Health Systems and Human Resources Development : The Changing Roles of Public and Private Sectors

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Introduction

As developing countries seek to pursue human resource development more vigorously through expansion of social services, including education, health, family planning, nutrition, and housing programs, it will be increasingly difficult for governments to organize, finance and deliver these services in sufficient quantities and qualities to meet population needs. Resource constraints in the health sector will be particularly acute as expanding economics continue to put upward pressure on the prices of pharmaceuticals, medical technologies, and the wages of trained health personnel making it increasingly costly to procure these medical goods, and train and retain health manpower. Moreover, bio-technology and bio-engineered medical products will spur continue health care inflation placing further strains on developing countries' health finance and delivery systems, particularly with regard to western drugs and curative care.

Hence, it is desirable to encourage developing countries to seek complementary roles from the private sector so that public sector resources can be more efficiently used to achieve social service goals.(1) By focusing on Thailand, the appropriate role of the public sector, the private sector and privatization can be described in broad terms. **The role of privatization within the public sector is also important, that is, the use of private incentives by public providers and governmental organizations** in addition to the role of independent private entities.

In the delivery of health services, privatization can come in at least two forms. **First, it can mean the transfer of ownership** and control of economic resources and activities to private sector entities. The public sector can transfer property rights and control of existing public economic resources or simply encourage the expansion of private sector activities in existing or new economic arenas. **Second** and more broadly, privatization implies **the use of private economic incentives in the organization and conduct of economic activities.** These private incentives can be implemented in purely public sectors, purely private sectors, and mixed and regulated industries. Privatization, therefore, can occur within the public sector even though a full private transformation, in the sense of transfer or establishment of private property rights, is absent.

The role of the public sector

There are sound economic and social reasons for public involvement in the production and delivery of health care and family planning services. Left completely to private interests, many goods and services will not be produced by the private sector in sufficient levels to attain social efficiency.

A. Many health and health-related services such as information and control of contagious disease are "public goods". One person's use of health information does not leave less available for others to consume; one person can not benefit from control of malaria while an other person in the same area is excluded. Other health services have

large **"externalities"** ----consumption by one individual has an impact on others. Immunizing a child slows transmission of measles, polio, and other diseases, conferring a **positive externality**. Polluters and drunk drivers create **negative health externalities.** Governments need to encourage behaviors that carry positive externalities and to discourage those with negative externalities.

B. Provision of cost-effective health services to the poor is an effective and socially acceptable approach to poverty reduction. Although health services are only one factor in explaining past successes in health development, there is no doubt that their role in the developing countries is important. Public health measures brought about the eradication of smallpox and have been central to the reduction in deaths from the vaccine-preventable childhood diseases. Expanded and improved clinical care has saved millions of lives from infectious diseases and injuries. Private markets will not give the poor adequate access to essential clinical service if it is not significantly subsidized by public fund. Public finance of essential clinical care is therefore justified to alleviate poverty. Such public funding can take the form of delivery free or below-cost public services to the poor or provision of subsidies to private providers and nongovernmental organizations that are voluntary non-profit and willing to serve the poor.

C. A health care system based purely on market mechanism is likely to fail to efficiently provide the population with sufficient quantity of services and quality of care. Market work best when information about goods and services are readily available and producers and consumers are equally well informed. In developing countries where many users of care are poorly educated, these users have difficulties in gauging the substantive quality and the appropriateness of the care they receive. Under these informational conditions private proprietary providers face incentives to provide too low a quality of service, inappropriate types of care non-efficacious care, and charge too high a price relative to the services provided. As a result, several institutional responses can be explored and the governments should take the lead in this connection. These responses include non-profit providers, regulation, education and information for consumers to make efficient choices, and public provision of health services. In many developing countries, direct public provision of health services is the most favored response as it affords control of quality, type of care and geographical distribution of facilities. There are tradeoffs, however, in terms of internal production efficiency, and political and organizational overhead.

