

Public-Private health sector mix-way forward

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Abstract

The debate on Public-Private mix has been around in South Africa (SA) for the past ten years. The debate arose out of a realisation of the weaknesses in the public health parallel with the ever-increasing private sector worldwide. The concept has been referred to in different terminologies, public-private mix, public private partnerships (PPP), public private initiatives (PPI). This paper aims to stimulate further debate on the subject, in the light of changing policies and political thinking in the country. The paper presents findings and examples from other countries, based on a review of literature on the subject. The paper concludes that in SA there is a strong potential for public private mixing, but warns that the process should be carefully implemented. **(SA Fam Pract 2004;46(9): 5-8)**

Background

The whole debate about the private-public mix in health care has its roots in basic economics principles of how to maximise benefits for the population from the existing resources within both sectors. It is therefore a statement of realisation of the limitation of resources. In recent years the tone globally has changed from a historically polarised debate between public and private sector, to a more compromising one of how to make both systems work effectively and efficiently, thereby providing universal and comprehensive coverage of health services to populations.

The aim of this paper is to examine the potential to enhance public - private mix health sector reform in health care services provision in SA.

Objectives are:

- Examination of advantages and disadvantages, strengths and weaknesses of both health sectors.
- Assessment of different models of PPP

Context of public-private mix thinking

The relative roles of public and private health care sectors in develop-

ing countries have changed considerably over time. The government was by the 1980s, viewed as the primary player in the health sector provision in many developing countries.

The view held since the Alma Ata declaration of the state as the 'vehicle for improving peoples' health status, was changed around the middle 1980s, with extensive international mobilisation for smaller role of governments along with promotion of the private sector. One important actor in this revolution was the World Bank.¹

The World Bank articulated its position in two reports,^{2,3} basically recommending a policy of reduction of government involvement in health care and promotion of the private sector. This new paradigm was associated with a world wide revolution in public sector management thinking, termed "new public management" The new public management fever had gripped the world with the primary objective of improving efficiency of service provision primarily through the introduction of market mechanisms into the public sector.⁴

These recommendations by the

World Bank have been challenged as being based on weak evidence on quality and efficiency of the private sector.⁵ Despite this information gap, many developing countries have implemented public - private sector reforms, including Zambia, Tanzania, Mozambique and Malawi.⁶ In Mozambique and Malaysia public sector doctors were allowed to work in the private sector.⁷ In China, extensive privatisation of health care facilities followed the breakdown of the commune system.⁸

Theory of public private sector reform.

The economic theory projects that in a perfectly competitive market, the demand and supply theory operates and price signals will determine the quantities demanded and supplied. The theory is however questionable in the light of market failure in health care, on the basis of an unlikely perfect competition and information asymmetry.⁹

There are also arguments of government failure to produce efficient goods and services. This phenomenon is well documented in formal and informal discussions and the media section of South Africa.

However this needs to be critically examined in the context of reduced government budgets on social services. A classical example of a counter argument to this assertion, is found in the remarkable achievements by Kerala, Cuba, China, Costa Rica and Sri Lanka, on health indicators. Following on active government intervention, these countries' health indicators are much better than anticipated for their incomes.¹⁰

Strengths and weaknesses of the private sector

Bennett and Coklough document four types of arguments that support strengthening of the private health care sector.¹¹

1. Efficiency and Quality

The World Bank argues that the economic theory suggests that the private sector, because of profit incentives, is more technically efficient than the public sector and quality is argued to be inextricably linked to efficiency.²

Closely allied to these arguments is the responsiveness of the private sector to consumer preferences. The counter argument to these assertions, efficiency in particular, is the issue of market failure in health care. Le Grand argues that, because of the moral hazard, adverse selection and high administrative costs, the private sector, with fee for service system of payment, is also generally inefficient.¹²

In SA, privatisation of some health services to such institutions as Life Care and SANTA, was purely for efficiency reasons. Whilst these gains were noted by the state, the quality of services from the same institutions is equally questionable. A report of an evaluation by the department of health (DoH) of these institutions with respect to their TB services confirmed the poor quality assertion by the DoH.

