Improving Innovative Health Care Delivery Systems that Serve the Poor

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ABSTRACT:

The general argument for the decentralization of health care is the potential for improved service quality and coverage. However, the experience of decentralization in developing countries has been confounded by subsequent decline of public health care spending. As a result the quality of care in many cases has been compromised and the poorest segments of the population left without access to publicly subsidized services. Decentralization may therefore be seen as an important factor in the dramatic expansion of private health care provision in developing countries in the past decade.

This paper presents available evidence on health seeking behavior by socio-economic status, using data from the World Bank's HNP Poverty Thematic Reports of 22 countries in Africa.
We provide evidence from health franchise delivery systems in Africa and Asia, that such a system can be a support for the public health care system suffering from weaknesses of decentralization.

Introduction

The general argument for the decentralization of health care is the potential for improved service quality and coverage. However, the experience of decentralization in developing countries has been confounded by subsequent decline of public health care spending. As a result the quality of care in many cases has been compromised and the poorest segments of the population left without access to publicly subsidized services. Decentralization may therefore be seen as an important factor in the dramatic expansion of private health care provision in developing countries in the past decade.

Several features of health care (e.g., the controversial nature of some services such as family planning, the importance of formal training for personnel, and the integrated nature of services make decentralization in this area more complex and potentially more difficult than in other sectors. Since decentralization in the health sector is often politically driven, the theoretical benefits tend to get more attention than the more concrete facts of actual experiences in other countries, which is mixed. Without proper planning and acknowledgment of the lessons learned by other countries, decentralization of health care can be disappointing at best and detrimental at worst. This note raises the issues to consider if decentralization is to bring about beneficial results.

Decentralization policy should include some coordination mechanism. Decentralization should enable local governments to design programs according to local preferences, health-seeking behavior.

Past experience shows that achieving the benefits of decentralization depends heavily on policy design. In general, careful attention must be given to health service needs and priorities in deciding which functions and programs to transfer and which to retain under central control. Successful decentralization demands acknowledging the role of private sector and health seeking

behavior of the poorest segments of the population. A more efficient mobilization of existing resources would have to involve the private sector.

In developing countries private health care providers, including pharmacies, are the most important source of medicine and medical care. Due to misunderstanding about the size and importance of private providers to clients, lack of knowledge about who makes up the private sector, and limited experience in systems that can organize and mobilize this heterogeneous group, these providers are frequently not included in public health service delivery planning.

This paper presents available evidence on health seeking behavior by socio-economic status on what strata of society benefit from publicly provided care and what strata use the private sector. Using data from the World Bank's HNP Poverty Thematic Reports of 22 countries in Africa, we assess the use of public and private health services by asset quintile groups, for treatment of diarrhea and treatment of acute respiratory infections, selected because these two childhood diseases are good proxies for publicly subsidized services.

We explore the range of systems that have been tested for working with private providers: from contracting to vouchers to behavior change and provider education, and conclude that health franchising has the greatest potential for large-scale programs in Africa that will address critical illnesses of public health importance.

We provide evidence from health franchise delivery systems in Africa and Asia, that such a system can be a support for the public health care system suffering from weaknesses of decentralization.

We demonstrate the proven effectiveness of this delivery system at increasing delivery point availability for public-benefit services and at managing quality. Finally, we argue that future planning of decentralization policy should include coordinating mechanisms with private providers. This assertion is based on the established demand for and supply of private medical services in Africa.

Methods

Data on health care service utilization by socio-economic status was gathered from the World Bank's Health Nutrition and Population Poverty thematic reports for twenty-two countries in sub-Saharan Africa (Gwatkin et al. 2004). We examine service use for the treatment of two very common childhood diseases, diarrhea and acute respiratory infections. Treatment for these two diseases are considered good proxies for publicly free-of-charge or highly subsidized curative services. For each disease we assess service use by socio-economic status and type of provider – public or private for both rural and urban populations. Socio-economic status are presented in terms of asset quintiles, estimated from the DHS household asset questionnaire, using the methodology developed by Filmer and Pritchett (2001). Provider type entails only two categories, public and private. We are therefore unable to distinguish between private for or not-for-profit, one of the limitations of these data. The DHS data used is limited to conventional medical providers and so excludes traditional healers. As DHS data is stratified by providers, we

know that traditional healers provide only very limited services for the two disease being studied, and so their exclusion introduces very little bias, while permitting better comparison between public and private sectors.

