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A FRAMEWORK FOR DETERMINING
PRIVATE SECTOR INITIATIVES
IN HEALTH

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Leaders in many countries wish to extend basic health services to their entire population. Yet in these countries the available resources are inadequate for the task. In the face of economic stagnation or deterioration governments either cannot or will not spend in what are considered to be the nonproductive sectors of the economy. It also is well recognized that government financed MOH systems have achieved effective coverage for only a small proportion of the total population while sustaining high operating costs. These systems are often plagued by chronic organizational and management problems which produce poor performance and an inefficient resource utilization. These factors frustrate persuasive arguments for sustaining or increasing the allocation of resources to health. Given a lack of economic growth, MOHs will have limited ability to command funds for health from general revenues.

In view of the likely scarcity of public resources for health, there is a growing awareness among national health planners and within the international health community of the need to develop alternative financial resources and delivery systems. Resources from the entire public and private health sector need to be maximized. However, the role of the private health sector must be understood and acknowledged if resources currently or potentially available are to be maximized.

This report will present an analytical framework for identifying and examining private sector initiatives in the health sector. It will also propose a methodology and budget for a multi-country study which will examine the potential for private sector initiatives in Latin America. In addition, a bibliography of data and reference material on the subject of private sector health programs is included.

AN ANALYTICAL FRAMEWORK

In order to identify, design, and implement systematically new private sector initiatives for health it is necessary to have an analytical framework to guide the process. This paper attempts to provide such a framework. It is based on a literature review, discussions with field personnel, and personal experience as a health care practitioner and advisor in Latin America.

The framework presented in this paper begins by defining the private sector. This is critical because ambiguity here impedes clarity of analysis. Next, the health sector is conceptualized along two dimensions: source of

finance and provision of services. The corresponding four combinations of this two dimensional matrix are each discussed in terms of the relevant field experience and the resulting issues. The final piece of the framework is a user analysis which examines consumer characteristics which influence demand for services.

Defining the Private Sector

The phrase "private sector initiatives for health" generates a considerable amount of confusion and controversy. This results in large measure from a problem of determining what precisely one means by the term private sector. Any definition of the private health care sector is arbitrary. The most limiting definition is the one which most frequently leaps to mind and equates the private sector strictly to privately owned profit-making enterprises. However, health activities within the private sector may include private direct personal expenditures for health goods and services provided by a government organization, fee for service practitioner, or voluntary organization. They may also include government subsidies for activities of private organizations or social security schemes. All of these undertakings would fall outside the above narrow definition of the private sector. In reality the health care sector is multitiered and the public and private subsectors overlap with respect to purpose, payment, and function.

The diverse nature of private activities in the health sector requires a definition that is sufficiently broad so as to capture the reality of the health sector and to encompass the full range of opportunities for new private initiatives in health. For the analytical framework presented in this report, the private sector is defined as including any non-governmental organization or individual engaged in the production or provision of health services or supplies irrespective of whether for-profit or not-for-profit or source of financing.

Conceptualizing the Health Sector

Kessler (1982) has provided one of the most functional conceptualizations for describing health activities. She categorizes public and private health care activities along two dimensions: source of finance and provision of services (Figure 1). Activities which fall into the lower right-hand cell are wholly within the public domain, i.e. health services are provided and funded by national, regional, state, and/or local governments. Activities in the upper left-hand cell are provided and financed exclusively by the private sector. Within this cell, we can identify a great variety of providers and financing mechanisms. Providers include (but are not limited to) modern and traditional practitioners (physicians, midwives, herbalists, etc.), pharmacists, private voluntary clinics and hospitals, for-profit and non-profit clinics, laboratories, hospitals, HMOs, and employer health programs.

Financing mechanisms encompass direct personal payments or prepayments, voluntary or employment-based insurance schemes, and contractual arrangements. Activities in the off-diagonal cells combine features of the strictly public or private cells. The upper right-hand cell identifies publicly provided

Figure 1

PRIVATE AND PUBLIC HEALTH CARE DELIVERY ACTIVITIES:
BY SOURCE OF FINANCE AND
PROVISION OF SERVICE

PROVISION OF SERVICES

		Private	Public
<u>SOURCES OF FINANCE</u>	Private		
	Public		

services that are privately financed. The lower-left hand cell represents private provision of services financed by public sources of funds. In principle, all the private financing mechanisms identified in the upper-left hand cell could be utilized to finance public care, and all the private providers identified in the same cell could provide care under public financing schemes. In practice, private financing for public care tends to be limited to service fees, drug purchases, and prepayment mechanisms. Social insurance mechanisms such as those in Korea or Brazil and the U.S. Medicare or Medicaid programs provide the few examples of public support for private health services.

The integrity of the cells is not flawless. Social Security programs for most developing countries, for example, tend to fall across the cells, and publicly financed hospitals often tolerate the use of their facilities by government physicians for private patients. Nevertheless, this two-dimensional conceptualization is quite useful for identifying the activities of the entire health sector and for determining where spending occurs and in what amounts. The matrix can also be applied to activities relevant to specific sectors such as primary health care, secondary and tertiary care, or health care support services (ie. education, training, production of drugs and supplies).

We shall now examine in more detail each of the four cells of the matrix. The purpose is to elaborate how one can examine these various components of the health sector in a systematic manner in order to provide a basis for identifying and designing new private sector initiatives.

Private Provision/Private Financing

Few developing countries have a complete picture of their health sector and the incompleteness is often greatest for privately administered and financed health care. Conventional wisdom holds that the volume of health services and expenditures in the non-government sector far exceeds that of the government. However, the literature which has examined these private activities tends to be fragmented, often stresses the particular orientation of the researchers, and is frequently incomplete with respect to operational and financial details. Gottlieb (1975) provides one of the rare detailed overviews of a health sector for Tanzania. A clear analysis of existing providers as well as sources of funding by the amount they contribute and methods of collection can indicate overall gaps in the supply of health goods and services, help distinguish resources that could be exploited, and establish realistic expectations for increased private participation in the health care sector. The principal purpose of this piece of the framework is to present a set of parameters which will facilitate a systematic description of the private provision and financing of health care and provide an integrated view of the private system.

Private Providers

The health provider system can be systematically described and examined along five parameters: organizational form, organizational purpose, activity type, activity locus, and technology level.

(1) Organizational Form

The following categories are useful for describing the type of organization providing health services or goods: corporate vs. cooperative; institutional vs. individual; religious vs. nonsectarian; foreign vs. indigenous; national vs. local. Private sector providers fall into all of these categories and clearly the type of organizational form will significantly shape any kind of initiative that can be undertaken.