D. The public sector plays a key role in attempting to achieve "equity" as it is a very important societal objective. This is the reason why both finance and delivery of services have been taken up by the public sector particularly in areas where effective demand is insufficient to stimulate private provision. Alternatives to public delivery include health insurance schemes which cross-subsidize low income workers or households and provide private delivery with economic incentives to serve these insurees or even the disadvantaged. When governments provide services and when they finance an essential package of clinical services for the poor, they usually face difficult decisions over the allocation of public resources. Cost-effectiveness analysis is only beginning to be applied to health. This is in part because it is difficult. Cost data are often weak and sometime vary, rise or fall sharply as a service is expanded. Private incentives even though can drive the production of services to be most cost-efficiently undertaken, it can also lead to non-competitive highly concentrated industries with price in excess of costs

and output levels insufficient to serve the general welfare. Therefore, if such conditions exist, some public response is warranted on efficiency grounds. That response may take the form of establishing public enterprises (providers) or regulating the prices and output of private providers especially through insurance schemes. In the long-run private contractors can provide cost-effective services if monitoring and regulatory mechanisms can be effectuated. Also long-run economic development will lead to equity in health services as increasing household income spurs effective demand for health services.

E. Economic strategies are usually not related to changes in health conditions, in spite of the fact that the health status of the population can be of critical importance for economic growth.[(2)] Strategies for improved health are usually not focusing upon economic growth and income distribution, in spite of the fact that these economic factors constitute one of the main determinants of health. The interrelationship between health and development leads public policies directed at development to include health services as an integral part of those policies.

In addition, the building of health infrastructure can lead to increased economic development through the encouragement of suppliers and related economic agents. Market and institutional arrangements formed by the health system provide a foundation upon which other related economic activities can take place. However, such spill-over effects are greater if public policy involves substantial private involvement in the health delivery and finance system.

The role of the private sector [(3)]

Government finance of public health and of a limited package of essential clinical services would leave most clinical services to be financed privately or by social insurance. The component of a package of essential clinical services of high cost-effectiveness will vary from country to country or even from region to region within a country, depending on local health needs and the level of income. The provision of curative services is one economic activity within the health services sector which should fall under the auspices of private enterprises. **Governments can facilitate efficient private sector involvement in health by policies to :**

1. **Promote private finance of all clinical services outside the essential package,** which will require regulation of social and private insurance to discourage cost escalation.
2. **Encourage private suppliers to compete both to deliver clinical services and to provide inputs** such as drugs, medical equipments and other supplies, and to provide them to publicly financed health services as well as to privately financed ones.
3. **Generate and disseminate information** on provider performance, on essential equipments and drugs, on intervention costs and effectiveness, and on accreditation status of institutions and providers.
4. **If markets for health manpower are well developed, then the education and training of health care workers can be accomplished by the private sector.**

However, the traditional public sector approach towards a health system model has involved public medical and paramedical education and training, followed by, sometime compulsory, public sector employment. For example, in Thailand, most of the health personnel are produced by the public sector (Table 1), with compulsory public

employment at low salary. Under this model, the public sector recovers a portion of the educational investment through employment at below market wages. If medical services are privatized, the medical trainees will capture future economic returns through in the private sector or in the public sector with private incentives. Education and training of medical and paramedical manpower in this case is largely a private goods and governments need not to subsidize it heavily.

Nevertheless, this depend also on the categories of personnel[4]. Those categories which focus on individual care, and have high chance of getting private benefits fit best with the private goods model e.g., doctors, pharmacists, dentists. Those categories which focus on community care for the poor, and have low chance of getting high private benefits fit best with the public goods model e.g. public health workers.

Privatization of health services

Certain mechanism can be employed in privatization of health service i.e.