Health franchising experience in Africa is limited, and survey data does not exist. Evidence from surveys of franchises in India, Pakistan, and Nepal, conducted for cross-country comparisons of franchise programs, are extrapolated to the conditions of Africa and tested against the findings of a surveyed private provider network in Kenya (Montagu 2002b, CORT 2001). These studies were conducted for design and internal evaluation of the various franchises, or as part of a doctoral dissertation comparative analysis. The methodologies are all similar, employing provider interviewers, client exit interviews, household interviews and, in one instance, mystery client surveys. All surveys were randomly sample representative surveys, with 100 or more respondents in each sample. For more information on the survey data see original reports referenced above.

RESULTS

Service utilization by type of provider
Table 1 shows the distribution of under-five children that were ill, and the use of health services for diarrheal disease by socio-economic status in 22 sub-Saharan African countries. It is not a surprise that in most countries the children from the lowest quintile are more likely to be ill with diarrhea than the children from the highest quintile. It is also not surprising to find that in the 22 countries examined the poorest children are less likely to be seek medical care when ill with diarrhea. The poorest children are more likely to live in areas that are poorly served by health services; they come from households of less educated parents with fewer means which combined could explain these disparities. Overall, of those children seen medically, the majority of the poor did not access public services for treatment.

Table one also shows that in the majority of the countries examined here, the rich make relatively more use of the public services for treatment of childhood diarrheal disease. Of those seeking services, the poorest rely on the existing private providers. The DHS surveys from which this data are taken are nationally representative samples and therefore service selection can be inferred to result from the combined effects from both availability of services and choice of provider.

Table 2 shows similar results for service use for treatment of acute respiratory infections in children. Of the 22 countries, only three (Namibia, Zambia, and Tanzania) have 50% or more of the poorest children who received treatment using public services. For the remaining countries most of the poor are being treated by private providers.

To further explore the private sector role in service provision to poor people, we looked at individual countries and present 2 country cases in figures 1 and 2 as examples. With the exception of the three country outliers mentioned above, we can group the remaining countries into two groups exemplified here with Mozambique (Figure 1) and Uganda (Figure 2). In Figure 1 we can infer that in Mozambique of those ill with diarrhea, the percentage of children seen in the private sector does not significantly differ across socio-economic groups. The largest

difference between rich and poor are in receiving any treatment at all, with richest more likely to receive care. In fact, Mozambique is one example of countries where the rich make more use of the public services than the poor. Figure 2 shows the use of services for acute respiratory diseases in Uganda. This figure exemplifies another group of countries where most of those who seek medical care at any socioeconomic level do so through the private sector. The public sector use represents only a small fraction across all socio-economic groups.

Health franchising delivery systems
Health franchising has been used successfully to improve health services in vastly different societies. In India, a health franchise has improved the sexual health of inter-city truckers through education, contraceptives and sexually transmitted infection (STI) diagnosis and treatment near highway rest stops (Smith 2002). In Nicaragua, Marie Stopes runs a similar health franchise for sexual health services. The Well-Family Midwife Clinic franchise in the Philippines provides save deliveries through over 100 outlets.

In sub-Saharan Africa the franchise system has proven successful as well: in Ethiopia the Biruh Tesfa (Ray of Hope) program increased contraceptive use by 30% among the 10 million people covered by its 92 clinics. In Zimbabwe, New Start franchised HIV testing and counseling that has increased monthly visits from 230 in 1999 to 4,000 in 2003.[1] In Kenya, the Sustainable Healthcare Enterprise Foundation's Child and Family Welfare Shops (SHEF/CFW) program provides affordable generic drugs through franchised community health workers. SHEF/CFW generates income from 80% of its franchisees, despite serving low-income customers in rural areas.[2] Survey data from India, Pakistan, Nepal, and elsewhere shows that clients respond positively to franchise brands, and that the volume of target services provided by franchisees is higher than that provided by equivalent non-franchised private providers. Quality measures are difficult to gauge in the private sector, but one study from Nepal [3] found that counseling provided to mystery clients was more complete and more objective from franchise member than non-franchise members. A multi-country survey of franchises found that staff to patient ratios were significantly more favorable to good care in franchises than non franchised providers (Sulzbach et al 2002). The existing evidence is that franchising of private providers improves both accessibility and quality of services.

