Mixed Health Systems

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# Financing and Delivery Mechanisms of a Health System

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## Public/Private Mix

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<td>Mainly private provision, public finance</td>
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<td>Mixed provision, mixed finance</td>
<td>Netherlands</td>
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<td>Mainly private provision, private finance</td>
<td>Switzerland</td>
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Mixed health systems have been defined by Oxfam as entailing “centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services” (Oxfam 2009)

Many Low and Middle Income Country (LMIC) health systems are characterized by (Nishtar 2010)

- Diversity in health care provision
- Dominant, poorly organized private markets
- Compromised public services
- Blurred public-private distinction
DIVERSITY IN HEALTH CARE PROVISION
Diversity in health care provision

- Ownership or payment type: *Public ➔ private*
- Recognition: *Formal ➔ informal*
- System of knowledge: *Western ➔ indigenous*
- Cadre: *Professional ➔ non-professional*
Human Resources for Health: Axes of Diversity
DOMINANT, POORLY ORGANIZED PRIVATE MARKETS
The private health sector in LMIC

• Health care provision by:
  – Large corporate/for-profit hospitals
  – Small hospitals/nursing homes/clinics
  – Private non-profit hospitals/charitable institutions
  – Qualified practitioners/GPs/consultants
  – Informal sector/unqualified practitioners

• Out-of-pocket payment is the chief financing mechanism for health care in several countries in South and South-East Asia, Africa, the countries of Central and Eastern Europe, and the former Soviet Union (Normand 1999)

• In 34 countries in Asia and Africa, including many of the most populous nations (Bangladesh, China, India, Nigeria, Pakistan), more than half of total health expenditures are private out-of-pocket transactions (Lagomarsino et al. 2009).
Private health care in LMIC

- Non-state providers are more numerous and accessible than public sector providers in BD, India (Standing and Chowdhury 2008)
- Greater utilization of the private sector for common illnesses reported in Vietnam, Indonesia, and several African countries (Limwattananon 2008).
- Private sector health care is often the first point of contact for, both rich and poor, patients in rural and urban areas of low-income countries
  - Geographical availability of practitioners/facilities
  - Greater responsiveness and efficiency
  - Perceptions of better quality of care
  - Easy access to drugs, laboratory services

Evidence on Services provided by the Private Health Sector

1. A review of Demographic and Health Survey data from 38 countries showed that for children in the poorest income quintile, 34% to 96% of children seeking treatment for diarrhea and 37% to 99% seeking care for ARI received the care in the non-state sector
2. In India, the non-state sector distributed 65-70% of Oral Rehydration Salts used in the country
3. In Sub-Saharan Africa the majority of malaria episodes are initially treated by private providers mainly through the purchase of drugs from shops and peddlers

Private health care: deficiencies

- Usually unregulated, often compromises on quality of care
- Overmedicalization, unnecessary investigations and treatment (Radwan 2005): price gouging, individual and public health harms
- Rent seeking: taking kickbacks for unnecessary referrals (Mæstad & Mwisongo 2010, Anand 2008)
- Negligence, discrimination and denial of care (Sheikh et al 2003, Rahmati-Najarkolaei et al. 2010)
- Predominantly locate in urban areas (Lagomarsino 2009)

Evidence of Poor Technical Quality Provided by Private Sector

1. Unnecessary use of antibiotics for treatment of diarrhoeal diseases and non complicated infections (Egypt, Pakistan)
2. Insufficient use of ORS for treatment of dehydration (Bangladesh, Nigeria, Pakistan, Sri Lanka and Yemen)
3. Under-dosing of antimalarials (Viet Nam)
4. Inconsistent, non-standard prescribing of antiretrovirals (Zimbabwe, Senegal)
5. Over the counter sales of non prescribed ARVs (Viet Nam)
6. Non-adherence to treatment guidelines in TB care (India)

Source: Bennett et al 2005
COMPROMISED PUBLIC SERVICES
Low government spending

- Private health expenditure continues to dominate in low and lower middle income nations (WHO 2001). In LMIC, public expenditures on health care constitute no more than a third of total health expenditures (Nandakumar 2004).

- In many LMICs public financing for health is typically lower than what people pay directly out of pocket for health services (Nishtar 2010).

- Disproportionally high expenditure towards large capital investments, leaving recurrent costs, including salaries and maintenance, under-funded (CMH 2005).
Inefficient application of funds

• Deficits in the management and oversight of government health care services in LMIC (CMH 2005, Peters 2002)

• Poor standard of essential services, vacancies in government service, lack of procedural transparency and accountability, compromised credibility among communities (Nishtar 2010, Peters & Muraleedharan 2008)

• In many countries where governments provide free or nearly free health care services, users from all income groups including the poor still prefer to pay for care in the private sector (CMH 2005)
BLURRED PUBLIC PRIVATE DISTINCTION
Private behaviour in public service

- Public and private health sectors have evolved from and co-exist in broader social, political and macroeconomic contexts, overlap in financing mechanisms and employment arrangements make (Lagomarsino et al. 2009, Nishtar 2010)

- Dual job holding is common: publicly employed doctors (also nurses, midwives and other health workers) supplement their salaries through second, private jobs (Macq et al. 2001)

- Out-of-pocket payments are often made to public providers (Lagomarsino et al. 2009)
Partnerships

• Semi-formal:
  – Indian government gives vaccines to private providers and facilitates referral networks for tuberculosis care (Peters 2002, Dewan et al 2006)
  – Private doctors often having links with government medical facilities (Standing and Chowdhury 2008)

• Formal:
  – Contractual arrangements in many countries (Mills & Brugha 2002)
  – SSA: integration of faith-based services through government subsidies, manpower, inclusion in reporting and referral systems (Harding et al. 2003)
Mixed health systems syndrome: summary

Diversity in provision
- Public – private
- Formal – informal
- Western – indigenous
- Large corporatized hospitals – solo / family-run establishments

Compromised public services
- Low public expenditure
- Inefficiencies in public spending
- Poor management, oversight and services in public sector

Dominant, poorly organized private markets
- OOP payments predominate
- Private provision outnumbers public
- Exploitative practices common

Blurred public-private distinction
- Private doctors linked to government facilities
- Informal payments
- Dual practice
- Formal PPPs
What does this mean for users of care?

- Unnecessarily high costs of health care
- Variable quality of care provided
- Irregular ethical conduct of health care providers
- Unavailability / unequal distribution of health care providers