CHAPTER 2

Literature Review

The term private sector comprises individuals, institutions and organizations working outside the direct control of the state. This is divided into two broad categories i.e. for-profit and non-profit. These two groups differ sharply in terms of their objectives and the target population. In general, non-profit private sector provide heath care much in line with the government policies and are often supplementary to the public services. But the for-profit organizations, whilst not necessarily purely financial, are narrower than those of the public sector. In many cases they provide only more remunerative services which tend to be easier to provide and most in demand ("skimming the cream"), leaving the responsibilities for the poor, for emergency care and for training to the government.

WHO (1991) reported that countries spent variable proportion of health expenditure in the public and private sectors. In 1987 Sri Lanka spent 53% in public and 47% in private sectors compared to Chile's 56% and 44% (1990) or Iran's 63% and 37% (1991) respectively. A comparative figure is provided by the Thai MOPH for the year 1987 as 24% in the public and 76% in the private sector. This situation elaborates the vast expansion of private health care financing in Thailand.

The statistical report of the MOPH of Thailand (1993) shows that for the general hospital services there are 219 (21%) private hospital against 810 (79%) belonging to the government, state enterprises and municipalities. These hospitals have 14,919 (17%) and 72,410 (83%) beds respectively. The proportion of private hospital beds in 1989, 1990, 1991 and 1992 were 12%, 13%, 14% and 15% respectively. This situation highlights the rapid growth of private hospitals in the country. The pace of growth of private hospital is continuing throughout these years. The same report shows that in 1993 there were 8,699 health centers in the country compared to 11,395 private clinics once again highlighting the strength of the private health sector. It should be noted here that most of these private

clinics are located in the cities and towns and like the private hospitals, are out of reach of the vast majority of the rural population.

Several documents discussed about the various types of P/P mix used in different countries. In one such paper by the WHO (1991) summarized several of these activities in a good number of countries. Contracting out public services to the private sector is a common practice in many countries such as Sri Lanka, Chile, Iran, Malaysia, Nigeria and Zimbabwe. Such services include security, laundry, food supply, special diagnostics e.g. CT scan, maintenance of medical or office equipment, special therapy etc. In most cases, contracting services to the private sector improved work efficiency while in some cases it proved to be little bit more expensive. Tangcharoensathien (1994) studied several form of contracting out in Thailand.

Some countries are working on the increased responsibilities of the private sector for the provision of health care. In Zimbabwe, emphasis has been placed on the provision of non-essential drugs, traditional practitioners role in the mental health and terminal case care. Hungary is promoting health insurance with choice of public and private providers. Some countries are adopting policies by increased competitiveness of the public sector vis-à-vis private sector. For example, Nigeria increased pay to the government doctors to attract back to the public sector. Iran has increased revenue from private care in the public facilities that is used to improve quality care.

Promoting preventive care within the private sector has been another innovative way of engaging P/P mix in the health sector. Nigeria provides free vaccines and condoms to private clinics. Iran provides cold chain facilities and free vaccines to the private sector. In Zimbabwe, public sector promote condom availability in the bars and other private enterprises. Sri Lanka has integrated family planning and immunization in the private sector.

Several countries have developed support for the private practitioners. Iran organizes regular refresher courses for the private sector doctors and other health staff. Nigerian government institutions accepts specialties training responsibilities for the private sector doctors and staff in return for trainee services. Services similar to Nigeria exists in many other countries as the public sector is usually the leader in the area of training and human resources development. Emerging private sector training institutions are available in the Philippines, India and others.

Aljunid (1995) have examined the role of private medical practitioners and their interactions with the public health services in Asian countries. In almost all Asian countries, private sector facilities are readily used by the consumers - the OPD and IPD services. In most instances, the practitioners work both in the public and private sectors. Regulation concerning private practice by the public health staff are ambiguous and are poorly enforced. Most of the health workers are trained at the expenses of the public fund and yet no suitable method has been devised to keep them working in the public sector. He pointed that current practices of mandatory public service, non-practice allowance and seeking permission to work in the private sector are the means governments have used to retain health personnel in the public sector. Some form of interactions exist between public and private sector in terms of patient referral and disease notification. Further research is necessary to document and analyze these interactions if policies are to be developed to encourage good quality, cost-effective health care in the private vis-à-vis public sector.

Nittayaramphong (1994) and Tangcharoensathien (1995) have described the rapid growth of private hospitals in Thailand particularly during the Sixth National Social and Economic Development Plan, 1986-1991. While such growth has contributed to the competitive development of the health sector especially curative health care in the country, it has created some negative consequences in the health sector. Tangcharoensathien (1995) have done significant works to document these issues especially, that of the human resources development, `brain drain' from public to the private sector, provider induced cost escalation of health services due to high-tech diagnostic tests or over-prescription of drugs. Despite these important revelations, very few solutions could be found for these complex and often interdependent socio-political issues.

Bennet (1991) argues that while market forces should be respected in a free market economy, there is a pervasive problem of imperfect information in the health care industry. As a result, it is very difficult to apply pure market mechanism in the health care industry. This especially true when it comes to the age old argument of ensuring equitable care and especially to the notion of `health as a basic human right'.

In Thailand no known systematic study has been done on overall effects of the public-private mix management in a district or

provincial level hospital. A case study has been conducted on public-private mix primary medical care (curative only) for the clients covered by the Social Security Scheme implemented by the Nopparat Rajathanee Hospital, a public hospital in Bangkok. While this shows promising results, the matter require further examination at the district and provincial settings as the vast majority of health care facilities are there and where resources are becoming more scarce. This is where private sector involvement is more crucial as the most of the population depends on the public hospital.

Supakankunti (1995) in an unpublished paper examined the factors affecting the private health care provision in Thailand. Her findings suggest that in 1991, the factors which have positively affected the supply of private hospital beds are per capita income and the number of public hospital beds while the population per physician has negatively affected the supply of private hospital beds. This signifies the shortages of doctors, nurses and others staff in the country. For the year 1992, the results suggest that the number of public hospital beds have positively affected the provision of private hospital beds while public sector health expenditure seems to have a negative correlation with the number of hospital beds.