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[1] "New Hope with New Start," *PSI Profile.* http://www.psi.org/resources/pubs/new_start.html
[2] WWW.cfwshops.org
[3] Montagu unpublished study for PSI/Nepal

Tables and Figures

Table 1: Percent ill and use of health services for treatment of diarrheal disease by socio-economic status for selected African countries.
(population 0 - 5 year olds ill 2 weeks preceding the survey)

Country Name	Treatment of Diarrhea														
	% ill					% seen medically					% seen in Public Facility				
	poorest	2nd Q	mid	4th Q	richest	poorest	2nd Q	mid	4th Q	richest	poorest	2nd Q	mid	4th Q	richest
Africa															
Benin	28.4	30.4	25.5	24.8	18.4	24.4	20.3	23.0	23.2	42.0	20.1	17.7	19.7	16.7	26.1
Burkina	22.3	18.3	20.5	21.5	17.9	89.3	84.8	87.5	87.7	74.5	9.5	14.6	11.9	11.4	22.7
Cameroon	21.9	20.6	18.4	15.0	12.8	85.0	82.2	78.9	79.4	74.9	12.7	13.8	15.7	16.2	17.9
C. Afr. Rep.	28.1	22.5	19.5	23.5	18.7	23.8	22.4	34.0	33.3	40.7	20.1	20.0	33.2	27.4	29.3
Chad	18.9	21.4	21.7	24.2	21.4	8.7	18.6	14.8	21.3	32.6	3.7	7.3	5.4	10.0	25.9
Comorros	24.9	25.4	21.5	19.7	23.4	22.6	23.3	30.2	42.9	43.2	17.7	18.3	20.9	35.7	21.6
Cote D'Ivoire	21.2	20.4	18.8	24.6	24.1	14.0	19.2	19.0	29.4	37.6	11.9	17.9	17.4	27.2	35.5
Ghana	21.6	22.9	21.5	18.9	14.2	17.0	20.2	24.2	30.4	34.0	13.6	13.5	15.4	21.5	28.0
Kenya	19.4	18.7	17.8	15.4	13.1	41.4	50.2	37.1	45.9	48.5	26.3	29.6	24.8	30.5	23.4
Madagascar	29.2	21.8	26.1	31.3	26.2	38.9	35.4	31.9	40.7	55.7	27.0	21.2	23.7	31.8	24.2
Malawi	23.7	20.7	23.4	19.3	21.0	46.7	40.1	48.5	49.4	61.6	36.1	28.1	34.1	33.8	41.6
Mali	29.0	26.8	27.8	25.7	16.2	7.6	15.2	12.0	14.0	22.0	4.2	11.4	10.2	13.3	19.8
Mozambique	20.9	26.5	19.4	20.7	18.4	25.2	28.1	35.3	34.8	54.3	25.2	28.1	29.4	34.3	52.9
Namibia	27.0	27.5	22.9	15.2	10.6	66.4	68.8	73.4	63.5	66.1	65.9	68.8	73.4	62.5	61.4
Niger	36.9	37.0	41.1	41.5	32.4	13.0	14.0	11.8	18.3	35.3	12.5	12.3	11.5	16.8	33.2
Nigeria	19.9	20.5	19.9	16.7	10.8	20.5	24.5	24.2	31.1	42.8	19.7	22.5	19.0	30.2	32.5
Senegal	15.3	17.1	14.4	14.7	13.7	29.4	30.9	37.2	35.7	33.7	26.3	27.6	33.3	27.5	26.5
Tanzania	13.7	11.7	14.8	15.4	12.3	44.3	60.6	56.0	59.0	66.1	39.2	47.8	50.1	53.4	52.1
Togo	32.6	32.6	31.0	35.5	21.4	16.4	15.5	20.4	16.8	30.2	15.5	12.6	18.5	32.2	23.5
Uganda	29.9	22.0	22.7	24.9	17.0	52.0	51.2	50.9	60.7	64.9	25.7	24.8	18.6	21.1	19.9
Zambia	24.5	23.9	22.1	26.8	19.4	42.0	43.7	42.0	47.7	44.3	41.8	42.9	42.0	45.2	31.8
Zimbabwe	28.9	23.5	25.0	21.0	17.3	26.4	27.3	32.1	31.4	34.8	25.3	20.0	26.3	27.6	19.0

Table 2: Percent ill and use of health services for treatment of diarrheal disease by socio-economic status for selected African countries.
(population 0 - 5 years old ill 2 weeks preceding the survey)

