

HEART

HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Comparative advantage of the private sector in delivery of health services

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Query: What are the areas of likely comparative advantage of the private sector in delivery of health care services for public health goals particularly in the areas of MNCH and SRH including work with adolescents and SGBV?

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1. Overview

While there continue to be ideological debates about the value of private healthcare, private healthcare services are already widely used across LMICs; by up to half of healthcare seekers in sub-Saharan Africa¹. About 45 per cent of sick children from the poorest income quintile across 26 African countries go to a formal or informal private provider rather than a public provider for health care (Berendes et al., 2011). Poorer patients get sick and go without care more frequently, and spend proportionately more of their incomes on private healthcare than the wealthy (Montagu et al., 2011). Many people use a mix of public and private services. This rapid review summarises the major themes of the literature comparing the public and private healthcare services, focusing on sub-Saharan Africa (SSA).

There is a considerable body of evidence on the private provision of healthcare in low- and middle-income countries, often focusing on SSA. Several systematic reviews have been conducted on aspects of private healthcare, including direct comparisons of public and private. These focus on the effectiveness of each system, whether health outcomes are improved, the quality of care provided, and whether healthcare is equitably accessible to all strata of the population.

¹ http://ps4h.org/country_data_files/SSAfrica.pdf

However, the evidence base is not robust (Yoong et al., 2010). Assessments of interventions tend not to be rigorous and do not provide firm conclusions (Montagu et al., 2016). There is generally mixed and sometimes directly conflicting evidence on all areas comparing private and public healthcare (Campbell et al., 2016; Rao, 2016). No firm conclusions can be drawn on whether one is 'better' than another, as the results vary considerably by context. Evidence on the relative advantages of the private sector is largely inconclusive (Saksena et al., 2012) and more research is needed (Powell-Jackson et al., 2015). There is no evidence to support claims that the private sector is more efficient, accountable, or effective than the public sector (Basu et al., 2012). Policy implications are therefore unclear.

The arguments in favour of private healthcare suggest it is more responsive and efficient, while arguments in favour of public services suggest they are more equitable and better equipped than the market to respond to health needs (Powell-Jackson et al., 2015). Some studies find that the private sector is unregulated, has financial incentives for inappropriate healthcare, and is expensive (Campbell et al., 2016). The literature therefore revolves around the key issues of quality, cost, and equity.

The **quality of care** in private sector providers may be slightly higher than in the public sector, particularly in patient-focused areas such as waiting times, confidentiality and staff attitudes. These indicators are often cited by patients as their reason for choosing private services and seen in the literature as the major advantage of private care. However, private services in LMICs are often unregulated, and there are serious implications around the health outcomes achieved, including drug resistance and disease control (Yoong et al., 2010). The technical health outcomes are not significantly better in the private sector. The conclusion from the literature is that the quality of care is not significantly different in public and private services, but that private services are much more likely to have untrained staff and provide incorrect care.

There is very little evidence on the comparative **cost-effectiveness** of the private sector. This varies considerably across country contexts and types of services. There is no conclusive evidence that the private sector is more cost-effective or more efficient than the public sector. The literature warns that increased use of private services may crowd out or decrease the funding available to the public sector.

The major criticism of private sector services is that their higher user fees create **inequality** of access, limiting their use by the poor. The literature is quite clear that private for-profit health services create inequality. Private non-profit, or services run by NGOs, appear to mitigate some of the inequality effects.

The private sector is defined as all providers and services outside the public sector. This can include for-profit and non-profit, traditional healers, religious healing, shops and pharmacies, and formal private clinics. Formal private providers are those recognised by the law, such as hospitals, medical practitioners, and churches; informal providers are not recognised and include lay health workers, shop keepers and 'quacks' (Berendes et al., 2011).