(2) Organizational Purpose

The basic objectives of the provider will also influence the shape of any initiative. While the specific objectives of every organization will vary depending on its particular circumstances two general categories which are fundamental for the analysis of private health institutions are profit-making vs. nonprofit-making. Both categories of institutions may represent significant shares of the provider market in many countries, yet the motivational differences often lead to very different behavioural patterns. The differences often result in providing care to distinct segments of the market. For-profit groups may attend the more affluent groups who have greater purchasing power and therefore a stronger effective demand, while non-profit providers may subsidize delivery of services to the less affluent consumers.

Another distinction that is useful is whether the health provision is a primary or secondary purpose of the organization. Health services are sometimes provided by organizations whose primary activities are quite unrelated to health, for example, a factory which operates a clinic for its employees, a community development organization that has a medical post as one of many other activities, or a credit union that provides doctor's consultations for its members. These organizations are likely to have different orientations and would respond differently than would hospital providers or physicians in private practices to suggested initiatives.

(3) Activity Type

Generally, most categories of medical and health care activities can be found in both the private and public sectors. However, the division of activities between the public and private sector may be quite sharp. Preventive activities may be more predominant in the public sector. Private clinics may be prominent for primary care but may be conducted on a part-time basis. Hospital care falls almost entirely into the public sector for some countries yet the same doctors may practice in both public and private hospitals. The production of drugs and medical supplies is generally in private hands, although the government sometimes has intervened in the form of public enterprises. The distribution of drugs and supplies tends to be dominated by private pharmacies but distribution also takes place through public health outlets. In rural areas, private practitioners are more likely to be traditional healers and midwives than modern practitioners.

(4) Activity Locus

The geographical distribution of private health care services is clearly relevant to planning. The rural vs. urban distribution is a first cut, but by no means the only one. Regional differences in health care services need to be identified and related to the demographic changes. The greatest concentration of people and services will likely be in the capital city but the greatest growth may be occurring in a smaller city experiencing more rapid economic development. The opportunities for increased private sector activities in that area might be more plentiful.

(5) Technology Level

Private sector providers encompass a broad spectrum of technological sophistication with respect to the health care provided. It is necessary to identify the distinct levels and to examine the effect that changes in the technology may have on other providers, on consumption patterns, and on the structure of the health sector. In general, greater sophistication is found in major urban areas and in hospitals. Private hospitals frequently hold a technological edge and actively promote increased use of more sophisticated techniques and equipment. The clientele associated with technologically sophisticated services are more educated and affluent and prefer to purchase more sophisticated services.

Traditional medicine practitioners in contrast, use low-level technology. Information regarding these providers is scarce but the literature is sufficient to reveal the prevalence and importance of their services. Indeed, there are strong indications that for some circumstances consumers prefer to pay for the services of traditional practitioners rather than receive free care in the modern sector. Finding innovative ways to utilize these practitioners and to upgrade their technical skills is an important area for exploration. Such an effort was successfully initiated in Bangladesh (Claquin, 1981) but was subsequently abandoned, ostensibly because modern health practitioners objected. Similar efforts are under consideration for Guatemala.

Private Financing

Adequate data on sources and levels of private sector financing are difficult to obtain. Estimates of private expenditures on health goods and services are generally derived from national accounts. While these aggregate estimates are useful for providing a broad overview of private sector spending they cannot provide planners with detailed information regarding who is spending how much for what kind of services. Studies on health financing and expenditures have attempted to measure private health expenditures through more direct and careful examination of payments received by physicians, pharmaceutical sales, payments made to hospitals and other institutions, etc. However these methods provide insufficient information with respect to consumer characteristics. Household budget surveys are potentially useful resources for this type of information, but these studies frequently lump together all health expenditures.

Detailed expenditure data disaggregated by type of good or service and income class is required. In addition household budget surveys may be heavily biased towards either urban or rural areas and thus would tend to over or understate actual allocations. Special studies of consumers and providers to supplement available information may be a necessary prerequisite in many countries before planning and implementing private sector health initiatives.

The sources of financial flows include but are not limited to the following:

- 1) activities of private hospitals and clinics
- 2) activities of physicians providing consultation on a fee-for-service basis regardless of the physician's affiliation
- 3) purchase of drugs and other pharmaceuticals
- 4) payment for diagnostic tests and therapeutic activities at privately owned labs
- 5) activities of indigenous practitioners on a fee-for-service basis

Private financing mechanisms for these flows can be placed in four categories: user fees; prepayment and insurance; employer programs, and subsidization.

(1) User Fees

This type of financing is considered to be the most prevalent form of private payment. In Guatemala, a government health survey reported that seasoned agricultural workers spent between \$80 and \$150 annually in fee-for-service care. The data weaknesses mentioned above impede empirical confirmation for other countries. Anecdotal evidence does suggest that people are willing to spend significant amounts of their discretionary income on health services if these are perceived to meet their felt needs. Advantages and weaknesses of this system are considered under private financing of public services.

(2) Prepayment and Insurance

Prepayment and private health insurance schemes do exist in most Latin American countries, but they do not have broad coverage. Private insurance is basically an urban-based financing mechanism for the population with stable employment, by implication usually not the most medically needy. Contribution to premiums are shared between employer and employee. WHO (1978) reports a range of employer contribution of between 6.5 and 75 percent. Coverage may be inadequate for major hospitalization. Premiums for comprehensive coverage can be held artificially low if insurance companies anticipate that most hospitalization expenses will be incurred in the government sector without any request for reimbursement. Insurers are both local companies as well as multinationals. Data on premiums and client profiles are not readily available but would be useful information to obtain before launching a new health initiative.

Prepayment plans have tended to be organized around public or quasi-public rather than private provision of services. The reason for this situation

relates to the difficulty that prepayment plans have in achieving and maintaining economic viability. Prepayment schemes are addressed in more detail under private financing of public care.

(3) Employer Program

In place of insurance, indigenous and multinational companies often provide direct care for employees and their families. Ueber Raymond (1982) indicates that a study will soon be available which analyzes in detail the successes and failures of selected corporate projects to provide primary health care. Labor unions represent potential pressure groups for mobilizing support for the creation of worker health programs. Some multinational companies have expanded their health programs beyond workers and their families to the community in which they reside. These expanded efforts are sometimes undertaken to obtain goodwill and government support.

Public Provision/Private Financing

Government health-care delivery systems use a variety of external financing methods to help defray the costs of providing services. Private financing mechanisms, often referred to as community financing, offer a major source of support. Stinson (1982) provides the most comprehensive review of community financing schemes for primary health care. He reviewed reports from more than a hundred projects and programs in the developing world and identified eight sources of financing alternatives which have helped defray recurrent and one-time costs for public sector health services. The eight financing alternatives are as follows:

- 1) personal service fees
- 2) drug sales
- 3) personal pre-payment
- 4) production-based prepayment
- 5) income generating schemes
- 6) community individual labor
- 7) donations and ad hoc assessments
- 8) fund raising through festivals, raffles, lotteries etc.

