สำนักงานวิทยทรัพยากร
จุฬาลงกรณ์มหาวิทยาลัย

CHAPTER 2

Review of Literature

2.1 Health Care Delivery System

Most health care providers in less developed and developing countries fact the similar problems, that remain dauntingly constant (Cassels, 1995):

- Scarce resources are used inefficiently: public funds are being spent on inappropriate and cost-ineffective services, too much is spent on salaries compared to operating costs, and on tertiary rather than primary levels of care. Existing services are badly managed, money does not get to where it is needed, and it is hard to monitor how it is spent. Systems for purchasing goods and services fail to ensure value for money.

- People cannot access the health care they need: this results from a variety of factors - an individual's poverty, geographical location, age, sex, or lack of employment, unavailability of services to treat particular problems and bad planning and management of services.

- Services do not respond to what people want: people will not accept poor quality services uncritically just because they are there, and services in many countries are therefore grossly underutilized. In the public sector , people face long waiting times, and inconvenient health services. In the private sector, they face high price of services that can create inequity in access to care (Muschell, 1995).

The concepts to solve these problems are suggested from many documents, concerned with "Health Care Reform". One of the key concepts is an effort to join forces between public and private health sectors that is known as public-private mix.

2.2 Privatization in the Health Sector

Privatization can be defined as a process in which non-government actors become increasingly involved in the financing and/or provision of health care services (Muschell, 1995). Privatization involves changes in public and private roles

and responsibilities in the health sector, and generally includes changes in actual ownership of the means of financing and/or producing health care.

2.3 Combinations of Public and Private Sector Financing and Provision

The provision of services, however, does not necessarily have to match the financial organization (Donaldson and Gerard, 1992). There are many different combinations of public and private responsibility for the financing and provision of health care services can be depicted as in Table 2.1.

Table 2.1: Possible Combinations of Public and Private Sector Financing and Provision

	PROVISION	
FINANCING	PUBLIC	PRIVATE
PUBLIC	CELL A	CELL B
PRIVATE	CELL C	CELL D

The table provides a convenient means of depicting alternative financing and provision relationships between public and private health sectors. In the case of cell A, both finance and provision are combined within the public sector, such as in many countries in the developing group, in which government as the public sector has to provide and finance health care at the same time. In many countries, general practice would fall in to cell B, such care being provided by private clinics and private hospitals, the public sector may buy services from them, for instance under the social security act in Thailand. The private financing can purchase both public and private health provision. Cell C represents private finance and public provision i.e. patients who have private insurance are admitted into public hospitals or patients who pay out of pocket in public hospitals but cell D represents those who are financed by private arrangements i.e. private insurance or out of pocket, and going to purchase health services at private hospitals. The most popular one possibly is public finance and private provision.

2.4 Approaches to Privatization

Much confusion has occurred about the privatization process, because policies designed to actively increase private sector involvement in health care financing and provision can result in complex, often blurred relationships between public and private sectors. Sometimes the same people are engaged in both sectors, and health facilities may be used for both public and private provision (i.e. private rooms in a public hospital). Because of the inherent complexity of privatization strategies, the implications for the role of government are difficult to predict, and will vary from strategy to strategy and from setting to setting (Muschell, 1995). Muschell also suggested approaches to privatization such as:

2.4.1 Divestiture of public assets

In the strictest sense, privatization involves a transfer of ownership, in which the State divests itself of public assets to private owners. the primary objective of divestiture is to reduce the scale of government commitments.

Many countries have established divestitures, for example the government of the Czech Republic plans to transfer 70% of existing hospital beds to the private sector by 1996. Private sector financing of health care is also being encouraged through the development of private health insurance schemes. In China, health reforms begun in the 1980s fueled a rapid rise in the role of the private sector in both financing and provision. Many village health centers were sold and converted into private clinics. According to the experiences of various countries the divestiture can have impacts in ways such as mentioned by Muschell:

Potential impacts of divestiture

Equitable access to care: Too much reliance on private sector financing mechanisms may result in inequities in access to care. In the Czech Republic, private insurance companies are beginning to compete on the basis of patient selection, which may serve to diminish equity.

Efficient used of resources: While divestiture of public assets will undoubtedly reduce the burden of public sector financing, there is a risk that higher health care costs may be associated with uncontrolled privatization, as private

providers seek to maximize revenue. Efficiency may be diminished further if providers have incentives to provide unnecessary and expensive care.

Quality of care: There is sufficient evidence, particularly from non-health sectors, that competition and private initiative can lead to better quality goods and services. In the private provision of health services, however, quality of care is often in delicate balance with competing objectives of efficiency, equity and resources generation. In China the rural health care system eroded during the recent period of rapid privatization, and there is considerable debate about the extent to which privatization policies may have led to a deterioration in the health status of the rural poor. It is conceivable, therefore, that cost containment strategies and/or profitability objectives could compromise efforts to improve service quality.

