

# **Economic Dynamics and Health Systems: Analysing Public- Private relationships**



**Presentation in session on ‘Can mixed health  
systems be equitable?’**

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# How do private and public interact over time in health markets?

- Inequity is a characteristic of whole health system.
- Move from a static 'public-private mix' framework to one more informed by economic analysis of market structure, incentives, interactions – a more dynamic analysis?
- Still limited literature on how the private and the public mutually influence each other through market dynamics.

1. Some propositions concerning interaction, based on UNRISD project and other literature
2. An illustration concerning low income commercialisation from Tanzania

Sources: UNRISD project, *Commercialisation of Health Care*, DFID and ESRC funded research, talk my own responsibility

# UNRISD project on health care commercialisation, 2003-5

## **‘Commercialized’ health care:**

- provision of health care through market relationships to those able to pay;
- investment in, and production of goods and services for cash income or profit, including private contracting and supply to publicly financed health services;
- health care finance by individual payment and private insurance.

A single framework of analysis of : private sector expansion, market liberalization and privatization of state assets.

# What are 'economic dynamics' in health markets?

- Incentive structures generated by competition patterns in specific markets
- Business strategies shaped by ownership, organisation and business structure
- Variety: current industrial economics emphasises heterogeneity and innovation in markets, not convergence
- Feedback effects on quality and inequity as market structure changes.

# Propositions on inequity, backed by (some) evidence

1. Public/ social insurance health systems are core redistributive institutions across the world: e.g. public health spending is redistributive across Africa.
2. Private market-led provision for private payment is regressive or at best neutral; also exclusionary.
3. Interaction of sectors therefore the key to inequity of outcomes.

# **Market segmentation via investment and market-making can embed inequality**

- MNC investment strategy in middle income countries focuses on market segmentation and risk containment.
- Secondary care commercialisation raises costs sharply especially associated with private insurance; hard to universalise.
- Private risk-rated insurance may be most inequitable private market development.

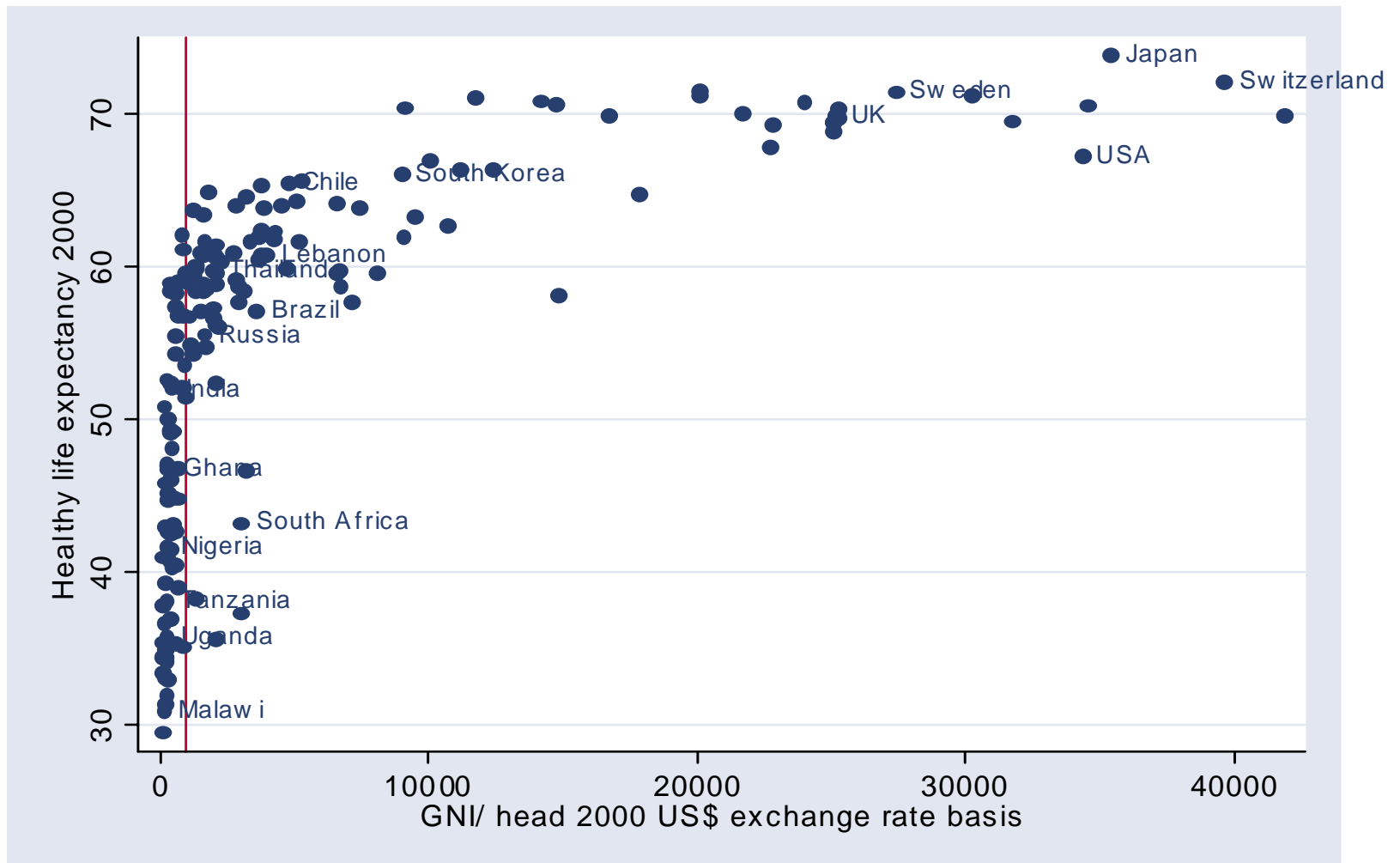
## **Commercialisation of *public* sector can undermine its redistributive and public health capabilities**

