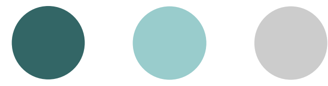

# Private providers operating in a public logic: from theory to practice

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# Content

- Private versus Public in health care delivery: a blurred distinction -> need to clarify our thinking
- Possible research implications
- From a technical-academic perspective to the real-life arena

# Public versus Private: two possible logics to analyse this dichotomy

- *To whom 'belongs' the health service? What is the identity of the provider?*

  -> administrative-institutional logic

- *What kind of care is offered? What drives the provider?*

  -> logic determined by the values and the goals of the health workers and the health services

"The illusion of a clear dividing line between public and private in health care". Hans Maarse (editor). *Privatisation in European Health Care. A comparative analysis in eight countries.* Elsevier gezondheidszorg, 2004

- General practice in Belgium
- *Médecins de campagne* in Mali
- Government hospitals in China
- …

This also applies to the case of faith-based hospitals in sub Saharan Africa

# Public versus Private:
# What is the appropriate dichotomy?

Administrative guardianship / Institutional identity of the health service

Finality of the health service

| | Public | Private |
|---|---|---|
| Public | A | B |
| Private | C | D |

# Public versus private finality

## Possible criteria?

- A social perspective
- Non-discrimination
- Population-based
- Government policy guided
- Non-lucrative goals

D. Giusti, B. Criel, X. de Béthune, Public versus private health care delivery: beyond the slogans, *Health Policy & Planning* (1997); 12(3): 193-198

# Research challenge: go beyond the conceptual definition of public finality and design a more operational definition

- Why?
  - Health system managers and financers need a tool to evaluate and regulate providers, and to inform the general public

# Research challenge: go beyond the conceptual definition of public finality and design a more operational definition

- How?
  - Need for measurable criteria – with all the limitations of measurable things… (-> go beyond reductionist approach of some P4P experiences)
  - Possibly arrive at a kind of composite score?
  - Possibly different weight of individual criteria (coefficients)?
  - Need to test and to evaluate different scenarios

# Example of criteria for public finality: the case of a first line health service

- **Input** indicators
  - Use of essential and generic drugs
- **Process** indicators
  - Respect of a critical number of rules and regulations in terms of package of care offered to the population
  - Compliance of diagnostic/therapeutic behavior vis-à-vis certain key technical guidelines for clinical decision-making
  - Use of health information procedures like family files storing individual patient information
  - Participation to referral & counter-referral policies and procedures (systems perspective)
- **Output** indicators:
  - Utilisation of the facility by poor population groups
- **Outcome** indicators
  - Patient enablement

# Obstacles in the real-life world

- This debate is more than merely a technical-academic debate: cfr faith-based hospitals in SSAfrica
  - Financial dimension
    - "Why would gvt pay for hospitals that will (gvt reckons) anyhow do their best to find the resources to function?"
  - Political/Ideological dimension
    - Opposition/resistance from gvt administration towards a pluralistic health care delivery system?

# Final thoughts: what is needed today?

- More pragmatism and less ideology in the debate
- Willingness of private sector to respect national policy guidelines and to integrate in national planning
- Political will from public health authorities to genuinely cooperate (respect of mutual identity, look for win-win)
- Institutional capacity of the MOH to play its stewardship role