Chapter 3

Literature Review

In reality P-P mix in health care system has been practicing in different countries in different ways for a long time. Some of them are very unorganized and some are not come into account. But to achieve the goal "health for all" WHO and World Bank are encouraging to reproduce various efforts in different countries and there are considerable literatures that discussed public-private mix in health care. World Health Organization and World Bank have produced many literatures regarding this topic. Many workshops, seminars, symposiums have been organized to analyze and evaluate P-P mix situation. However, The literature of significance with this study is concerned with following issues:

3.1 Concept and definitions of public-private mix
3.2 Contracting out

3.1 Concept and definitions of public-private mix

Though in terminology the public-private mix in health care is a new concept but virtually the public-private mix service in health care has been existing for a long time. The public-private mix in health care has several possible meaning. Normand and Weber (1995) stated that, funding organizations may be allowed to own providers of care, or may contract with independent providers for the supply of services. It is possible to mix private ownership of facilities with tax or social insurance funding or to fund public service provision through private financing mechanism. In other words there is no need for funding and service provision to be owned by the same sector; it is feasible to have combined organizations for both funding and provision, or a separation of funders and providers. Most countries have a mixture of system for financing health services, but

there is normally one source of funds, which plays the largest part in giving most people access to most of their care.

Berman (1996) stated that in describing and assessing the public-private mix, the mix in terms of financing, for example, might have little relationship with that found in provision. The mix of providers in terms of numbers and capacity may differ from the pattern of use and spending. Therefore, Various combinations of these two dimensions of public and private health activities may be involved, as show in the table 3.1.

Table 3.1 - Possible combination of public and private sectors financing and provision

	Responsibilities for provision		
Financing source	Public	Private not-for profit	Private for-profit
Public	General tax revenues used for direct public provision. (No mixing) Cell A	Public contributions used to purchase the services of NFP providers. (Contracting out) Cell B	General revenues used to purchase the services of private for-profit providers. (Contracting out) Cell C
Private	User fees paid for private use of public facilities. Cell D	User fees paid of NFP facilities. Cell E	Private payments paid to providers in private practice. (With in comprehensive system, type of mixture) Cell F

Source-Muschell, 1995

3.2 Contracting out

According to WHO, (1995) contracting out is public contribution used to purchase of NFP providers (Cell B in Table 3.1) and general revenue used to purchase the service of private for profit providers (Cell C in Table 3.1) with certain terms and condition but it can vary in different situation.

3.2.1 Rationale for Contracting

Contracting involves shifting partial or complete responsibilities for provision of clinical or non-clinical services to the private sectors, while the responsibilities for financing remains with public sector (Muschell, 1995).

Mills (1996) advocated that health policy appears to have entered an era where public sector management is out of fashion and encourage competitive forces and private sector involvement is in fashion. Yet the evidence is unconvincing either that public sector provision has necessarily failed, or that competitive contracting can do any better and does not introduce a new set of problems. There is some evidence that selective involvement of private sector through competitive contracting out increase efficiency.

Roemer (1993) described that medical care given by private physicians and financed by public programs abounds in the welfare-oriented health systems of Western Europe, Canada, Japan, Australia and New Zealand. This is predominantly care by general medical practitioners, since most specialists are employed by public or voluntary hospitals on salary. The two largest publicly financed medical care programs in the United States, Medicare for elderly and Medicaid for poor pay fees to private providers for services to eligible persons. Preferred provider organizations in the United States also use the contractual approach.

Medicare is a uniform federal program that provides compulsory hospital insurance to the elderly as well as optional medical coverage to which nearly all elderly subscribe.

Medicaid is a program operated by the states, with matching federal dollars but different criteria and benefits from one state to another, that finances health care for poor households.

Jõnson and Musgrove (1997) mentioned that the contract approach involves an agreement between third-party payers (insurers) and health care provider aimed at greater control over total funding and its distribution. This approach tends to be found in social insurance systems with predominantly private non-profit providers.

In developing countries, public hospitals including those sponsored by social security programs are typically supported by periodic payments based on annual global budgets. Private hospitals both non-profit and proprietary usually are paid on a per diem or even per item basis.