- Influences access and equity *within* public sector
- Undermines public health orientation
- Shifts professional cultures towards private aspiration
- Undermines regulatory benefits in private sector: more universalist public systems generate higher quality private sector with more complementary role.

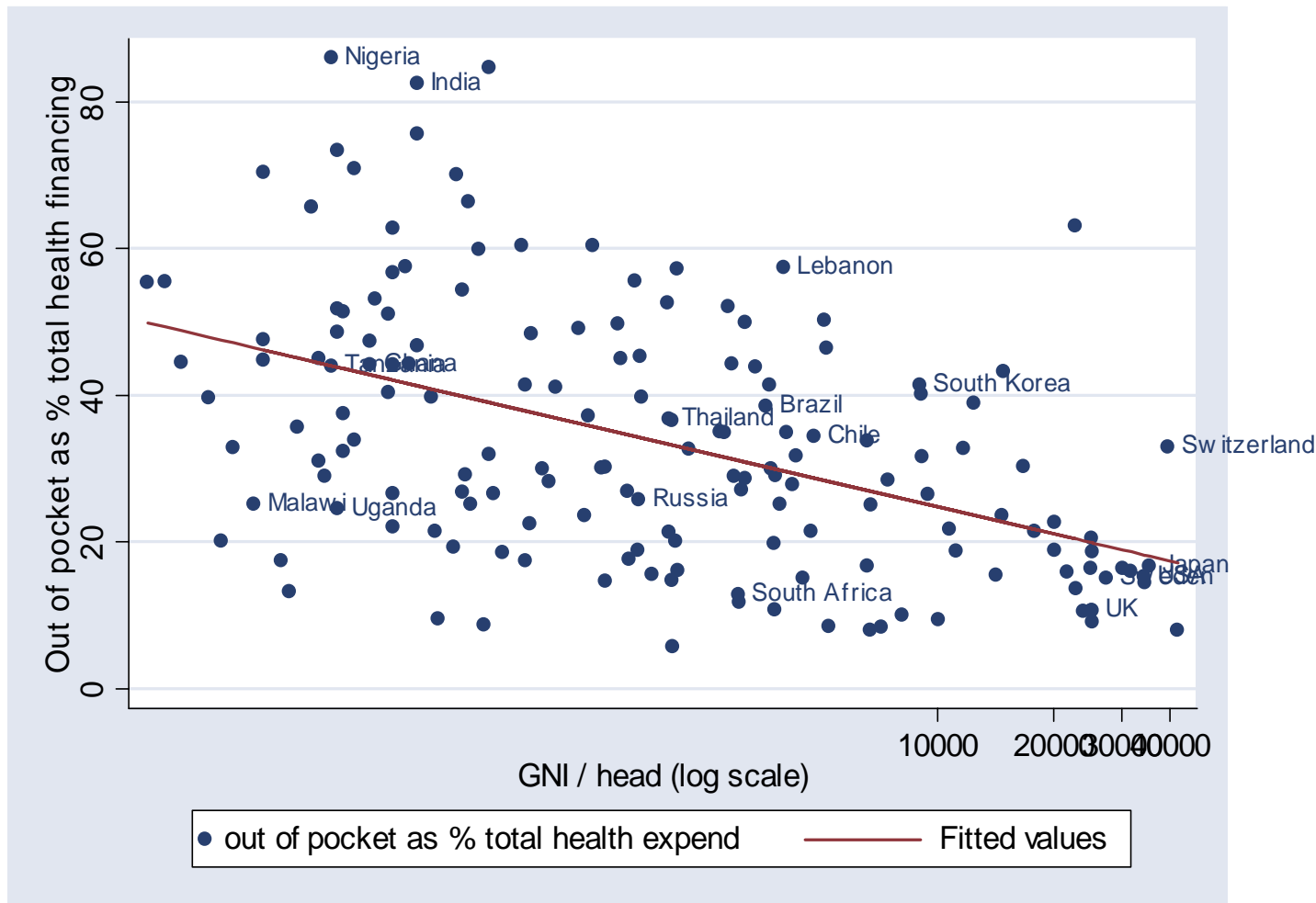
## **Low income commercialisation in conditions of generalised poverty is very damaging (African evidence)**