The latter four alternatives have limited application and tend to be used for one-time costs rather than for the sustained support of recurrent costs. Only the first four alternatives will be considered in this report.

(1) Personal Service Fees

Personal service fees are the most common method for private financing of publicly provided primary care. The circumstances of payment vary widely, but both cash and in-kind payments are utilized. The former are more common. Pricing policy for services may be established nationally, regionally or at the local level. Sliding scales seem to be somewhat more prevalent than flat fees. Revenue generated by fees maybe used as general revenue or for specific purposes such as compensation of health workers or purchase of drugs and supplies. The amount of revenue generated is usually quite small. Most of the projects

identified by Stinson recover less than 30 percent of recurrent costs. One notable exception was the Hospital EPC in Cameroon which recovered 95 percent of its recurrent costs with service fees.

There are several advantages of a fee-for-service system. Fees are an economically viable system as evidenced by the long-term survival of privately provided care and they can discourage overutilization. They also are a familiar system and therefore easy to introduce. However, service fees have serious weaknesses. Services provided for personal service fees tend to be curatively oriented and are available only to those with the ability to pay. Consequently, as a financing system, it places the entire financial burden on those who are ill and does little to encourage preventive activities or help the poor.

(2) Drug Sales

Drug sales by public providers of services are another common source of private financing. They tend to emphasize a limited number of basic drugs with proven efficacy rather than a full range of supplies. Marketing arrangements include revolving funds and in some cases arrangement with private pharmacists. Pricing policy varies; drug prices may be heavily subsidized by the government or sold at a slight markup over wholesale. Revenues from drug sales may be used for general revenue or to compensate health workers, but the most common use is to generate revenue for a drug revolving fund.

The advantages and weaknesses of a drug sales system are similar to those for service fees. Individuals are accustomed to paying for drugs in the private sector, and revolving drug funds can be self-financing mechanisms if properly managed. However, Quick (1982) points out that the technical problems involved in drug revolving funds may be substantial. Funds may fail to "revolve" due to unanticipated increases in prices, inadequate accounting, inappropriate expenditures, and unanticipated increases in demand. Nonetheless, solutions to these problems are available (Quick, 1982,1982).

(3) Prepayment Scheme

Prepayment schemes are not presently common mechanisms for financing public health services. Stinson reports on 9 prepayment mechanisms that are production or marketing based and 22 programs that use personal prepayment or membership fees to defray primary health care costs. The populations served by personal prepayment schemes range from a single village to several hundred thousand individuals. In India and Bangladesh, four projects of this type have functioned for over a decade but most are recently established. Production-based schemes service populations as small as 5,000 in India and as large as a substantial proportion of China's rural population. The major advantage of prepayment plans is that they spread health care costs across both ill and well. Broad enrollment is essential in order to acquire a service population with a balance between healthy and ill. Premiums are low and only a few relate premiums to average household income. Some schemes accept in-kind or cash payments. Nevertheless, most prepayment plans are unable to collect premium payments which are large enough to allow the plan to achieve economic viability.

None of the personal prepayment schemes reported by Stinson are economically self-sustaining. They are unable to recover the full cost of providing primary health care. Many cover only fixed costs and most collect substantial additional revenue from service fees and outside support or government subsidy. Some plans have problems of adverse selection, ie. they attract individuals whose health care costs are higher than average. In addition, many individuals are reluctant to pay for care before they need it or to pay a minimally trained community worker when private practitioner care is available. For these reasons renewal and premium collection rates are low and some schemes have been forced to close after only a few years of operation.

(4) Production-based Prepayment

One of the nine production-based prepayment plans is in Latin America. Small coffee growers have formed a marketing association (Coffee Growers Association) which devotes some of its revenue to purchase health care from the government. The Coffee Growers Association contracts with the Ministry of Health to operate clinics in a particular region. Coverage and quality of care have been improved as a result of the introduction of private funds and the leverage provided by the Association leadership. Detailed information regarding the economic performance of this plan could not be obtained for this report, but the scheme merits a closer examination. Premium collection for production-based plans would tend to be more stable and therefore more economically viable than for personal prepayment schemes.

Little information is available regarding the characteristics of consumers of public health care services which rely on private financing. Reviews of programs have tended to focus on describing the organization and operation of services rather than on who is consuming them. It is not known if consumers are predominantly rural and urban, economically well-to-do or medically needy. This area is a significant gap in information which should be remedied before expansion of these types of models is contemplated.

Information comparable to Stinson's review of financing sources for primary health care could not be obtained for private financing of publicly provided secondary/tertiary care. A variety of patterns are known to exist, for example:

- 1) direct personal payment for private beds in public hospitals;
- 2) personal payment to physicians for hospital-based services;
- 3) personal payment for hospital laboratory, x ray or drug services, etc.

However, detailed information as to the frequency of their use, pricing policy for the services, level of support they provide for operating costs, or a profile of consumers is not available.

Private Provision/Public Financing

The discussion of this subsector is brief because most examples of privately provided but publicly financed health care delivery prevail in the industrialized countries, eg. Medicare and Medicaid in the U.S. and social insurance in

Japan. Although this pattern for health care services is not a common phenomenon in the Third World, examples can still be found. Social Security programs in some Latin American countries tend to fit the pattern loosely. (Social Security programs will be reviewed in another report). Government insurance programs for civil servants are another example, but details regarding these programs are inadequate.

A cautionary note is in order regarding initiatives involving public financing of private services because they may have unintended effects. The Korean experience provides a useful example. The Korean Government has instituted a rural health insurance program to cover physicians' fees. The implementation of the program had a considerable effect on consumers' choice for primary health care. Utilization of physicians' services rose and the cost to the government in reimbursement increased. Consumers' and providers' reactions to the policies inherent in the insurance program caused a shift away from a low-cost primary health care program (based on community health practitioners) to a more high cost method of care (Dunlop, 1982). A missing element in this initiative appears to have been a full understanding of user demand, an aspect covered in the final piece of our analytical framework.

Public Provision/Public Financing

It is beyond the scope of this report to review the activities within the publicly provided/publicly financed health sector. Such reviews are adequately treated elsewhere. However, it is relevant to stress here the strong rationale and logic for public sector provision and financing of certain health activities. To assume that any and/or all health care activities could be carried out by the private sector is unrealistic and erroneous.

Many governments in the Third World have accepted full responsibility for providing free, or nearly free, comprehensive health and medical service for their populations. The justification for assuming this responsibility has evolved for important political and historical reasons that include:

- a belief that health and medical care are a human necessity ranking in importance only after food and shelter;
- a conviction that health services should be distributed according to need rather than effective demand (ie. willingness and ability to pay); and
- a general preference for a non-profit form of organization for care.

Further justification for public provision and financing of health service rests on the need to alter the results which are achieved by the market place. The logic and rationale include the following.