3.2.2 Services for Contracting out

A great variety of services and functions may be contracted out that is described in Table 3.2. Contracting arrangements are fairly common for intermediate health care input e.g. non-clinical services such as laundry and catering, hospital billing, etc. At the Mulago hospital in Uganda, meals for staff, elevator services and the management and maintenance of steam facilities are contracted out. In Zimbabwe, the maintenance of instruments and electronics provision of laundry services and supplies of certain drugs are based on contractual agreements (Source, AFRO communication, cited in Muschell, 1995)

A limited amount of contracting already exists in developing countries. The contracts studied included ones for non-clinical services, all of which were awarded on a competitive basis. Of the clinical contracts only one country, South Africa, had introduced competitive tendering; else where the contracts were negotiated with a chosen provider (Mills, 1996).

Table 3.2-Services that may be contracted out

Category	Examples
Clinical services	Hospital facility Primary care facility Specific specialty or primary care service Specific diagnostic procedure Specific surgical procedure Public Health activity Laboratory tests
Non-clinical services	Pharmacy Catering Laundry Cleaning Maintenance(equipment, building) Security
Functions	Personal recruitment and employment Management Printing/photocopying Building design and construction Computing Purchasing

Source-Hillman and Christianson, 1984; cited in Mills, 1997.

Mills (1996) focused that the evidence on non-clinical contracting suggested that contracting was capable of delivering services at lower cost. Quoted from Bhatia's data (1995) Mills (1996) concluded that contractors had lower cost than public providers did and that contracting the catering service was cheaper than direct provision. The same was

probably true in Thailand for cleaning (Tangcharoensathien et al 1995) and in Mexico for various non-clinical services (quoted in Mills, 1996).

According to Mills (1996), the South African study of contracting for district hospital care provides important insights into the gains achievable from clinical contracting as well as the problems associated with it. The contractors were highly successful in delivering services at a cost below that of public sector, largely through lower staffing levels and higher productivity. A few aspect of quality were superior to that of directly provided services for examples cleanliness and building maintenance but others, particularly aspects affecting clinical care, were no different.

For making contracting arrangement an obvious problem in developing countries is that they are often characterized by lack of health facilities, and difficulties of physical access further limit services available with in a specific geographical area. Thus in many rural areas there is an obvious lack of competition for particular type of medical care and contracting for clinical seems to make little sense. However, points can be made against this view.

Mills (1996) described that in rural areas where only facilities are adequate to service the local population, the contracting arrangement could involve a management contract for an existing publicly owned facility, or leasing the building. Where a facility does not exist, the contract could involve the private sector building and then operating the facility (The Islamic Republic of Iran is operating this type of contracting)[1]. NGOs are frequently thought to have potential for supplying services on behalf of the public sector.

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2 the author has owned experienced about Islamic Republic of Iran.

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3.2.3 Impact of Contracting out

Impact of contracting out with For-profit subsector

Impact of contracting out has considered in terms of equity, efficiency and quality of care.

Equity: most of the economics books define equity in health care in a similar fashion that is as follows: *Horizontal-equity criteria*: 1) Equal expenditure for equal need; e.g. equal nurse cost per bed ratios in all equal hospitals. 2) Equal utilization for equal need; e.g. equal length of stay per health condition. 3) Equal access for equal need; e.g. equal waiting time for treatment for patients with similar conditions. 4) Equal health/reduced inequalities in health; e.g. equal age- and sex-adjusted standardized mortality ratios across health regions. *Vertical-equity criteria*: 1) Unequal treatment for unequal need; e.g. unequal treatment of those with treatable trivial versus serious conditions. 2) Progressive financing based on ability to pay; e.g. progressive income tax rates and mainly income tax financed (Donaldson and Gerard, 1993).

In theory, developing contracts with the private for-profit subsector has the potential to increase access to health services for disadvantaged groups, to the extent that contracts encourage an increase in the availability of service. But in Thailand changing financial mix, in particular the CSMBS (civil servant medical benefit scheme) policy reforms allowing more budget from the ministry of finance to be channeled to private hospitals will seriously affect the financing of public services (Tangcharoensathien and Nittayaramphong, 1995). When contracting for hospital care is introduced in urban areas where facilities are plentiful, then there is a danger that competition may distort the behavior of public hospitals. And encouraging them to concentrate on services where they are in competition with private sector rather than on those that provide greatest health benefit to the local population (Saltman and Otter 1992, quoted in Mills, 1996).

Efficiency: according to economic literature the efficiency defined as-*Allocative efficiency*: Pursuing health care programs that are worth while (benefit exceed costs) or

for programs that are worth while, expand up to the point where marginal benefits equal marginal costs. *Operational efficiency*: For worth while programs, ensure that the best use is made of scare resources to meet the program's objectives (Donaldson and Gerard, 1993).