- Private provision for poor people *very* low quality
- Interaction with public fees associated with widespread exclusion and abuse
- Health care payments a key source of impoverishment
- Much unregistered payment to informal providers, and rising self-treatment
- Market dynamics drive out better private providers

# Low income experience important: greatest health inequality is below \$1000 per head



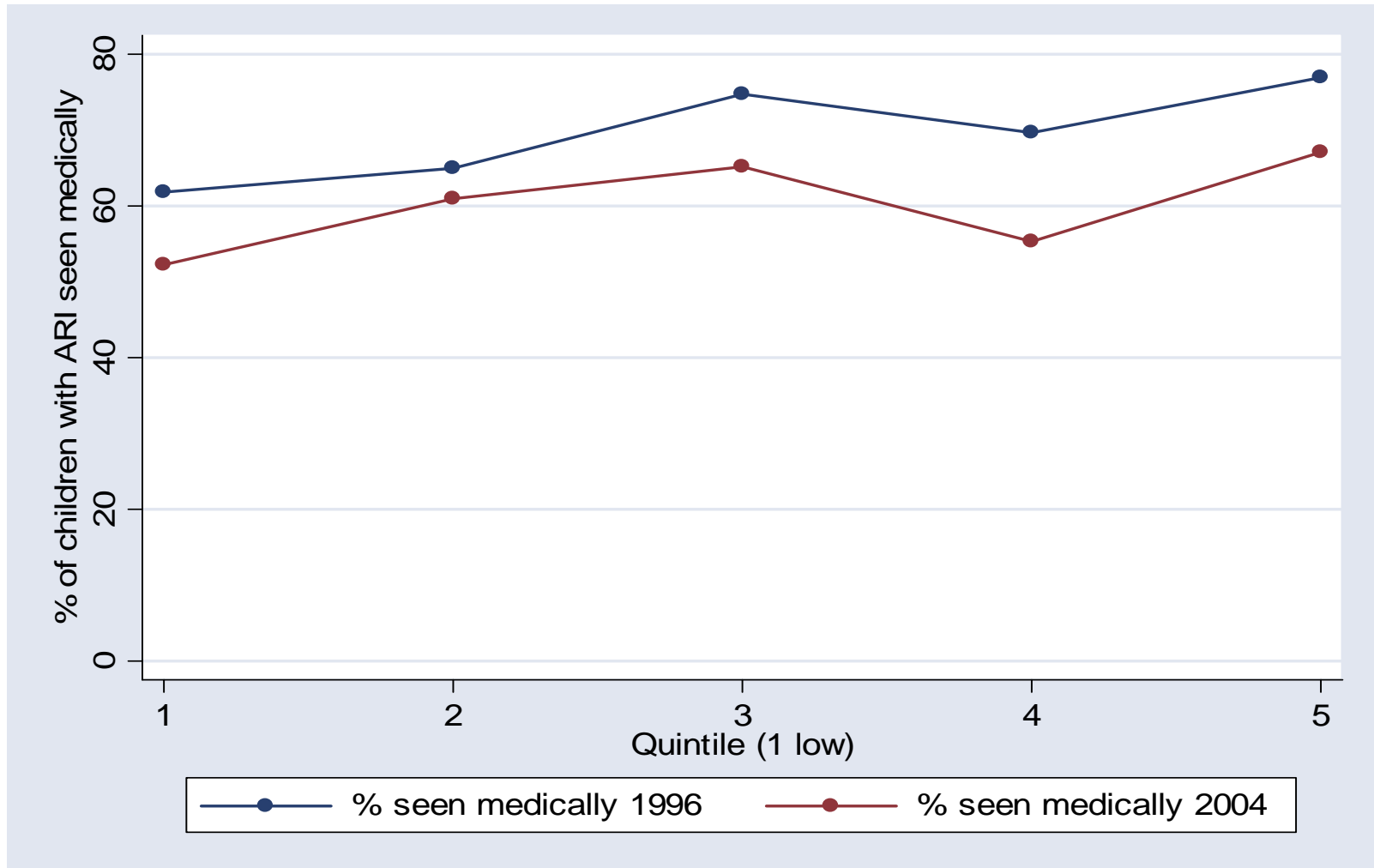
# And poorer countries' populations are more burdened by out of pocket financing



