an attempt to change the approach to contracting. Lack of competition and lack of capacity in many areas relevant to health service contracting are likely to remain widespread. If the South African government pursued the recommendations of the National Committee of Inquiry described above (Department of Health, 1995), these constraints would be equally relevant. Unless a great many scarce resources are devoted to the writing of individually specified contracts, contracts for a service as broad as that required of a district surgeon will always be incomplete.

This has several interesting consequences. Issues such as the motivation and attitude of providers to the service that they deliver may be more important than what is written or not written in a contract. How this can be measured or influenced is a subject of growing interest. For instance, it is likely that district surgeons set the quality of care they deliver at a level low enough to ensure what they perceive to be a reasonable income from the low payments. In response to this, neither the purchaser (province) nor the consumer (patient) has an effective sanction. The province is cautious of losing a doctor upon whom it relies. Consumers have a similar perspective — even if services are not good, they may be all that is available and people are fearful of complaining (Palmer, 1999). Influences that temper this power of the doctor to determine quality unilaterally are likely to be more complex and specific to different situations. The reputation effect in a small town is important. If a general practitioner gives poor-quality care to State patients, this will become known to private patients, who are both more valuable and more able to exercise an “exit” option. The doctor’s feeling of obligation to the community in which he lives is also likely to be important. In effect, this is a situation where all influences on the service delivered lie well outside the contracting process.

The second set of factors described here, the way that the contract is specified and awarded, are more amenable to change, but this must be tempered by an acknowledgement of how much they are influenced by a lack of competition and/or capacity for contracting. Contracts could be written differently and updated more frequently. The award process could be made more transparent and standardized, and more explicitly open for other types
of provider to bid. However, contracts will only be written and administered better if capacity for this can be improved, and no matter how well organized the award process is, if there is only one candidate for the contract in a rural area, how relevant is an approach which assumes choice and competition? A more formal bidding process aiming to reap the virtues of anonymous competition will not work if there are no competitors. An incumbent doctor may even be encouraged to price his services higher, once it is demonstrated that there is no realistic competition.

Conclusion

This chapter has described some external factors which are key to any contracting process, and the likely impact that they will have on contract design and the award process. Issues such as monitoring capacity and the way any breach of contract is dealt with have not been explored. Nevertheless, it is clear that, in the setting described, any attempt to simulate a model of competitively awarded, well-specified contracts will run into severe difficulties. Two recommendations can be made. Firstly, policy-makers in low-income and middle-income countries should beware of policy prescriptions from multilateral and bilateral agencies which encourage contracts but do not acknowledge the likely context in which they are to be applied. Secondly, while contracts for services such as primary care may still be desirable in many instances, it should be recognized that, in a situation such as that described here, the quality of service delivered may be influenced more by the motivation and ethical viewpoint of each individual doctor than by anything contained in the contract document.

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