A. User fees

Charging for public services and deciding on raising the user fee level to cover more of the cost, although politically unpopular domestically in many developing countries, has several attractive features. First and most obvious, user fees help finance medical services by directly generating revenues at the point of delivery and therefore, the services are at least partially self-financing. This is increasing important as the countries seek to expand social services under continuing resource constraints. Second, public providers can earn "profit " on particular services, which are in high demand in the health care market and use these excess revenues to cross-subsidize services to needy beneficiary populations. This combines the financing and equity objectives of health care policy. Third, public sector user fees may stimulate private sector activities as consumers substitute private services for public care in response to rising charges.

Wherever the public sector introduces or raises the user fees it means that there is policy to privatize the demand side. User fee is really a co-payment and hospital service are normally the prime area of privatization. The effectiveness of user fees as a financing mechanism largely depends on households' willingness to pay for medical services. Whenever an increase in a medical fee results in a less than proportional decline in demand, providers can expect revenues to increase.

B. Contracting-out

The public sector can contract-out the service provision as well as the insurance to the private enterprises. For example, the social security health insurance in Thailand contract private hospitals to deliver health services to the insurees through a capitation payment mechanism. The government can sold out public facilities and becomes purchaser of services. In health care, this policy depends a great deal on the attitude of the government towards the private health services sector. However, when the prevailing disease pattern changes from contagious diseases to behavioral diseases, it will be more and more justified to privatize by contracting-out the service provision. The challenge for most governments in this respect is to withdraw from areas of health-care provision best left to the private sector while concentrating resources and attention on things that only governments can and will do : responding to market failures (such as

externalities associated with infections disease control or public goods associated with provision of information) and investing in health and education for the poor.

C. Private ownership

The greatest potential for private ownership lies in the provision of curative services because economy of scale for investment and production of services can be realized at relatively modest size. This implies many market areas and many product types of health services. Research would be required to help identify which type of facilities, in what areas, and what product type of services, will be most conducive to privatization. Some specialty services may not be demanded in sufficient volume to support multiple private providers within a market areas. Under these conditions referral networks will exploit economies of scale.

D. Type of national health systems : classified by economic level and health systems policies.

According to data available in the year 1985, Dr. Roemer[5] has classified countries of different economic level (GNP per capita) into four distinct features of market intervention in their health system policies namely entrepreneurial and permissive, welfare-oriented, universal and comprehensive, and socialist and centrally planned (figure.1). As country move from one cell to the other, market intervention in health services also move along.

Conclusion

While the world is moving towards free market economy, the changing pattern of health services from mainly public provision to a mix public/private provision, create a high demand for development of appropriate policies, strategies, and plan for solving problems in health services and HRH.

These policies, strategies and plan should be developed through a consultative participatory approach with support from knowledge created through Health System Research[6]. In developing policies for public/private mix health services and HRH development, researches into the demand, supply of health services as well HRH production and the appropriate roles of the public sector are really needed.

Table 1 Production of various cadres of health personnel in Thailand, 1996

Cadres	Public		Private
	No.	years of compulsory work	
Doctors	848	3	30
Dentists	317	3	-
Pharmacists	808	2	92
Graduated nurses	3,037	4*	356
Physical Therapist	121	-	13

* only those institutions in MoPH.

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	Entrepreneurial & Permissive	Welfare-Oriented	Universal & Comprehensive	Socialist & Centrally Planned

Affluent & industrialized	United States 1	West Germany Canada Japan 2	Great Britain New Zealand Norway 3	Soviet Union Czechoslovakia 4
Developing & Transitional	Thailand Philippines South Africa 5	Brazil Egypt Malaysia 6	Israel Nicaragua 7	Cuba North Korea 8
Very Poor	Ghana Bangladesh Nepal 9	India Burma 10	Sri Lanka Tanzania 11	China Vietnam 12
Resource-Rich	13	Libya Gabon 14	Kuwait Saudi Arabia 15	16

Figure 1 Types of national health systems : classified by economic level and health systems policies. (Roemer M.I., 1991)

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