1) Special characteristics of collective or public goods

A good is a collective or public good if one person's consumption of it does not diminish what is left for others. Weisbrod (1973) provides the example of health benefits which accrue to a group from a spraying campaign

against flies and mosquitoes. There is no way to exclude individuals from "consuming" this good, and the benefits accrue equally to all residents of an area. Consequently there is no incentive for anybody to offer to pay for the service, and the result is an apparent absence of demand. Financing through voluntary means for public goods are likely to be inadequate. Therefore the intervention of the government is advantageous in order to insure that collective goods will be available.

2) External Relations in Consumption

Health and medical services can affect individuals other than the immediate recipients. In the case of a communicable disease, the benefits of a vaccine to prevent illness or treatment to contain it extend not only to the person who receives either, but also to the members of the community who do not. Another important externality in consumption is the satisfaction that individuals derive from other individuals' consumption of medical care. This attitude promotes equal access to medical care for individuals regardless of their economic status or resources. Regardless of the type of externality, if individuals consider only the benefits which accrue to themselves, the price they are willing to pay for these services will be too low. Consequently, the private market will fail to produce a satisfactory amount of services and public intervention is required.

3) Declining Unit Costs

Some health and medical services can be obtained only by a sizeable investment in large and costly facilities. Hospitals are an example. The ratio of fixed to variable costs is often large but such facilities can be operated at declining unit cost. Services that would be too expensive to produce for an individual or small group could be less expensive for a large group.

Other arguments advanced in support of public intervention in providing and financing health services include:

- the importance of the availability of health services;
- the uneven and unpredictable incidence of illness and the difficulty inherent in financing long-term and/or serious illness;
- the social concern for future generations and the disharmony introduced by their neglect.

Finally, health professionals regard consumer's choice as unreliable. If individuals underestimate the risk of illness, professionally perceived priorities will diverge from individually felt needs. Therefore public intervention is required to offset the workings of consumer choice.

These special characteristics of health and medical services mark them as exceptions to the economic propositions that determine demand and supply in other market sectors of the economy. These characteristics must be taken into

account in the identification and development of private health care initiatives and in establishing realistic expectations for what the private sector can accomplish.

Two important issues need to be raised regarding publicly provided and financed health care services. The first concerns how consumers "pay" for care in the economic sense. It must be recognized that resources used for public health services pay an opportunity cost in terms of the forgone outputs of other goods and services which could have been produced had those resources used for health been allocated to alternative activities. In this sense, consumers in the aggregate do pay for health services that are ostensibly "free". Consumers also "pay" for health care by some combination of taxes or deficit financing induced inflation. Thus, "the beginning of wisdom in thinking about health-sector financing is to be clear that there is no such thing as 'free' health services...the issue...is not whether consumers should pay for health services, but rather, what is the best way for consumers to pay for health services" (Stevens, undated).

The second issue pertains to government responsibility for effective management of public resources. Concern over the chronic shortfall of available financing to Ministries of Health must result not only in approaches which maximize the use of private sector resources and interests but also in evaluations and adjustments in public health policies and programs which establish cost containment measures and improve financial management. Linkages between the public and private health sectors which increase (or decrease) health costs must be identified and appropriate policy responses developed and implemented.

Colombia provides an example of an attempt to move in the direction of cost containment for the delivery of care. In 1973 the National Health System was created and forced all private institutions to submit to a series of controls that were intended to facilitate the coordination of medical care. Both public and private hospitals are now obligated to seek government approval for their annual budgets, their hospital development programs, and their proposals for the purchase of medical equipment to the national government for approval (Kefauver, 1980).

User Analysis

The foregoing section of the analytical framework focused on the supply side of the health sector. To be complete, the framework must also encompass an analysis of the factors which influence demand. The literature on the economics of health care tends to concentrate disproportionately on the problems of supplying health services in resource poor economies. The factors underlying demand are taken for granted or underanalyzed, yet these factors are critical for determining opportunities for new private health initiatives. User analysis becomes a vital component for this framework, i.e. identifying what people are willing to pay for.

The great diversity of health care providers is the result in part of a similar diversity of users. There is not a typical health consumer. Consumer profiles should be developed for each type of provider in each of the four cells described in the previous section in order to understand the characteristics of distinct consumer groups. The characteristics for which data should be collected include income, education, employment, age, marital status, ethnicity, health status, health beliefs and practices. Such data may be available from secondary sources. However, original data collection may be required as well. Understanding these characteristics is critical because they influence the types of services consumers can or would be willing to use and pay for.

The second step in the user analysis is to determine the economic demand for specific health services according to distinct consumer groups. The difficulties in quantifying health expenditures due to deficiencies in data sources were pointed out previously. An analysis of consumer expenditure in Bangladesh showed that 4% was spent on health by higher income groups and 2.5% by poorer families (WHO, 1978). Consumer expenditure surveys in ten Latin American cities in five Andean countries revealed that the mean expenditure share of the family budgets spent on health ranged from 1.2% to 3.7% across all income ranges (Musgrove, 1978). However, for all these surveys all types of medical care and goods were lumped together, thereby preventing any activity-specific analysis. The need to disaggregate is illustrated by a Korean survey (WHO, 1978) which did specify expenditure items and which revealed that 57% of urban household health expenditures went for drugs. Pharmacists and self-prescription were therefore shown to be very important factors in Korean health care delivery. This type of disaggregated information can identify the important role that certain types of providers may play or can indicate a gap on the supply side.

It would be important to extend the demand analysis and attempt to determine price and income elasticities specific to income class and type of service. Such estimates are not readily available in developing countries. In the 1930's, Stigler estimated income elasticities for doctors' services in the United States to be 0.52 at a per capita income of \$1000 per year rising to 0.81 at \$4000; Feldstein estimated an income elasticity of 0.6 based on 1958 household survey data (Klareman, 1965). Heller (1982) carried out an empirical analysis of the demand for medical care in Malaysia. He found that total medical demand was inelastic with respect to income and prices. However, consumers were very responsive to differences in prices of alternative types of health care services and were also sensitive to the relative amounts of travel and treatment time required by the alternative services.

The user analysis must combine the foregoing elements to gain a clearer understanding of consumer behavior. Consumer behavior must be related to the provider characteristics and financing sources analyzed in the previous section.

Possible Initiatives and Related Issues

To conclude this section on the analytical framework, let us briefly examine two experiences with privately provided/privately financed health care delivery which may offer possible models for private initiatives and at the same time raise important unresolved questions regarding private sector involvement in health care.

Dent-Plan is a capitation prepayment plan in Kingston, Jamaica. The plan provides routine dental care for a fixed figure per enrollee during a three-year contract period. To be eligible, an enrollee must be an employee of a firm or company that purchases the service on a group basis. The cost of the plan is shared between employer and employee. The providers are a group of five dentists organized into a group practice dental center (Dental Associates) patterned after a Health Maintenance Organization. Using this model the providers themselves assume the financial risk of bringing enrollees up to an acceptable level of dental health and maintaining them at that level.