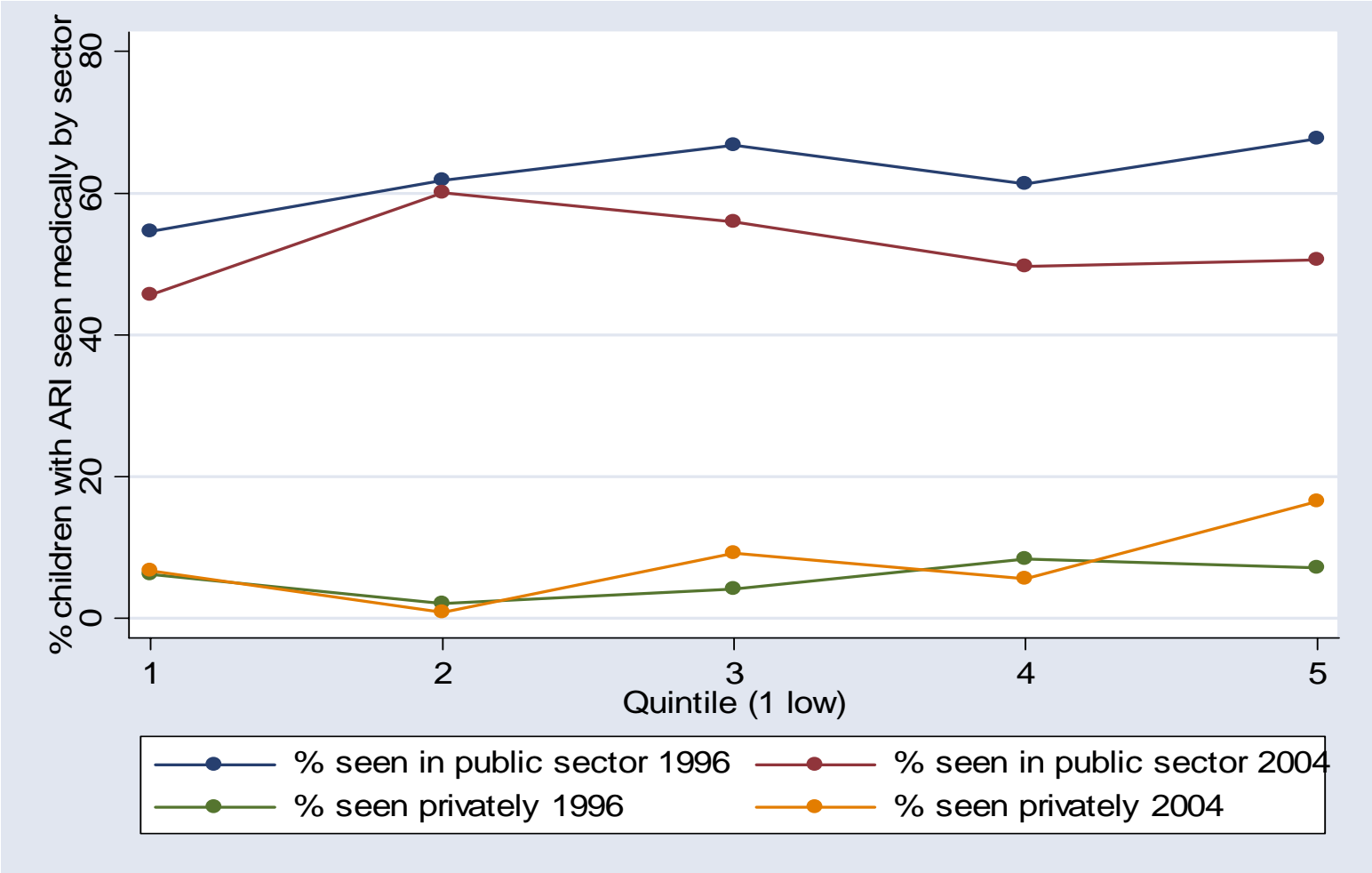
## **Example: Low income fee-based commercialisation in Tanzania**