Contracting is a strategy aimed at improving the productivity of public resources by taking advantages of efficiency gains- that perceived to exist in the private sector. In the case of Namibia, the contracting arrangement for surgical care has been reasonably successful in containing costs, but there is evidence that GPs often give priority to their own private patients over patients covered under contracts. Some times the government may not be an effective negotiator when faced with the threat of a contractor pulling out; hence there may be a tendency over time for contracted services to benefit at expense of public provision (Mills, 1996).

Quality: it has also been suggested that contracting may lead to quality improvements. The potential for quality improvement (and cost containment) through contracting is maximized in an environment of competition for contracts. But contracting can lock the government into contracts that have to be paid regardless of their financial circumstances. This is likely to be a major problem in the poorest countries, which can afford to fund few services at a reasonable level (Muschell, 1995).

Impact of contracting with NFP subsector

Equity: not-for-profit providers, usually NGOs, frequently establish health facilities in area where government facilities do not exist, providing access to health services for population with otherwise limited alternatives for care, contracts with NFP providers can ensure that disadvantaged groups have access to a minimum set of essential services.

Efficiency: better policy coordination between the public sector and NFP provides on such issues as the location, size and staffing patterns of health facilities should lead to improvement in overall efficiency of the health sector (WHO, 1995).

Quality: services provide by the NFP subsectors are often perceived to be a higher quality than those are available in the public sector facilities. Quality difference has been linked to more consistent availability of drugs in NGO facilities and in some cases to better technical skill of NGO staff (WHO, 1995).

3.2.4 Examples of Contracting out

Recently, contracts with for-profit provides for the provision of preventive and curative health care services have become prevalent. In Namibia, surgical care in rural area is often carried out by teams of GPS in private practice, under contact with ministry of health. Zimbabwe has had some experiences developing contracts with mine hospitals for the provision of services to eligible populations. And in UK, as many as 30 different clinical services have been contracted to the for-profit subsector, many contractors are foreign companies.

Some countries use social security funding to pay for-profit providers, which represents a variant on the contracting strategy. Normand and Weber (1995) gave some examples. In Egypt, services are provided by a mixture of public and private providers. Most outpatient care is given by private practitioners, working in their own facilities or in public or private clinic under contract to social insurance. Contracts for care by private providers are mainly on a fee-for-service basis. In Thailand, social security institution contracts with private provider on capitation basis. The capitation mechanism was designed to contain cost. But in Brazil and Islamic Republic of Iran, social security institution contracts with private provider on a fee-for-service basis. In Poland, the government is developing contract with NGOs to conduct public health campaigns (WHO, 1995)

In German system, care is provided by self-employed physicians and a mixture of public and private hospitals. Patients can choose services from any appropriate provider. For outpatient care, almost all physicians have their own surgeries and a self-employed. Around one-third of hospitals (but nearly half the beds) are publicly owned, 35 percent of beds are provided by non-profit making and voluntary organizations and 15 percent by private profit-making hospitals. Contracts between hospitals, physicians and health funds are generally through negotiation between the associations representing the three parties. The contracts, which specify the pay of providers, are signed with associations rather than individual providers (Normand and Weber, 1995). Some examples of contracting and reasons for contracting are placed in Table 3.3.

Actually, there are many literatures by health economists, health policy planners, many questions, and debates and the objectives are to make a healthy present and future generation by using P-P mix. Some of them are beyond of this study, some are not directly related. Therefore, this study has tried to highlight some significant parts related with the objectives of the study and help to make a guideline.

Table 3.3-The Examples of contracting out

Country	Service contracted	Reasons
Bombay (India)	Catering	Reduced load on management; expected to be cheaper; reduces wastage and pilferage; means catering not affected by strikes of municipal workers
Mexico	Clinical	Provide services for insured population in area where social insurance facilities inadequate.
	Non-clinical	Lower costs (especially for labor); higher quality; fewer labor problems.
South Africa	District Hospitals	Make use of private sector capital for hospital construction; reduce government administrative burden; enable new hospital building to be open.
Thailand	Medical equipment	Obtain latest equipment; avoid difficulty and delays in getting government approval and funds; overcome difficulties of maintenance.
	Non-clinical	Obtain cheaper and better quality service.
Zimbabwe	District hospital	Lack of government facilities in area and mine hospital with spare capacity available.

Source-Mills, 1997