2. Equity

The World Bank Report argues that private sector growth results in transfer of demands of the affluent from the public to the private sector, (e.g. sophisticated clinical services), thus setting free state resources for use in under-privileged. This theory, well supported in most SA health policy documents, is highly questionable as there is no evidence of successful redistribution of resources to the under privileged, with no available accurate means test.

Chandra *et al.*, provide a counter argument that, with the affluent leaving the public sector, medium term standards of care may decline, as the articulate middle class will no longer be available to voice people's concerns.¹³ This is one of the highly sensitive areas of debate in South Africa, with political ideologies based on class often creeping into the discussions.

3. Additional Resources

With the growth in private sector, there is an increased flow of resources into the health care system, relieving pressure on the government resources.² However, there are concerns that this depends on the ability to pay by the population.

4. Consumer Choice

This is based on the principle that health care is 'a good' in its own right and, enhancing liberty, allows individuals to select products or services that match their own preferences.

Potential for private provider involvement (examples)

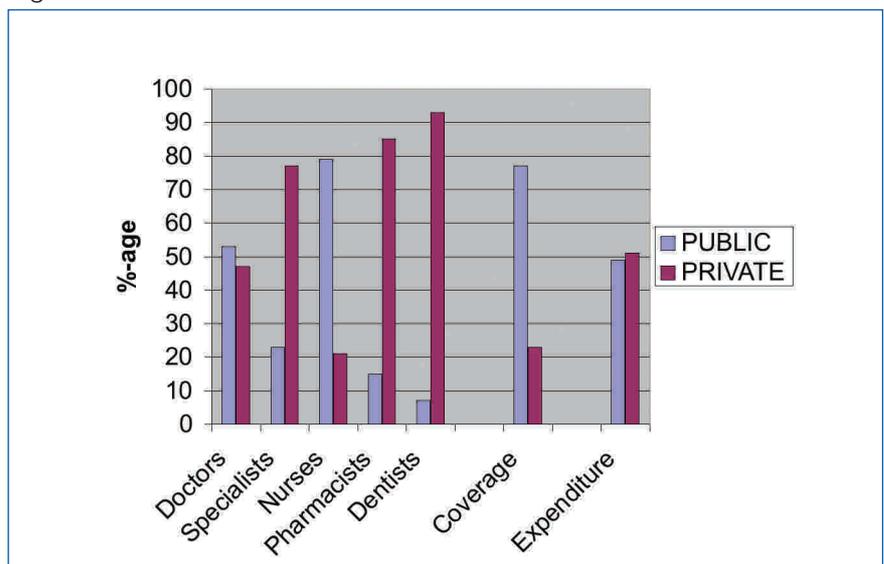
Notwithstanding the external pressure from the World Bank and other agencies, the growing private sector in countries is a force that cannot be ignored.

There is a long list of countries that have implemented PPP strategies from which SA could learn important lessons from their experiences. Some of these are: The United Kingdom's NHS, introducing quasi-markets (a form of PPP)¹⁴, Nepal¹⁵, Zambia¹⁶, Pakistan¹⁷, Bombay¹⁸.

In Africa, 23 % of health facilities in Kenya and 40 % in Ghana, are private¹⁶.

A brief discussion of experiences in Malawi; with some detail about SA, where there is huge private sector activity and where the health sector reform is high on the agenda, highlight some experiences and potential for private sector involvement

Figure1: Distribution of Health Care Resources 1992/3.



Source: Health Expenditure and Finance in SA. 1995.

in health care.¹⁹

In South Africa, the new Health Act refers to a co-ordinated relationship between private and public health establishments in the delivery of health services and, that the public health sector will be permitted to contract with private practitioners to provide services. These are interpreted to be early foundations for public-private partnerships.

Figure 1 summarizes the distribution of health resources in SA and augments the above perceptions about the early foundations of quasi-markets.

The distribution of resources is so skewed towards the private sector while the same sector is delivering services to only a minority (23%) of the population.²⁰ This is a classical situation that the government cannot ignore and has to find strategies to ensure coordinated comprehensive services provision and/or financing.