- Fee-based system associated with falling access to care and shift to drug shops and self treatment
- Price and proximity dominate care seeking; strong price competition in poor segment of market
- Much private urban slum provision very poor quality, very low skills, poor hygiene
- Segmenting private market by income; 'emptying middle' .

# Drop in % of children in Tanzania with ARI seen medically 1996 and 2004



# Public sector use falling, poor use private sector but not rising except among better off



## Shift to self-treatment in drug shops: Children with cough/ fever and with diarrhoea: % of all visits by ownership

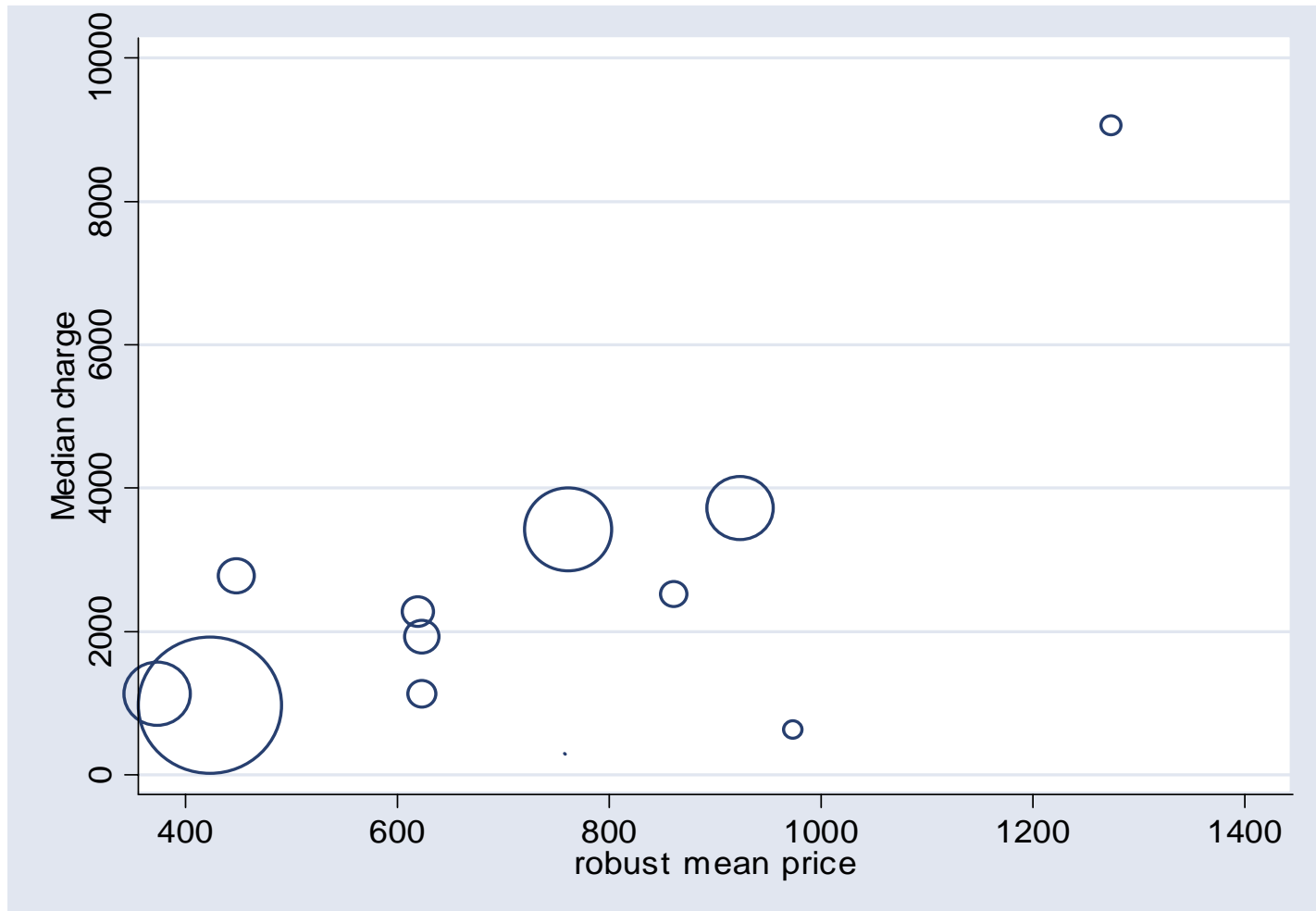
Type of facility	Children with cough/ fever		Children with diarrhoea	
	1996	2004	1996	2004
<b>Public facilities</b>	<b>79.25</b>	<b>63.79</b>	<b>81.79</b>	<b>67.12</b>
<b>Religious/ NGO facilities</b>	<b>4.18</b>	<b>5.86</b>	<b>6.19</b>	<b>5.56</b>
<b>Private facilities</b>	<b>3.89</b>	<b>7.77</b>	<b>3.09</b>	<b>7.59</b>
<b>Private pharmacies</b>	<b>12.68</b>	<b>22.57</b>	<b>8.93</b>	<b>19.73</b>
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>

Source: last 3 slides, calculated from Demographic and Health Survey data for Tanzania, 1996 and 2006

# **Low income fee-based commercialisation in Tanzania (2): private providers**

- Reputable private providers squeezed out of middle and lower end of market
- Failure of employers to pay – on time or at all
- Surviving private providers crowding up-market – over-capacity
- Business owners found pharmacies / drug shops more profitable than facilities.

# Dar es Salaam health centres and dispensaries: emerging segmentation: median charges plotted against robust mean of prices, weighted by usage, TShs, 1998



# Low income fee-based commercialisation in Tanzania (3) : all providers

- Very unstable private businesses, high turnover
- Very hard to raise investment funds, finance mainly from other businesses
- **All** facilities that offer better care, in all sectors, relied on subsidy in addition to charges:
  - Private: staff and resources from public sector
  - NGO/FBO: donations and government funding
  - Government: payment for staff and some medicines

## **Low income fee-based commercialisation in Tanzania (4) : dynamics**

- Very wide variation in probity and quality *within* each sector including government
- Acute problems of managerial control of staff and resources – use of mainly family labour
- Few partnerships; some sub-contracting of facilities and revenue sharing in private sector
- NGO/FBO sector split between charitable facilities and those serving better off

# **Low income fee-based commercialisation in Tanzania (5)**

- Heavy reliance on private spending and subsidy that is very badly used in terms of health system capacity and equity – and it's getting worse
- Commercialisation of care for the poorest and most vulnerable is very problematic
- Market dynamics are taking the system towards worsening inequity, need for more provision free at point of use.