Counterpoint

‘Counterpoint’ is an occasional feature presenting discussion of a topic that is currently under debate in quality of care circles. We invite readers to submit Letters to the Editor adding their opinion to the topic.

Low quality of care in low income countries: is the private sector the answer?

The article by Samandari et al. [1] in this issue describes an impressive example of a specialized private health care institute, its funding, organization, delivery of care and measures to ensure quality of care. The authors then generalize, claiming that privately funded quality health care could be a sustainable and equitable model ‘for the developing world’.

The private sector is indeed very important in low and middle income countries (LMICs) by its sheer size and growth [2]. It provides a large proportion of health care; in India, 80% of the 390 000 qualified allopathic doctors work in the private sector, which provides one-third of inpatient and two-thirds of outpatient health care [3]. Since the late 1980s multilateral agencies such as the World Bank and the World Health Organization (WHO) and major donor agencies have adopted a policy to promote the private sector in LMICs. Contrary to common belief, the private sector is by no means utilized mainly by the rich. Gwatkin [4] reported that 47% of the poorest quintile sought outpatient care from private providers compared with 59% of the richest quintile.

One of the key arguments, albeit based on scanty evidence, was the belief that the private sector is more efficient than the public one and provides better quality of care at lower cost [5]. There are, however, reports describing low quality of care in public facilities in LMICs [6]. Hence, intuitively the private sector seems to be the answer to the problem of low quality of care frequently provided in the public sector.

In this counterpoint article, I will explore which specific lessons for the improvement of quality of care need to be learned and whether the L. V. Prasad Eye Institute (LVPEI) can provide a model in this regard to be replicated by the private sector in LMICs in general.

According to the description given, the LVPEI is a centre of excellence providing state-of-the-art, sophisticated and comprehensive eye care. There are interesting features which any health care institution, whether public or private, whether in the south or north, can learn from; the concern for and monitoring of patient satisfaction and adherence, the systematic studies on community views and acceptability of service offers, the monitoring of outcomes through the routine information system and random record review. These are all features of a well-run continuous quality improvement program. It would have been interesting, though, to see the costs of these programs in order to judge their reproducibility in other settings.

So far so good. But is it or can it be a model? Two arguments call for caution.

1. The LVPEI has unique features that will be hard to replicate for private providers in LMICs. It was founded by a re-migrant charismatic leader and has enjoyed massive external and national funding through charities, particularly by movie producer L. V. Prasad whose name it carries. The entire initial investment, construction and equipment as well as one-third of running costs come from these sources. The LVPEI is unique in its specialization; blindness has traditionally been a focus of philanthropy. It would be difficult to generate similar funds for, say, acute respiratory infections, diarrhoea or malaria, the top killers of children in the LMICs. The third feature that sets the LVPEI apart from the bulk of private sector providers is the fact that it is a huge non-profit institution. This is in contrast to the setting of the vast majority of private health care providers in India who are for-profit solo practitioners.

These circumstances raise concerns as to replicability which will be addressed later. The authors remain quite vague as to exactly how such a model can be woven into the comprehensive health care delivery system of a low-income country spending between 5 and 20 US dollars per capita a year on health care.

2. Is the private set-up of the LVPEI the cause for the high quality of care it provides? The provision and monitoring of quality of care is impressive but, the challenge in policy research is not to identify what works but rather to understand the conditions that make a policy work in some settings and not in others [7]. No evidence was given in the paper in support of the hypothesis that the private set-up led to the high quality standards. So, let us review the literature on quality of privately provided health care in LMICs focusing on India. The evidence comparing quality of care of public with private providers in developing countries provides, at first glance, a puzzling paradox. Most surveys on satisfaction, for example the study by Gibson et al. [8] report higher satisfaction of patients receiving private care compared with those receiving public care. However, this is not always the case when quality of care is defined as adherence to standards, for example correct prescription of drugs (reviewed in Brugha and Zwi [5]). Uplekar and Cash [9] followed the management of leprosy by 106 private practitioners and found that none of them followed the WHO
recommended scheme. Gilson et al. [10] reported that more drugs per visit and more non-essential drugs were prescribed by private compared with public providers. In one investigation into the treatment of infectious diseases, 100 private practitioners in Bombay were interviewed and were found to use 80 different treatment regimens for tuberculosis, most of which were inappropriate, too short and too expensive [11]. The average cost of treatment was more than three times the cost of the regimen recommended by the National Tuberculosis Programme. These examples contradict the assertion that the quality of care offered in the private sector as a whole is superior to that of the public sector, at least in LMICs.

Where do we go from here?

Rather than suggesting ‘models’ of how to improve the quality of care in the private sector of LMICs, I would like to close with three notes of caution.

The first relates to the obvious and much heeded policy recommendation of regulation for improving quality of care in the private sector. This is easy to propose. However, like many policies developed in the north for use in the south, it is based on an assumption that the state has the capacity and the means to design, implement and enforce such regulation [12,13]. In LMICs to date, there has been no convincing evidence of successful regulation of the private health care sector, particularly in the field of accreditation, licensing and quality assurance.

Secondly, any policy designed to improve the quality of care will fail if it does not take into account the organizational and financial setting of private providers. It needs to provide context-specific incentives based on a thorough understanding of provider and consumer expectations and behaviour [5].

Thirdly, the importance of the private sector in LMICs, the huge array of multilateral and donor institutions and the magnitude of the claims regarding the improvement of quality of care and its promotion stand in sharp contrast to the dearth of evidence on which they are built. We certainly need more research into this nexus.

The paper by Samandari et al. [1] gave one specific example of a non-typical setting of private care, which provided a large number of good ideas and policies promoting quality of care in that specific setting. But it is not a model that can be replicated in a sustained way by the private sector at large.

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References