

health sector reform

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A fair price? Charging for health care in Cambodia

Evidence suggests that user fees exclude the poorest members of society from health care. However, some argue that charging those who can afford to pay can benefit the poorest. In Cambodia, can user fees for public health services provide better wages for staff, and improved services, while encouraging people on low incomes to seek treatment at public hospitals?

The French non-governmental organisation, Enfants & Développement, together with the Centre for Development Studies at the University of Wales, Swansea, undertook a study at a district hospital in Kirivong Operational District to find out what effect charges had on people seeking medical care – particularly those on the lowest incomes.

In Kirivong Operational District, private health care is flourishing with 511 private practitioners operating, of whom 75 are qualified. Around 430 laypeople sell drugs over the counter in shops, in markets or from door to door.

Although the district hospital's services were officially 'free' to users, informal payments were made as doctors' needed to subsidise their low earnings of between US\$ 20 and US\$ 45 per month. Relatively low fees were introduced for a period of five months to reflect the quality of the services. Fees were then increased when the hospital was able to offer obstetrics, surgery and better care overall.

The study found that:

- When hospital treatment was free, only 20 percent of patients first attended a private doctor or drug seller before visiting the hospital. When fees were introduced this figure rose to 73 percent.
- Private doctors and drug sellers increased their charges as the fees of the district hospital rose. Treatment from a drug seller doubled from US\$ 2.7 to US\$ 5.4, while private treatment by a qualified doctor tripled from US\$ 6 to US\$ 20.
- The total cost per patient rose from US\$ 3.2 when hospital treatment was free, to US\$ 19 when fees had to be paid.
- Deaths in the hospital rose from 6.6 per 1,000 patients to 13.6 per 1,000. People may have delayed seeking treatment due to the costs involved, or they may have received inappropriate treatment from unqualified private providers before admittance to hospital.
- The 'poorest' patients using the hospital fell from 16 percent when treatment was

free to 5 percent once fees were raised. Introducing, and then increasing, medical fees created a 'medical poverty trap'. The poorest members of society delayed seeking care from a qualified practitioner. Their inability to work meant they sank into even greater poverty. Many bought inappropriate drugs from unqualified sellers. Some people had to sell land to pay for treatment.

The following need to be implemented:

- The private sector must be regulated to prevent profiteering by drug sellers and qualified practitioners.
- People should be able to use the public health sector immediately rather than seek advice from private and unqualified drug sellers.
- If subsidies for the poor are to work effectively, a central fund should reimburse health facilities for treatment provided to the poor (i.e. equity fund).
- In the long term, in order to prevent the 'medical poverty trap', a community-based health insurance scheme should be set up. Premiums for the poorest members of society could be paid by the equity fund.

Neil Price

Centre for Development Studies, University of Wales, Swansea, SA2 8PP, UK
T +44 (0) 1792 295877 F +44 (0) 1792 295682
n.i.price@swansea.ac.uk

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Indian women get better care in the private health sector

In India outpatient health care is provided largely by the private sector. Indian women favour the private sector as the quality of care is superior to that in the public health service. Under these circumstances, should reforms prioritise improvements in the public sector or encourage better performance by private providers?

Outpatient care in India has been dominated by the private sector for several decades. Many more doctors work privately than for the government. The Indian Institute of Management, together with the London School of Hygiene and Tropical Medicine, carried out a study in Karnataka State to compare the two sectors. 18 private doctors and 25 public sector doctors were observed over a period of 5 days. The

private doctors worked in the rural Kolar District while the public sector practitioners were based in Mysore District. All of the doctors were qualified and around half of the consultations were carried out by a female doctor. The study found that:

- Consultations in the private sector lasted more than twice as long as in the public sector. A patient spent on average less than three minutes seeing a public sector doctor. Private patients spent almost seven minutes with the doctor.
- The private doctors were more likely to examine the patient.
- They were also more likely to explain their diagnosis to the patient, to give advice on diet and to ask the patient to return.
- One third of public sector patients received an injection compared with two thirds of private patients.
- The average cost of drugs in the public sector was half that of the private sector.

The quality of care is much higher in the private sector both in terms of the thoroughness of examination and communication between doctor and patient. However, private doctors may be

over-prescribing drugs.

Improvements in public health care are necessary if women are going to choose to use it in preference to the private sector. The Task Force on Health and Family Welfare, established in 2001, planned extensive reform for the Indian health service. It included steps to reduce corruption, increase public-private partnership and consider issues such as nutrition, clean water, sanitation and decent housing. Results from this study suggest that, when considering reform:

- greater regulation is often ineffective
- the advantages of continuing medical education are mixed
- communities, patients and health providers must work together to bring about improved quality of care in the public sector.

John Cleland

London School of Hygiene and Tropical Medicine, 49-51 Bedford Square, London WC1B 3DP, UK
T +44 (0) 20 72994621 F +44 (0) 20 72994637
John.Cleland@lshtm.ac.uk

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Migrating nurses Importing skills; exporting shortages

Facing nursing shortages, health systems in developed countries are recruiting nurses from other developed and developing countries. What is the impact of this on recipient and source countries? How can health systems plan for the effects of the increasing migration of nursing staff?