In practice, boundaries can be blurred between public and private; both formal and informal cost recovery schemes operate at public facilities, and the same provider or clinician might work in both sectors (Patouillard, et al 2007). Many systems receive funding from both sectors (Basu et al., 2012). In particular, results change when the definition of private sector includes or excludes unlicensed physicians and drug store salespeople (informal providers) (Basu et al., 2012). When these are included, the private sector is the main source of healthcare for LMICs, but when excluded, the public sector is the main source (Basu et al., 2012). Within the private sector, the evidence shows that non-profit providers are more efficient than for-profit providers (Rao, 2016). NGOs providing healthcare are generally seen as private, although they may not charge for their services. The difference between free-at-the-point-of-use NGOs and out-of-pocket-expenditure on private doctors can be enormous,

and it is important to differentiate between the types of providers when reviewing the evidence on private services.

2. Health outcomes

The ultimate criterion for assessing health services is whether they deliver on public health goals, reducing disease and mortality. There is a good evidence base assessing health outcomes, generally concluding that private services are weak in public health, particularly epidemic prevention and drug resistance. This is often due to the unregulated nature of private services and incorrect or unnecessary prescriptions (see quality of care section below).

A systematic review assessed the health outcomes of private versus public care settings in LMICs (Montagu et al., 2011). It reviewed 21 studies, 18 of which were in urban settings. The results showed that patients in a private healthcare setting were less likely to die than patients in a public healthcare setting. However, patients in a private healthcare facility were more likely to have unsuccessfully completed TB treatment than patients in a public healthcare facility, defined as defaulted, failed treatment, transferred out or death. The authors conclude that the health outcomes in middle-income countries from private clinical services are broadly equivalent or better than government services. Despite these results, the authors note that the quality of evidence is low or very low, and thus these conclusions cannot be relied on.

Another systematic review assesses the performance of the public and private sector healthcare delivery in LMICs (Basu et al., 2012). 102 articles suggested that providers in the private sector more frequently violated medical standards of practice and had poorer patient outcomes. Diagnostic accuracy, medical knowledge, correct prescription and adherence to medical management standards were lower among private providers than public. Public sector services experienced more limited availability of equipment, medications, and trained healthcare workers. Public sector services had greater success rates in treating HIV and tuberculosis. The review suggests that a fast-paced privatisation had worse health outcomes, with negative effects, while a slower-paced privatisation appeared not to worsen patient outcomes (in Latin America).

A rigorous review which assessed 80 studies from LMICs comparing public and private found that the formal private sector scored higher on drug supply, responsiveness and effort (Berendes et al., 2011). The authors suggest that drug availability may be due to greater funds, and that providers are motivated to encourage clients to return, so responsiveness and effort are higher. However, the differences between the sectors were small, and the authors do not support the conclusion that one sector is better than another. It also found that many services scored low on infrastructure, clinical competence and practice, irrespective of public or private status.

Private markets often fail to deliver public health goods, particularly preventative services and planning to curb epidemics (Basu et al., 2012). There are serious implications around the health outcomes achieved, including drug resistance and disease control (Yoong et al., 2010). The literature is quite clear that neither public nor private services meet all the healthcare needs, and that both must have investment in order to improve health outcomes (Campbell et al., 2016).

3. Quality of care

Quality of care is often cited by patients as a main reason for choosing private healthcare. Better and more flexible access to providers, shorter waiting times, greater sensitivity to patient needs, and greater confidentiality are seen as strengths of the private sector (Montagu et al., 2011). However, the technical quality of care provided in LMICs is often poor, with potentially adverse health outcomes (Yoong et al., 2010). Most studies comparing private and public health services assess the quality of care provided by each (Berendes et al., 2011).

Private healthcare can be poor technical quality and potentially harmful (Patouillard, et al., 2007), sometimes because the sector is unregulated. Governments tend not to pay attention to or invest resources in the private sector, resulting in weak quality of care and low standards (Berendes et al., 2011). It is common for private sector providers to pander to consumer requests by dispensing unnecessary drugs and injections rather than providing the correct medical care (Berlan & Shiffman, 2012). Perverse incentives for unnecessary care can compromise efficiency and effectiveness (Powell-Jackson et al., 2015). A systematic review shows that reported efficiency tended to be lower in the private than in the public sector, resulting in part from unnecessary testing and treatment (Basu et al., 2012).