Country Name	Treatment of Acute Respiratory Infection														
	% ill					% seen medically					% seen in Public Facility				
	poorest	2nd Q	mid	4th Q	richest	poor	2nd Q	mid	4th Q	rich	poorest	2nd Q	mid	4th Q	richest
Africa															
Benin	17.1	18.8	15	12.3	14.2	23.8	27.3	28.4	31.4	62.4	18.5	24.3	24.2	20.5	24.2
Burkina	10.2	12.3	11.2	10.6	11.1	15.7	12	17.1	18.9	34.3	13	12	15.6	18.1	31.1
Cameroon	7.7	12.3	6.2	8.2	8.4	19.2	39.9	48.7	56.5	51.3	3.2	21.9	38.3	25	33.8
C. Afr. Rep.	27	29.2	28.1	29	27.6	30.1	29.1	45.3	46.6	56.1	26.8	21.5	41	37.4	49.9
Chad	10	12.4	14	13.7	13.7	4.5	15.5	19	18.6	35.5	0.5	7.2	6.6	12.4	26.5
Comorros	26.1	23.7	20	20.2	19.6	41.5	64.3	62.5	44.2	58.1	33.8	44.6	45	32.6	38.7
Cote D'Ivoire	11.5	15.2	10.6	13.8	19.1	15.4	33.2	36.5	43.6	63.6	14.2	30.2	30.6	42.9	61.3
Ghana	13	12.1	9.9	6.9	8.2	22.6	38.2	59.5	48.3	58.6	13.2	27.3	42.9	41.4	44.8
Kenya	23.1	21	19.4	20.6	15.2	54.9	53.6	51.6	55.1	78.5	37.9	30.6	34	35.9	40.3
Madagascar	27.3	25.6	25	21.4	16	35.1	33.5	32.1	36.9	59.3	26.4	25.4	25.7	32.3	36.8
Malawi	16.8	14.4	13.8	13.6	13.3	49.2	54.7	53.4	49	65.1	31.2	39	32.7	39.4	43
Mali	15.4	16.6	15	15.3	13.9	15.5	14	16.8	23.9	44.3	13	11.2	12.4	22.5	41
Mozambique	11.7	11.2	10.4	10.2	16	17.3	31.9	45.8	56.5	46.1	16.9	30.8	45.8	54.8	45.9
Namibia	26.2	22.9	19.2	11	11.1	63.4	68.7	65.7	68.1	74.4	63	68.7	65.7	68.1	61
Niger	13.3	14.7	15.7	13.7	13.3	20.5	14.6	15.2	29.1	58	17.6	14.1	15.2	27.2	55.6
Nigeria	6.7	8.9	5.8	6.3	5.1	32.6	33.2	34.6	40.1	51.6	32.6	31.8	34.6	38.6	43.1
Tanzania	11.6	12.9	14.2	13.9	12.3	61.8	65	74.8	69.7	77	52.4	60.8	65.7	58.9	66.3
Togo	21.9	19.6	19.5	21.4	18.1	18	18.3	22.9	36.3	48.2	18	18.3	19.9	28.2	32.2
Uganda	32	28.8	27.2	28.1	18.6	48.9	58.1	64.3	69.3	74.9	22	21.6	24.3	24	26.7
Zambia	12.9	13	11.3	15.5	10.3	62.9	65.3	73.8	74.1	81.4	57.9	56.3	65.4	70.1	48.1
Zimbabwe	34.9	28.4	25	20.3	16	44.2	47.4	54.7	64.5	62.1	38	38.8	44.2	56.4	41.8

Figure 1: Distribution of diarrheal disease cases by type of provider sought according to socio-economic status in rural Mozambique.
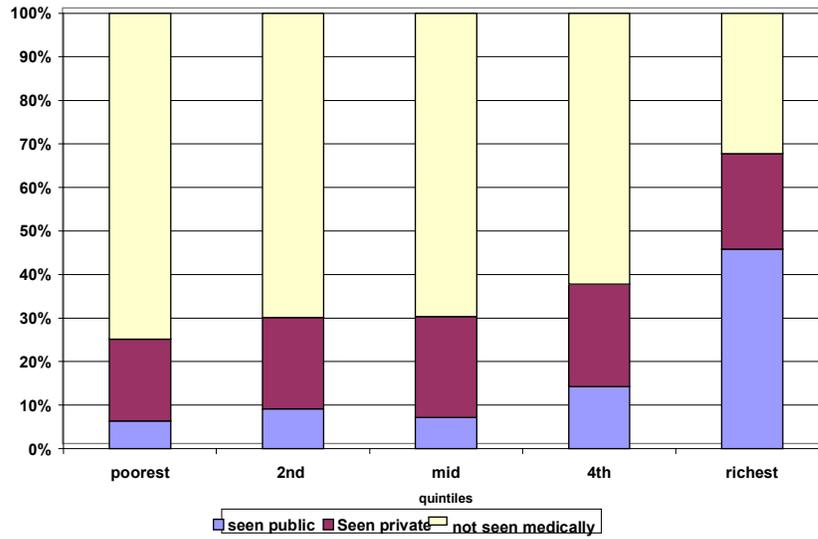
Figure 2: : Distribution acute respiratory disease cases by type of provider sought according to socio-economic status in rural Uganda.