The Dent-Plan has been organized and functioning for less than a year. Therefore its financial viability remains untested. The providers state that they have been very successful in convincing employers and employees to enroll in their plan, and they expect to reach a break-even point within a year. The plan merits continued examination as it may offer a viable model for delivering other types of health services.

Cooperative-based health care delivery may be another alternative mechanism for initiatives in the privately funded and provided health care sector. Norris (1975) argues that it is neither necessary nor desirable to create new systems solely for the purpose of delivering health and medical services for a given population. He further argues that to cope successfully with a nation's health needs, attention should be directed to:

- 1) an effective centralized resource which can initiate, evaluate and replicate local efforts;
- 2) local capabilities which can identify, organize, and sustain effective programs.

AID's past investments in credit union cooperative development in Latin America may present appropriate opportunities in terms of both resources and institutional capabilities for developing new health initiatives.

Harrison (1982) and Hougen (1982) report on cooperative health care delivery in the Santa Cruz area of Bolivia. They identify the appealing characteristics for this form of health care as follows:

- 1) the history of cooperatives is well-rooted and their socio-economic and geographic coverage is wide-ranging;
- 2) the services are available to small rural farmers and middle class urban residents;

- 3) the cooperative movement expresses and responds to the interests of its members and is committed to providing high quality services to its members.

The three cooperatives that Harrison and Hougen discuss are savings-and-loan cooperatives, managed by professional staffs which answer to Boards of Directors. Together they service a total membership of 69,000. In addition to savings and loan services, each offers a different array of services which include: consumer goods store, pharmacy, dispensary-clinic, insurance, agriculture and technical assistance.

Each cooperative has followed similar procedures in the operation of health delivery arrangements. The cooperatives have identified frequently-needed-specialty physicians who are offered patient volume in exchange for a lower than average fee-for-service. There is variation among cooperatives with respect to physician reimbursement and membership charges for services. One cooperative has full payment for health care benefits from its general administrative overhead, i.e. physician services to members are free. However, a surcharge is levied against all members to defray the cost of services. The other two cooperatives charge levies only against those who are seeking care. The preventive dimensions of the health care offered through the cooperatives are limited. The programs are primarily for curative ambulatory services rather than comprehensive care. The components provided have grown in an ad hoc fashion and were designed to assure access to physicians without long waits or high fees. However, the cooperative system merits careful study with attention to the possibilities of expansion.

While the private sector may hold considerable potential for expanding access to health care and alleviating the financial burden of overwhelmed Ministries of Health, the entrance of non-government providers and financiers into the health care arena is not without problems. McGreevy (1982) points out that in Brazil, the mix of public and private health service has produced:

- 1) inadequate services and poor geographic distribution;
- 2) excessive use of high technology;
- 3) excessive expenditures on medicines and drugs;
- 4) unnecessary exams;
- 5) underutilization and contempt for public hospital facilities;
- 6) overproduction and overbilling for services by private physicians to compensate for low levels of remuneration.

Several important issues are raised regarding private sector involvement in health care and they require further analytical attention:

- 1) Does a strong private sector absorb a disproportionate share of health resources to deliver services that are used mainly by more affluent, salaried urban populations and exacerbate the gap between rich and poor?

- 2) Will private sector delivery of services encounter the same pitfalls of bigness and centralization as MOHs?
- 3) Do elasticities of demand vary by provider? by preventive and vs. curative services?
- 4) Are there a set of incentives which would encourage the private sector to provide more than curative services?
- 5) Can quality of service be monitored in the private sector?

METHODOLOGY FOR MULTI-COUNTRY STUDY TO ASSESS
PRIVATE SECTOR OPPORTUNITIES IN THE HEALTH SECTOR.

The identification of appropriate private sector health initiatives for LAC should be carried out in two stages. The first, a research study, will generate descriptive analyses of the health sector for each country utilizing a common methodology and identify the potential for private sector initiatives. The second, a region wide workshop, will generate additional insight and examine implementation strategies.

The methodology for carrying out a multi-country study is derived directly from the conceptual framework already described. The individual country studies will be descriptive, diagnostic, and prescriptive. They will describe in detail both public and private health sector activities, and diagnose key problems and opportunities. They will specify initiatives involving the private sector which would effectively respond to the opportunities identified. Details for these country studies are supplied below.

The second stage in the process for identifying private sector health initiatives will be conducted in a workshop forum. The purpose of the workshop will be to help develop new perspectives on the health sector which stress opportunities for the increased participation of the private sector in health programs. Cross-country comparisons of the health sector will help derive generalizations with respect to constructive and effective interaction between the public and private sectors in the context of health programs. The workshop format can also be utilized to explore implementation strategies.

The Country Studies

Individual country studies should consist of three components: sector description, opportunity identification, and initiative specification. Each are described below.

(1) Sector Description

A thorough and systematic description of the health sector is a prerequisite for adequately identifying opportunities and specifying initiatives. Three key questions guide this description:

- who is providing what type of services in what quantity?
- who is financing these services at what levels?
- who are the consumers of the health goods and services?

These perspectives flow from the supply and demand aspects of the conceptual framework already described.

(a) Health Care Provider and Financer Inventory

The providers and financers of health care must be identified and described in terms of each of the four cells described in the framework:

- private providers and private financers
- private providers and public financers
- public providers and private financers
- public providers and public financers.

The providers in each of these cells will need to be distinguished by those providing primary health care, those providing secondary/tertiary care, and those producing or supplying supporting goods and services to the health sector. Providers may be individuals or institutions within the modern and traditional health subsectors. Some, such as doctors, will operate in both individual and institutional settings and private and public roles. Financing may be provided both by individuals, (ie. user fees) and institutions. For each of the provider categories in each of the cells, data should be gathered on the numbers, type of good or service provided, volume of activity, location, and organizational description. For each of the corresponding financers, data should be collected on the source and level of financing and organizational or administrative aspects.

There is a close interrelationship between the provision of health care service and the financing mechanism. Gathering and presenting the descriptive data in terms of these cells, will permit one to identify and focus on the strengths and weaknesses for the sector as a whole in providing and financing care. With this information in hand, it will be possible to identify new areas for private initiatives for either provision or financing.

(b) Health Care Consumers

A fundamental element in a feasibility study for any private sector initiative is a consumer analysis which assesses the factors affecting demand for goods or services. A consumer analysis requires detailed information on household expenditure patterns disaggregated at least by income and geographic location. This concept must apply to the health care sector as well. However, household expenditure surveys which provide detail regarding health expenditures are not commonly available. Nevertheless, it is usually possible to assemble considerable data which describes the characteristics of the types of consumers being attended by different health care providers. This information in fact provides a third dimension for the provider-financer cells.