2.4.2 Contracting Out of Health Services

Contracting out, a combination of private provision and public financing, is emerging as a common policy issue in a number of developing countries (McPake, 1994). Other means of contracting out mentioned by Muschell (1995): contracting involves shifting partial or complete responsibility for the provision of clinical or non-clinical services to the private sector, while the responsibility for financing remains with the public sector. The theoretical case for contracting out suggests many advantages in combining public finance with private provision. It has been argued that some of the advantages of private provision can be obtained, and some of its disadvantages avoided, by imitating private sector mechanisms within the public sector. In other words, a public sector framework for the provision of services is maintained with a Ministry of Health overseeing the sector and possibly the maintenance of the concept of a National Health System. Within this framework, traditional public sector characteristics such as direct central planning, free provision, global budgeting and salaried public employees are exchanged for characteristics which have traditionally been associated with the private sector.

However, practical difficulties such as those of ensuring that competition take place between potential contractors, that competition leads to efficiency and that contracts and the process of contracting are likely, only contemplate restricted contracting of small-scale non-clinical services in the short term. Prerequisites of more extensive models appear to be the development of information systems and human resources to that end. Some urban areas of larger countries may have the existing preconditions for more successful large-scale contracting.

The evidence on non-clinical contracting suggested that contracting was capable of delivering services at lower cost. For example, data from Bombay (Bhatia, 1995, quoted in Mills, 1995) clearly suggested that contractors had lower costs than public providers, and that contracting the catering service was cheaper than direct provision. It is probably true in Thailand for cleaning (Thangcharoensathien et al, 1995) and in Mexico for various non-clinical services (Alvarez et al, 1995, quoted in Mills, 1995). However, it is interesting to note the evidence from Bombay that the quality and quantity of the diet was worse in the contracted service (though this was probably the result of fixing the price per meal prior to the tender).

A South African study, of contracting for district hospital care, provides important insights in to 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 the public sector, largely through lower staffing levels and higher productivity. A few aspects of quality were superior to that of directly provided services(e.g. cleanliness and building maintenance), but others, particularly aspects affecting clinical care, showed no difference. Despite the contractors' lower cost, the cost to the public sector of the contracts (price plus transactions cost) was actually higher than direct provision: in other words, the contractors were making high profits.

A study in Zimbabwe about contracting out of clinical services was reported by Mcpake and Hongoro (1995). The main objective of the research was to assess the success or otherwise of this case of contracting between public and private institutions in the health sector. The approach used to judge this was to make a comparison of certain characteristics of service provision in the contracted hospital and the hospital which is directly managed by government. They found that contracting is increasingly recommended to developing countries as a way of improving the efficiency of the health sector. The study highlights a number of important issues affecting contracting in developing country settings:

First, contracted institutions attain powerful bargaining positions if there are no viable competitors and the government does not itself retain capacity to offer an alternative service.

Second, specific skills are needed for the management of contracts at all levels. If the process of contract development responds to a crisis driven agenda

resulting from civil service retrenchment and public expenditure cuts, it is unlikely that adequate consideration will be given to development of such skills and the retention of key personnel. If such details are neglected, otherwise feasible efficiency gains will prove elusive.

Then, it should be noted that the essential features of the contracting out are competition (Mills, 1995) and purchasing power (Tangcharoensathien et al, 1994).

Potential impacts of contracting out

Equity: Developing contracts with the private networks has the potential to increase access to health services for disadvantaged groups, to the extent that contracts encourage an increase in the availability of services.

Efficiency: Contracting out is a strategy aimed at improving the productivity of public resources by taking advantage of efficiency gains that are perceived to exist in the private sector. One condition for contracting out to yield gains in efficiency is that competition for contracts among potential suppliers exists or that, at least, markets for such contracts are contestable.

Quality: It has been suggested that contracting out may lead to quality improvements. The potential for quality improvement (and cost containment) through contracting out is maximized in an environment of competition for contracts.

Satisfaction: This condition is essentially the same as those for improved equity, efficiency and quality. If contracting out serve to enhance quality, cuts costs and improves access, consumers are likely to be satisfied.

Many of the managerial and informational needs discussed above are relevant to contracting out. To prepare contracts and assess bids from competing suppliers of services, individuals with the necessary skills in contracting out design and proposal evaluation are required. Objective indicators of performance and information systems are essential for managing contracting out. There is a need to

disseminate information on successful experience in this area to help countries determine the extent to which reforms involving contracting out are relevant to their particular circumstances.

2.5 Public Management of Privatization

As the privatization, especially contracting out, can improve health service efficiency, then the public sector as the fund holder needs to improve its capacities, to plan and manage evolution of new public and private relationships. Muschell (1995) suggested the formation of well-planned policies toward the private sector requires the development of an enabling environment for effective public management of privatization, including:

- investment in information, and in information systems capable of generating relevant data about resource flows and performance in both public and private sectors;

- strengthening of public sector capacity to set performance standards, and to monitor and enforce those standards;

- strengthening of management skills, particularly skills in establishing and supervising contracts. The development of contractual arrangements may be impeded in many countries where funding or managerial experties is limited;

- flexible and responsive organizational structures - and the institutional capacity - to adequately monitor and motivate the private sector to achieve social goals.