Another big private sector that has not been included here are the traditional practitioners. There are more than 200 thousand of these in SA, with huge, but non-quantifiable consumers of their services.

It therefore appears from the situation analysis of SA health services that the debate in this country can no longer be about whether or not the public sector should work with the private sector but how best to transform SA health services between the two sectors to offer a universal, comprehensive, effective and efficient health care to all citizens of the country in an equitable, affordable and sustainable manner. Price summarises the debate in SA by providing a challenge on whether the trend of decreasing equity and access to health care should not be countered by drawing on financial resources currently being spent by the private sector through a national health insurance scheme, and the degree of private provider integration into the publicly financed health system.²¹

To further illustrate the capacity and potential of private provider integration into the public health system, a study was conducted in 1996 by this author, investigating potential for private sector GPs involvement in the national TB Control Program, in SA. The study concluded on overwhelming willingness by the private doctors to manage TB patients in their rooms, citing immunisations and family planning as other public services that they were successfully rendering.²²

A similar study by the same author (still to be published), on private doctors' involvement in sexually transmitted infections (STI) management, drew similar conclusions. Whilst one was excited by these findings, there are very important negative issues to be considered before considering engaging the private doctors, especially in SA. Ulepkar et al., in two separate studies in India, investigating private doctors' behaviour, concluded that these doctors were not following national guidelines in diagnosing and treating TB patients, with highly inefficient and potentially disastrous consequences to patients.^{23,24}

Conclusions from Ulepkar's studies persuaded the International Union Against Tuberculosis and Lung Disease (IUATLD) conference to adopt a carefully phased public-private engagement.

Potential for contracting out

One of the different mechanisms of engaging the private sector is contracting some services like catering, security, laundry, laboratory services, to this sector. Since the adoption of PPP policy in SA, there has been hysteria in many public health institutions to contract some of their services out to the private sector. Conclusions from studies in Bombay²⁵, Bangkok⁵, Zimbabwe⁴, and SA²⁶, were that there are certain conditions that influence the success of contracting out of services viz.:

- The private sector must have the capacity to supply services
- Government capacity to design, implement and monitor contracts.
- The characteristics of public services and the extent to which they are amenable to change
- Aspects of broader social, economic and political environment be considered.

Potential for NGOs

In many developing countries including SA, there has been a growing number of non-governmental organisations (NGOs) operating. Walt makes a distinction that NGOs are voluntary, aim to achieve some desired goals and do so without adopting formal government roles.¹⁹ Green and Mathias assert that the existence of these is in line with the recommendations of the World Bank of separation of service delivery and financing on the basis of efficiency.²⁷ They however dismiss as myth that NGOs perform better than government in service delivery as judged against efficiency, quality, sensitivity to the needs of communities and sustainability of service delivery. The other assertion is that NGOs are able to tap into resources, not readily available to governments.

Conclusions

Private and public sector relationship is an important aspect of health sector reform, a major political issue, with major implications to the health services delivery.

Different countries have unique characteristics and peculiar situations of health services delivery. It would therefore be naive to suggest blanket recommendation to all nations.

With the huge body of scientific evidence pointing in the direction of public-private mix, South Africa cannot afford to hide behind rhetoric and deny the existing information. At the same time, an understanding of limitations and weaknesses of

PPP should inform the decision on whether or not to undertake this paradigm and in what form.

This issue has been of concern in some countries including SA, where for example, abuse of public sector time and equipment was observed among some doctors allowed to perform limited private practice. This type of behaviour led the Department of Health in South Africa, in September 1999, to legislate against limited private practice in the country.

In developing policies towards private sector involvement, all countries, specifically South Africa, should clearly identify the role each party can and should play in a complementary action.

Mechanisms must be carefully worked out, drawing the strengths of the private sector to replace weaknesses of the public sector. The government however, remains fully accountable to its citizens and therefore should continue to monitor and control the private sector.

It is finally recommended that in SA, before blanket implementation of PPP initiatives, operational research be conducted to test the feasibility and practical issues that arise in the real world.

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