A systematic review assessing the performance of the public and private sector healthcare delivery in LMICs shows that the private sector had greater reported timeliness and hospitality to patients (Basu et al., 2012). Waiting times were consistently lower in the private sector. Private patients report preferring those facilities because of shorter waiting times, greater flexibility of opening hours, and better staff availability.

A systematic review conducted in 2007 examines 52 impact evaluations which assess outcomes of utilisation or quality of care (Patouillard, et al., 2007). Technical quality was assessed through observation of provider behaviour and of the physical attributes of the practice, and perceived quality as measured by the level of satisfaction expressed by patients. It finds that there is little evidence to show that interventions have a significant impact on utilisation or quality of care, although many programmes are considered successful in reaching the poor.

A rigorous review which assessed 80 studies from LMICs comparing public and private found no difference between the public and private sectors for patient satisfaction or competence, although formal private services appeared to be more client-centred than public ones (Berendes et al., 2011).

Pharmacy services are an important site of healthcare delivery in many LMICs. A systematic review of private pharmacy services finds that the quality of care offered is of a low standard (Smith, 2009). Reviewed papers highlighted the lack of presence of pharmacists or other trained personnel, the provision of advice for common symptoms which was not in accordance with guidelines and the inappropriate supply of medicines. The evidence base is small but very consistent.

Data from the Demographic and Health Survey from 46 LMICs shows that there is little difference in the quality of antenatal care (ANC) across public and private commercial care (Powell-Jackson et al., 2015). In SSA, the public sector provides 82 per cent of ANC. The study finds that the quality of care is largely the same across public, private commercial, and private not-for-profit services. The private not-for-profit sector consistently provided the highest quality of care, with the least variation between wealth groups. The gap between wealth quintiles was greatest in the private commercial sector, and the quality of care was consistently worse than the public sector for the poorest women. The private commercial sector was the worst-performing for quality of ANC care.

There is some evidence from a review of private healthcare interventions in Africa and Asia that franchising models, usually run by NGOs, can improve quality (Montagu et al., 2016).

4. Inequality

A major concern of the literature is whether private sector healthcare is pro-poor or pro-rich. As it generally relies on out-of-pocket expenditure, it is assumed that it is pro-rich (Patouillard, et al 2007). Both public and private sectors have user fees, but these are higher for private care (Basu et al., 2012). There is general agreement in the literature that private sector provision has led to unequal systems of care (Berlan & Shiffman, 2012). There are, however, some case studies where the private sector has been pro-poor or no inequalities were found.

Many of the positive effects of private services are concentrated among the higher socio-economic classes (Berlan & Shiffman, 2012), and it is uncontested that private services cost the individual user more than public services. The poor gravitate towards the least expensive services, usually public ones (Berlan & Shiffman, 2012). The richest quintile is most likely to use private services, although even the poorest quintile uses them for 20 per cent of outpatient visits (Saksena et al., 2012). In a study of family planning, ANC, and delivery care, Campbell et al. (2016) find that the richest quintile access and use all services more than the poorest, and that the private sector consistently favours the richest. However, in SSA, the public services also appeared to have inequalities between wealth groups.

A systematic review shows that private health services cater more to groups with higher incomes, resulting in disparities in coverage (Basu et al., 2012). There is some suggestion that the process of privatisation creates inequalities, such as clinics opening in areas of less need. Private contracting and social franchises showed potential for reaching impoverished groups, if targets of reaching the poor are included, although there is no available comparative data with the public sector (Basu et al., 2012).

Some interventions have shown pro-poor results, such as an Insecticide-Treated Net project in Zambia which distributed nets through the private retail sector, but using a voucher scheme in order to access the poor (Patouillard, et al., 2007). A review of Demographic and Health Surveys from 34 SSA economies finds that private sector participation is positively associated with reduced disparities between rich and poor as well as urban and rural populations, for access to health care facilities for births and treatment of ARI (Yoong et al., 2010).

Private care provided by NGOs has shown to have positive effects on accountability to users, in quality of care and coverage, particularly targeting the poor (Berlan & Shiffman, 2012). NGOs have been able to provide equitable access to services, including across rural and urban populations (Berlan & Shiffman, 2012). However, the market share of NGOs is very small, as they do not serve large numbers of people.