Research by the World Health Organisation explores the international migration of nurses and the implications for five countries: Australia, Ireland, Norway, the UK and the USA. The flow of nurses to these countries has risen during the 1990s, and, in some cases, recruitment is from developing countries. The researchers propose a number of policy options to manage nurse migration and make a number of recommendations for improving data on the health workforce.

Significant findings include:

- In 2001 internationally trained nurses accounted for two thirds of new entrants

to the Irish nursing register and over half of those added to the UK register.

- In the USA, overseas recruitment fell during the second half of the 1990s but has increased rapidly since 1998.
 - In 1990, nurses migrating to the UK came from 71 countries. By 2001 this had increased to 95 countries.
 - The majority of foreign trained nurses migrating to Norway and Australia (Victoria State) are from other high income countries, whereas in the United Kingdom and the USA the majority are from lower-middle income countries.
 - The proportion of nursing recruits from low income countries is highest in the UK (18 percent) and the US (11 percent).
 - Basic data for monitoring the migration of nurses and assessing impact is often inadequate, incomplete or not available.
- The evidence points to a sharp increase in the international flow of nurses. However, the absence of basic information makes it difficult to assess the impact of migration. For countries to plan for the effects of nurse migration, the ability to monitor trends in the inward and outward flow of nurses is essential.

Methods to improve the availability and comparability of data need to be promoted. Information must enable policy-

makers in both source and destination countries to address policy questions about the international migration of nurses.

Recruiting nurses from overseas can create a shortage in source countries that are not equipped to deal with it. Three policy options are proposed to deal with this:

- Improve the status, pay and working conditions of nurses in their own countries. This would moderate the factors driving them elsewhere.
- Encourage and facilitate managed flows of nurses between countries, including the option for nurses to return home.
- Arrangements for compensation to flow from the recruiting country back to the source country. Compensation could be financial – through direct remittances or educational support – or the return flow of better trained staff.

James Buchan

Faculty of Social Sciences and Health Care, Queen Margaret University College, Edinburgh, UK
jbuchan@qmul.ac.uk

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Lower costs do not mean better health care in Nigeria

Charging fees for medical treatment can bring in revenue and may discourage people from using health services unnecessarily. However, it can also prevent the poorest members of society from seeking treatment. Are Nigerians on low incomes willing to pay for health care when they need it?

Doctors' fees were introduced in Nigeria in the 1980s as part of its structural adjustment programme. The London School of Hygiene and Tropical Medicine, together with the University of Nigeria, carried out a survey in two communities, one urban and one rural, in Enugu State, south east Nigeria, to look at their different experiences of primary health service use.

652 households were asked about their health problems during the month before the study. Households were asked a number of questions, including how much money they had spent on food in the past week and whether they possessed certain consumer items. Households were divided into four socio-economic groups: 'poorest', 'very poor', 'poor', and 'least poor'.

The study found that:

- The urban dwellers were much better off than those in rural areas.
- Most of the urban households fell into the top two socio-economic groups, while the vast majority of villagers fell into the categories 'poorest' and 'very poor'.
- Rural households suffered more from

respiratory diseases, diarrhoea and hypertension than those in the city.

- Nevertheless more than 90 percent of the city folk sought health care in the preceding month compared with only 58 percent of the villagers.
 - The average monthly cost of treatment was US\$ 15 in the city and US\$ 4.40 for the villagers.
 - The most common way of paying for care was payment upon treatment. The second most used method (used much less frequently) was by instalments.
- The poorest people living in the city and those living in rural community experienced the greatest inequality. They spent the least amount of money on health care and were more likely to use traditional healers. The lower costs for treatment in the rural community may well have been caused by an inability to pay for the tests and treatment recommended by doctors.

The Government's investment in and building primary health care centres across Nigeria is a step in the right direction. However, if genuine equality in access is to be reached:

- primary health care services in rural areas should be improved so they are seen as attractive places to go for treatment
- public-private partnerships need to be set up to fund improvements
- schemes, such as fee exemptions, subsidies, and vouchers, should be introduced for the poorest

- funding should be provided for training in the private sector to improve the quality of health services
- primary health care services must be shaped to meet the needs of the communities they serve
- the quality of health services used by poorer groups must be as high as those used by the more well-off
- regulation and supervision of health services needs to be improved.

Obinna Onwujekwe

Health Policy Research Unit, Department of Pharmacology and Therapeutics, College of Medicine, University of Nigeria, PMB 01129, Enugu, Nigeria
T +234 42 259569 F +234 42 259569
onwujekwe@yahoo.co.uk

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id21
Institute of Development Studies
University of Sussex
Brighton, BN1 9RE UK
T +44 (0) 1273 678787
F +44 (0) 1273 877335
E id21@ids.ac.uk



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