Understanding the Emerging Role of the Private Sector in Medical Education

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20 March 2013, HIV Capacity Building Partners Summit
Overview of the Session

- Setting the context about the role of the private sector in health service delivery
- Understanding more about the emerging role of the private sector in medical education
- Focusing on financial and business challenges
- Personal reflections from private medical training institution proprietors
Myth #1: Health in Africa is financed primarily by the public sector
Health Financing in Africa

Sources of total health expenditures in 24 OECD and 10 Eastern & Southern African countries

- OECD:
  - Donors: 16%
  - Public: 25%
  - Other Private: 25%
  - Private (Out of Pocket): 44%

- AFRICA:
  - Donors: 36%
  - Public: 30%
  - Other Private: 7%
  - Private (Out of Pocket): 3%

Source: Marek T, et al. 2005
Private Sector Expenditures in Africa

Where Health Funds Come From

- Public: 100% of $16.7B
- Private: ~40% of $16.7B
  - Out of pocket: ~50%
  - Other private: ~50%

Where Private Funds Are Spent

- Public Providers: ~50% of $8.3B
- Private Providers: ~50%
  - For profit: ~65%
  - Social enterprise: ~15%
  - Non profit: ~10%
  - Traditional healers: ~10%

Healthcare Expenditure by Financing Agent (%)
Source: IFC Report, 2007

Healthcare Expenditure by Provider Ownership (%)

Private Financing Trends

• Over half of total health expenditures for households are in the private sector

• Private sector health expenditure is generally in the form of direct payments at the point of service

• Out-of-pocket health expenditures has increased in both absolute and relative terms

• Some evidence that donor funding may be affecting private investment in HIV

Source: AFD Diagnostic forthcoming
Myth #2: The private health sector mostly benefits the wealthy
All Population Segments, Including the Poor, Access the Private Health Sector

Use of private sector among POOREST QUINTILE in Sub-Saharan Africa for curative child care

Source: SARA Project 2004
The For-profit Private Sector Provides Care Across all Income Groups

Urban and Rural Population Receiving Care from Private for-Profit Provider of Modern Medicine

<table>
<thead>
<tr>
<th>Country</th>
<th>Lowest quintile</th>
<th>Highest quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>64</td>
<td>51</td>
</tr>
<tr>
<td>Uganda</td>
<td>53</td>
<td>67</td>
</tr>
<tr>
<td>Kenya</td>
<td>45</td>
<td>61</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>44</td>
<td>48</td>
</tr>
<tr>
<td>Ghana</td>
<td>39</td>
<td>48</td>
</tr>
<tr>
<td>Cameroon</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Madagascar</td>
<td>17</td>
<td>45</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Gambia</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Mozambique</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Average for 11 available SSA countries</td>
<td>45</td>
<td>46</td>
</tr>
</tbody>
</table>

*Percent: Most recent survey year available between 1995-2006
Source: WB Africa Development Indications 2006, team analysis
Myth #3: The private health sector is insignificant in Africa
Virtually Half of all Physicians Work in the Private Health Sector in Africa

<table>
<thead>
<tr>
<th>Geographic Region</th>
<th>% of physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia (6 countries)</td>
<td>60%</td>
</tr>
<tr>
<td>Sub-Saharan Africa (8 countries)</td>
<td>46%</td>
</tr>
<tr>
<td>Mali</td>
<td>50%</td>
</tr>
<tr>
<td>Kenya</td>
<td>74%</td>
</tr>
<tr>
<td>Latin American &amp; Caribbean (5 countries)</td>
<td>46%</td>
</tr>
<tr>
<td>North African &amp; Middle East (7 countries)</td>
<td>35%</td>
</tr>
</tbody>
</table>

Source: Marek, T. Presentation in South Africa 2005, WB 2005, IFC Country Assessments of the Private Health Sector
Private-for-profit Providers are a Sizable Source for HIV Testing in Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Chad</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>Guinea</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Uganda</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>13%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Most recent Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS)
Even Higher Reliance on Private Health Sector for STI Care

Source: Most recent Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS)
Private Healthcare Market in Africa Expected to Double by 2016

Total health expenditures


Source: IFC Report, 2007
Moving from Service Delivery to HRH: The Private Sector Role in Medical Education
Private Sector Actors in Each Building Block of the Health System

Private Sector Actors by WHO Health System Building Blocks

Globally, the share of total enrollment in private tertiary education is in 30 percent.

Asia is the region with the highest level of private tertiary enrollment (e.g., Philippines at 75 percent).

Growth in private medical tertiary education in Africa in the context of stronger emphasis for pre-service education.
Greater Linkages with the Public Sector in the Education Sphere

• Partnerships between the public and private sectors are more of a norm in medical education than in service delivery

• Few purely private models of private education→ high interdependence

• Public-private partnership (PPP) in medical education is a formal collaboration with any level of government and the private sector to jointly regulate, finance or deliver medical education
Public and Private Actors in Medical Education

**PUBLIC**
- Ministries of Health and Education
- Professional Councils
- Public Universities and Training Institutes
- Public Teaching Hospitals

**PRIVATE**
- For-profit or not-for-profit Universities, Teaching Hospitals, and Training Institutes (PMTI)
- Associations of Private Training Institutes
- Research Organizations
- Management Consultancies
## The Public/Private Mix in Medical Education

<table>
<thead>
<tr>
<th>Ownership / Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PUBLIC</strong></td>
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</tbody>
</table>

### PUBLIC

- **Traditional public institutions**
  - Subsidized or no tuition fees

### PRIVATE

- **Private institutions that receive government support**
  - Contracting out
  - Targeted vouchers
  - Tax incentives
  - Transfer payments or subsidized loans

- **Public institutions with private cost-sharing**
  - Tuition fees
  - Student loans
  - Private contributions

- **Independent private institutions (for-profit and not-for profit)**
  - Tuition fees
  - Student loans
  - Private contributions, equity or debt
Types of PPPs in Medical Education

- Contractual or “contracting out”
- Legal requirements or tax incentives
- Supply-side subsidies
- Demand-side subsidies
- Sale of public assets
- Voluntary or philanthropic partnerships
- Medical education franchising
Some Emerging Lessons

• PPPs in medical education are nascent compared to service delivery
• Growth of PMTI is a precursor to PPPs→ many barriers to the growth of PMTI in Africa still exist
• Effective student loan initiatives require the sharing of risk between public and private stakeholders and can benefit from innovative PPPs
• Major gaps in the adequate flow of information from the private education market to consumers
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There is significant potential for the growth of private medical education and PPPs.

However, there are major challenges—particularly around financial and business issues—facing private medical education.

Other issues around private medical education including quality of instruction; accreditation systems; and regulatory environment differ across Africa→ hard to generalize.

Often need to dig deep to the institution-level to truly understand the landscape.
Eager to Hear from the Audience

- What are the main challenges in private medical education in your country?

- Do you think the private sector has been adequately incorporated into human resources for health efforts? Why or why not?