Data can be assembled from secondary sources that will provide a user profile by type of services for the following consumer characteristics: income, education, age, sex, location, ethnicity, morbidity/mortality patterns, health attitudes and health practices. This type of information is required for assessing demand for services.

(2) Opportunity Identification

The Sector Description will provide the basis for a diagnosis of the problems and opportunities in the health sector for private initiatives. Opportunities can be identified within four categories: activity gaps, increased volume, collaborative undertakings, and shifted functions.

(a) Activity Gaps

An examination of the services and goods being provided relative to the consumer need and/or willingness to pay may identify some activities that simply are not being provided. In other words, if there exists unmet need or demand, consumers may be willing to pay for the local availability of particular services.

(b) Increased Volume

Opportunities may exist for increasing the volume of present private sector activities rather than creating new ones. If the present services are appropriately directed toward the health problems but are insufficient to meet demand, an increase in volume of services may have a positive effect on the health of the population. The focus of inquiry here is to specify the barriers to expansion, e.g. personnel, facilities, funding, management capacity.

(c) Collaborative Undertakings

This area of opportunity concerns innovations in terms of institutional arrangements. Specifically the current mix of provision and financing should be examined. Where both government and non-government institutions are carrying out comparable activities for similar consumer groups, arrangements for jointly operating facilities in order to reduce costs and increase efficiency and effectiveness should be explored. For example, sophisticated equipment or laboratory facilities if centralized can permit economies; combined supply purchasing might achieve volume discounts.

(d) Shifted Functions

A review of the costs and quality of publicly delivered and financed services or goods might identify some functions which would be desirable to shift to the private sector. This requires an examination of the comparative strengths and weaknesses of the government vs. non-government organizations. Such shifts might most appropriately involve financing mechanisms. Services might be shifted to a user fee basis where the users are a consumer group with the ability to pay. It might involve using private management groups to perform administrative functions in some facilities. Or it could take the form of geographic division of labor. Private providers who have facilities superior to the governments in one area might be compensated by the government for care provided to the population in that area.

(3) Initiative Specifications

For each of the opportunities identified in the above categories, one needs to specify the form of the private initiative to be undertaken, ie. who would do what, when, where, and how. Furthermore, the appropriateness, desirability and feasibility of the identified initiatives should be evaluated against the following criteria:

(a) Efficiency of resource allocation

- Estimate of costs in private sector compared to public sector
- Relate costs to units of goods or services provided
- Assess potential efficiency gains through private sector

(b) Effectiveness

- Assess impact of activity on health problems
- Assess which groups affected by undertaking

(c) Financial attractiveness

- Make pro forma cash flow statement
- Estimate investment requirements
- Calculate financial investment returns

(d) Implementation

- Specify barriers to implementation
- Specify how barriers will be overcome

(e) Legal and Political Feasibility

The Workshop

The workshop could involve the participation of the country AID Health Sector officers and possibly their government counterparts, AID Washington staff, and a selected number of special consultants.

Comparative analysis can enhance the value of the individual country studies. One objective of the workshop should be the review of individual studies to refine the methodology and generate guidelines for further data collection and analysis procedures. A second objective should be to compare and discuss the recommendations for private sector initiatives. This process

will serve to generate new ideas for different countries based on the analysis of colleagues in other countries. A third objective should be to discuss and evaluate the areas for private sector initiatives in relation to : 1) the known mortality and morbidity problems for particular countries and effective strategies for dealing with these problems; and 2) the professed health priorities of country governments and AID. Finally, discussions should also focus on developing implementation strategies for new initiative and abasis for follow through.

Budget for Studies and Workshop

The funds required to carry out 7 country studies are estimated at \$697,815. The workshop costs are estimated at \$630,350. The details of this budget are presented in Appendix A.

APPENDIX A

PROPOSED BUDGET FOR MULTI-COUNTRY STUDY AND WORKSHOP

MULTI-COUNTRY STUDY

1. Technical Assistance Personnel*

8 months per country at \$8,800/mth.
\$70.400 x 7 countries \$ 492,800.00

2. Per Diem**

30 days x 8 mth. at \$65.50
7 x \$15,720 \$ 110,040.00

3. Travel***

18 persons airfare at \$1,020.00 \$18,360.00
Local Travel 18 x \$300.00 \$ 5,400.00
\$ 23,760.00

4. Communications

56 months at \$75.00 \$ 4,200.00

5. Miscellaneous

DBA Insurance
(\$200 x 22 days x 8 mth. x 7) at 3.05% \$ 7,515.00
Special Studies 7 x \$7,000 \$49,000.00
Logistics Support 7 x \$1,500 \$10,500.00
\$ 67,015.00

TOTAL= \$ 697,815.00

* Technical Assistance costs assume \$200/day consultant fees plus 100% for indirect costs of sponsoring organization multiplied by 22 working days per month. \$200 + \$200 x 22 = \$8,800.00

** Per Diem rates are calculated based on the average of both seasons for the following seven countries: Jamaica, Haiti, Guatemala, Ecuador, Bolivia, Peru and Costa Rica.

*** Air fares were based on the average round trip costs of the seven countries listed above.

WORKSHOP IN WASHINGTON

1. Per Diem*

19 persons for 3 days at \$75.00 \$ 4,275.00

2. Travel**

Airfare for Health Officers
10 at \$1,020.00 \$ 10,200.00

Airfare for Other Attendants
6 from U.S. at \$400.00 \$ 2,400.00

3 from outside U.S. at \$2,500.00 \$ 7,500.00

Local Travel 25 x \$50.00 \$ 1,250.00

\$ 21, 350.00

3. Other

Rental of Conference Space \$ 1,500.00

Two Commissioned Papers \$ 3,000.00

Materials \$ 1,500.00

Reproduction \$ 500.00

Catering Services \$ 1,000.00

Miscellaneous \$ 1,500.00

\$ 9,000.00

TOTAL = \$30,350.00

We assume that funds to cover salaries or honoraria will come from some other source.

* Six of the twenty-five participants will be Washington based.

** Airfares for Health Officers are based on the same seven-country average as described in the multi-country study budget.