Some results show that cost is not always a barrier. In some places where private sector cost is much higher than public, patients still prefer the private sector, indicating that other criteria such as distance and quality may be more important to them (Saksena et al., 2012). Sometimes, public services are preferred even if they are higher cost than private (Saksena et al., 2012).

5. Cost-effectiveness

A recent review of private sector healthcare in Africa and Asia concludes that there is very little information on the cost-effectiveness of five major programme types (Montagu et al., 2016). Powell-Jackson et al. (2015), using data from the Demographic and Health Survey from 46 LMICs, notes that they are unable to identify the costs of antenatal healthcare in their comparison of public and private services. The wider literature on healthcare suggests there is no conclusive evidence that private or public healthcare is more efficient, as defined based on cost (Rao, 2016). Private non-profit providers have similar efficiency to public hospitals, but private for-profit hospitals have lower efficiency, perhaps due to perverse incentives (Rao, 2016).

Basu et al. (2012), in a systematic review, find that both generic and brand-name drugs are higher cost to the provider in the private sector. It also appears that the process of privatisation is associated with increased drug costs. Sometimes this is a result of the incorrect diagnosis and treatment given in the private sector. Fragmented purchasing and distribution in SSA also increases costs, particularly when patients are transferred between public and private sector facilities. In Mali, the availability of drugs in the public sector decreased prices in the private sector. A review from 2003 found that contracting public health services to private providers in Zimbabwe reduced costs. This review also notes that the process of privatisation crowds out the public sector and/or decreases funds available to public services. Contrary to prevailing assumptions, the private sector appeared to have lower efficiency than the public sector, resulting from higher drug costs, perverse incentives for unnecessary testing and treatment, greater risks of complications, and weak regulation.

One review suggests that investing in the quality of care provided by the private sector may be a pro-poor intervention as it would improve the effectiveness of the money the poor spend on healthcare (Berendes et al., 2011).

6. Accountability

There is mixed evidence on whether private services have better accountability to users (Berlan & Shiffman, 2012). Some of the positive evidence shows that the ability to select a provider increases consumer satisfaction, and perceptions of quality (e.g. waiting times, treatment, responsiveness) (Berlan & Shiffman, 2012).

Data on accountability, transparency and regulation of the private sector tends not to be available in LMICs (Basu et al., 2012). Data is widely available on public sector services, although it is not always of good quality (Basu et al., 2012). Public-private partnerships are also poorly evaluated for evidence of their effectiveness. Studies evaluated in Basu et al.'s (2012) systematic review do not support the claim that the private sector is usually more efficient, accountable, or medically effective than the public sector; however, the public sector appears frequently to lack timeliness and hospitality towards patients.

7. Increased utilisation and access

The private sector is assumed to increase availability and accessibility of services (Patouillard, et al. 2007). A systematic review conducted in 2007 provides a starting point for the examination of private healthcare in LMICs (Patouillard, et al. 2007). This review examines 52 impact evaluations which assess outcomes of utilisation or quality of care. However, one of its findings is that the evidence does not allow robust conclusions to be drawn as there is only weak evidence of impact, either positive or negative. Especially, long-term and sustainable impact is unclear. Therefore, they conclude that it is not possible to prove that private sector interventions benefit the poor and improve quality.

A review of Demographic and Health Surveys from 34 SSA economies finds that private sector participation is positively associated with greater overall access (Yoong et al., 2010). The authors find a strong positive association between increased private sector participation and access to health care facilities for births and treatment of acute respiratory illness (ARI).

There is some evidence from a review of private healthcare interventions in Africa and Asia that condom social marketing (creating demand for condoms); government contracting to providers; and voucher system can improve access and utilisation (Montagu et al., 2016).

8. Further resources

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Private Healthcare in Developing Countries website: <http://ps4h.org/globalhealthdata.html>

Center for Health market Innovations: <http://healthmarketinnovations.org/>

Jhpiego, healthcare for women and families: <https://www.jhpiego.org/>

World Bank Group Private Health Policy Toolkit:
<https://www.wbginvestmentclimate.org/toolkits/public-policy-toolkit/>

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11. Additional information

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