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APPENDIX B

Bibliography

- Arnhold, R., 1979. Paramedical Programs in Rural Bangladesh, Southern Medical Journal 72:6, 992-996.
- Barnett, A., 1980. The Economics of Pharmaceutical Policy in Ghana, International Journal of Health Services 10:3, 479-499.
- Barnum, H., 1980. An Economic Analysis of the Palli Chitkitsak Program and Village Health Care System in Bangladesh, Health Services International, Inc, USAID
- Bicknell, W. and Ann Lebourly, (undated). The Public's Health and Private Health Care, Health Policy Institute, Boston University, Boston, MA.
- Blendon, R., 1979. Can China's Health Care be Transplanted Without China's Economic Policies? The New England Journal of Medicine 300:26, 1453-1458.
- Blendon, R., 1981. Public Health Versus Personal Medical Care: The Dilemma of Post-Mao China, The New England Journal of Medicine 304:16, 981-983.
- Bureau for Program and Policy Coordination, 1982. Recurrent Cost Problems in Less Developed Countries, mimeo, USAID, Washington, D.C.
- Chao LiMin et.al, 1982. Financing the Cooperative Medical System, American Journal of Public Health 72: a supplement, 78-80.
- Cheng Xiao-ming and Ye-Xifu, 1982. Cost Analysis of Medical Care, American Journal of Public Health 72:9 supplement, 81-82.
- Claquin, P., 1981. Private Health Care Providers in Rural Bangladesh, Social Science and Medicine 15B, 153-157.
- Cross, P., 1982 Health Care Financing : A Preliminary Financial Study of the Health Care System on Dominica, mimeo, Management Sciences for Health, Boston, MA.
- _____, 1982. Health Care Financing: A Preliminary Financial Study of the Health Care System on St. Kitt/Nevis, mimeo, Management Sciences for Health, Boston, MA.
- _____, 1982. Health Care Financing: A Preliminary Financial Study of the Health Care Systems on St. Vincent and the Grenadines, mimeo, Management Sciences for Health, Boston, MA.
- Cumper, G.E., 1982, Report of Consultancy on Economic Anaysis of the Health Sector in Jamaica, Ross Institute of Tropical Hygiene, London.
- Di Paolo, V., 1979. Hospital Management Companies See Growth in International Market, Modern Healthcare, Febuary 46-47.
- Donaldson, Dayl, 1982. Abstract: An Analysis of Health Post-Based Insurance Schemes in the Lalitpur District, Nepal, mimeo.
- Dunlop, D. et al, 1982. AID Project Impact Evaluation Report No. 36: Korea Health Demonstration Project, USAID, Washington, D.C.

- Evans, J.R., K. Lashman Hall and J. Warford, 1981. Shattuck Lecture: Health Care in the Developing World: Problems of Scarcity and Choice, New England Journal of Medicine 305:5 November, 1117-1727.
- Frerichs, R. et al, 1980. Prevalence and Cost of Illness Episodes in Rural Bolivia, International Journal of Epidemiology 9:3, 233-238.
- Fuchs, V., 1979. Economics, Health, and Post Industrial Society, Milbank Memorial Fund Quarterly/Health and Society 57:2, 153-182.
- Gottlieb, M., 1975. Health Care Financing in Mainland Tanzania, Maxwell School of Citizenship and Public Affairs, Syracuse University, Syracuse, N.Y.
- Grosse, R. Demetrius Plessos and Helmy M. El Bermaway, 1982. Public and Private Health Care Expenditures in Egypt, Report prepared for USAID under grant AID/OTR-G-1740, Department of Health Planning and Administration, School of Public Health University of Michigan.
- Harrison, P., 1982. Local Level Financing Alternatives: The Case of Bolivia, Paper presented at the Conference on Health in Developing Nations: Focus on Latin America, University of Connecticut Health Center, Framington, Ct.
- Heller, P., 1978. Issues in the Allocation of Resources in the Medical Sector of Developing Countries: The Tunisian Case, Economic development and Cultural Change, 27, 121-144
- Heller, P., 1982. A Model for the Demand for Medical and Health Services in Peninsular Malaysia, Social Science and Medicine 16, 267-284.
- Hinneman, A. and R., Parket 1982. Costs of Care, American Journal of Public Health 72:9 supplement 83-88.
- Hougen, L., 1982. Providing Rural Health Services Through the Private Sector: Experiences of Selected Cooperatives in the Delivery of Health Care in Santa City, Bolivia, USAID mimeo.
- Howard, GR., 1978. Socioeconomic Factors Affecting Utilization of a Rural Indian Hospital, Tropical Doctor 8, 210-217.
- Kefauver, M., A. Buendia, and James Rice, 1980. Health Care in Latin America: A Look at the Colombian System, Hospitals, December 62-64.
- Kessler, S., 1982. Private Sector Health Initiatives, Paper presented at Conference of AID Health, Population, and Nutrition Officers in Latin America, 19-23 April, Berkeley Springs, West VA.
- Klarman, H., 1965. The Case for Public Intervention in Financing Health and Medical Services, Medical Care 3, 56-62.
- _____, H. 1965, The Economics of Health, New York, Columbia University Press.
- Mach, E.P., 1978. The Financing of Health Systems in Developing Countries: Discussion Paper, Social Science and Medicine 12, 7-11.

- Mbũru, F.M, 1981. Implications of the Ideology and Implementation of Health Policy in a Developing Country, Social Science and Medicine 15A, 17-24.
- Musgrove, P., 1978. Consumer Behavior in Latin America, Income and Spending of Families in Ten Andean Cities, The Brookings Institute, Washington, D.C.
- McGreevy, W., 1982. Brazilian Health Care Financing and Health Policy: An International Perspective, Population Health and Nutrition Department, mimeo The World Bank.
- Ohmura, J., 1978. Analysis of Factors Affecting the Need and Demand for Medical Care, Social Science and Medicine, 12A, 485-496.
- PAHO, 1982. Plan of Action for the Implementation of Regional Strategies for Health for All by the Year 2000: Financial and Budgetary Implications, Background document prepared for XXII Pan American Sanitary Conference, September, Washington, D.C.
- Ponce de Leon, R. et al, 1980. Decentralization: Administracion en los Servicios de Salud de la SSA: Analisis de un Caso IV. Ingresos por Cuotas de Recuperacion, Salud Publica de Mexico XXII, 155-165.
- Praiss, I., 1980. The Challenge of Health Economics to Medical Education, Israel Journal Medical Science 16:7, 547-551.
- Quick, J., et al, 1981. Managing Drug Supply: the Selection Procurement, Distribution and Use of Pharmaceuticals in Primary Health Care. Management Sciences for Health, Boston, MA.
- _____, J. et al, 1975. The Delivery of Primary Care Health Services Through the Cooperative Structure, mimeo.
- Robertson, R. and M. Anderson, 1979. Study of Coverage and Costs of the Rural Basic Health Sciences Program in the Dominican Republic, mimeo.
- Robertson, R. and D. Zschock, 1979. Health Sector Financing in Developing Countries: Guidelines, Monograph 8, OIH/USDHEW, Rockville, MD.
- Roemer, M., 1976. Does Social Security Support for Medical Care Weaken Public Health Programs? International Journal of Health Services 6:1, 69-78.
- _____, M. 1982. Governmental Support of Health Activities in Developing Countries, Paper presented at Annual Conference of National Council for International Health, 16 June, Washington, D.C.
- Segovia, J., 1974. An Answer to Roemer and Maeder about Social Security and Public Health Programs, International Journal of Health Services 7:2, 311-314
- Selowsky, M., 1979. Who benefits from Government Expenditure? A Case Study of Colombia, Oxford University Press, New York.
- Sorkin, A., 1975. Health Economics, Lexington Books, Lexington, MA.

- _____. A. 1982. Financing Health and Development Projects - Some Macroeconomics Consultations, unpublished paper.
- Stevens, C. undated. Rationalizing Health-Sector Financing: An Integral Component of the Primary Health Care Strategy for the Eastern Caribbean, mimeo.
- _____, 1980. Financing Health Care in LDCs: Some Distributional and Management Issues, mimeo.
- _____, undated. Egypt: Agricultural Cooperative Health Schemes, mimeo.
- Stinson, W. 1982. Primary Health Care Issues: Community Financing of Primary Health Care. Series 1: ç4 American Public Health Association International Health Programs, APHA, Washington, D.C.
- Sgontz, L. 1972. The Economics of Financing Medical Care: A Review of the Literatures, Inquiry 9, 3-19.
- Ueber Raymond, S. 1981. Transcript of Panel Discussion before the Governing Board, National Council of International Health, mimeo.
- _____, 1981. Speech given to the Advisory Committee on Voluntary Foreign Aid, AID Department of State, 1981.
- _____, 1980. Private/Public Sector Cooperation in International Health Principle for a Viable Coalition.
- _____, Paper presented at American Public Health Association Annual Meeting.
- Walkers, G., 1979. Utilization of Health Care: The Laredo Migrant Experience, American Journal of Public Health 69:7, 667-672.
- Weisbrod, BA., 1961. Economics of Health,

EXECUTIVE SUMMARY

The purpose of this paper is to suggest an analytical framework to guide the process of systematically identifying, designing, and implementing new private sector initiatives in the health sector. Because public and private activities within the health care sector overlap with respect to purpose, payment and function, the private sector must be broadly defined in order to encompass the full range of opportunities for new initiatives. In this paper, the private sector is defined as including any non-governmental organization or individual engaged in the production or provision of health services or supplies irrespective of whether for-profit or not-for-profit or source of financing.

The framework for this paper conceptualizes the health sector along two dimensions: source of finance and provision of services. The integrity of each category is not flawless. Social Security health programs, for example, tend to fall across more than a single category and publicly financed hospitals tolerate the use of their facilities by government physicians for private patients. Nevertheless, this two-dimensional conceptualization is quite useful for identifying the activities of the entire health sector and for determining where spending occurs and in what amounts. The four categories are discussed in terms of relevant issues and field experience. The purpose is to elaborate how one can examine these various components of the health sector in a systematic manner in order to provide a basis for identifying and designing new private sector initiatives.

Private Provision/Private Financing

Conventional wisdom holds that the volume of health services and expenditures in the non-government sector far exceed that of the government. However, the literature which has examined these private activities is very fragmented, and few countries have a clear picture of their privately administered and financed health care sector. A systematic analysis of existing providers and sources of funding can indicate gaps in the supply of health goods and services, help distinguish resources that could be exploited, and establish realistic expectations for increased private participation in the health care sector. Private providers need to be identified according to: organizational form; organizational purpose; activity type; activity focus; and technology. With respect to private financing mechanisms, the volume of financial flows and methods of collection should be identified according to: user fees; prepayment and insurance; employer programs; and subsidization.

Possible models for privately provided/privately financed initiatives are offered by a capitation prepayment dental care plan in Kingston, Jamaica; and a cooperative-based, self-financing plan for primary health care in Santa Cruz, Bolivia. These schemes raise unresolved questions regarding private sector involvement in health care but they merit closer attention and examination.

Public Provision/Private Financing

Government health care delivery systems use a variety of financing methods to help defray the costs of providing services. The most common method is

personnel service fees, but they tend to recover less than 30 percent of recurrent costs. Drug sales, personal prepayment, and production-based prepayment are other alternatives, but these schemes also have problems with financial viability. One production-based prepayment plan is the Coffee Growers Association of Colombia. The Association contracts with the Ministry of Health to provide services. Detailed information regarding economic performance could not be obtained for this report, but the scheme merits closer examination.

Private Provision/Public Financing

Examples for this category prevail in the industrialized countries, e.g. Medicare and Medicaid in the U.S., and social insurance programs. Some Latin American social security systems which provide health services tend to fit this category loosely; other social security programs fall across more than a single category. The subject of social security and health care will be addressed in another report.

Public Provision/Public Financing

Health Sector activities in this category are adequately addressed elsewhere and, therefore, are not reviewed in this report. However, the rationale and logic for public sector provision of health activities are worth noting. It would be erroneous and unrealistic to assume that any and/or all health care activities can be carried out by the private sector.

The logic and rationale include the following: special characteristics of public or collective goods; external relations in consumption; and declining unit costs. Justification for public assumption of health care responsibilities also rest on the following;

- a belief that health and medical care are a human necessity ranking after food and shelter;
- a conviction that health services be distributed according to need rather than effective demand; and
- a general preference for a non-profit form of organization of care.

User Analysis

The literature on the economics of health care delivery tends to concentrate disproportionately on the problems of supplying health services in resource poor economies. The factors underlying demand are taken for granted or under-analyzed, yet these factors are critical for determining opportunities for new private health initiatives. User analysis, i.e., identifying what people are willing to pay for, becomes a vital component for the framework, proposed here.

Consumer profiles should be developed for each type of provider in each of the four categories described in order to identify the characteristics of distinct consumer groups. Understanding these characteristics is critical because they influence the types of services consumers can or would be willing to use and pay for.

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Consumer expenditure data should be used to determine the economic demand for specific health services. Income and price elasticities specific to income class and type of service can help identify important roles that certain types of providers or financing mechanisms could play with respect to private sector initiatives.

The private sector may offer considerable potential for expanding access to health care and alleviating the financial burden of overwhelmed Ministries of Health. However the entrance of non-government providers and financiers into the health care arena is not without problems. In Brazil, the mix of public and private health service has produced: inadequate services and poor geographic distribution; excessive use of high technology; excessive expenditures on medicines and drugs; unnecessary exams; underutilization and contempt for public hospital facilities; and overproduction and overbilling for services by private physicians to compensate for low levels of remuneration.

Important issues are raised regarding private sector involvement in health care and they require further analytical attention. Some of these issues are as follows:

- (1) Does a strong private sector absorb a disproportionate share of health resources to deliver services that are used mainly by more affluent, salaried, urban populations and exacerbate the gap between rich and poor?
- (2) Will private sector delivery of services encounter the same pitfalls of bigness and centralization as MOHs?
- (3) Do elasticities of demand vary by provider? by preventive and vs. curative services?
- (4) Are there a set of incentives which would encourage the private sector to provide more than curative services?
- (5) Can quality of service be monitored in the private sector?

The paper concludes with guidelines and methodology for multi-country studies to assess private sector opportunities in the health sector.