

How equitable can be mixed health systems?

Public-Private Partnership
experiences in Zimbabwe:

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Background

- Govt retains leading role in health care provision and setting policy
 - The private sector has been there since - with significant contribution
 - Conventional private providers: for-profit; not for-profit, **industrial, mines and commercial farms**
 - For-profit – GPs, pharmacists, nurses, specialists in labs & traditional healers
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Main private providers

- Missions – 2nd after the Public sector
 - GPs – 75% of Drs in private practice (about 1,425 of 1,900 registered Drs)
 - On-site facilities (agriculture & mines)
 - Traditional practitioners (+50,000)
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Size and coverage

	Facilities N=1,080	Hosp beds N=18,200	Popn. N=12m
Public	72%	56%	
Missions	11%	38%	70% rural
For-profit	17%	6%	10%
Financiers	25 MedAid	1 million	75% pvt
Traditional healers		none	10%

Is this mixed system equitable?

- Politicians – serving those affording it
 - Technocrats – complements and at times subsidises the public sector
 - Middle view - inequities not due to private sector behaviour more than public sector mgt weaknesses (monitoring & regulatory frameworks).
 - Extremists – throttle the sector on evidence of attributed problems.
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Private providers - distribution



Assessing equitability of providers

- Geographical – rural versus urban
 - Services – curative versus preventive
 - Accessibility – prohibitive fees
 - Popn. covered – formal sector – (10%)
 - Cost contribution to health sector
 - Human Resources – experience, skills
 - Quality of care – not perceptions
 - Responsiveness to emergencies
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How they rate: for-profit practices

- Urban concentration – 80% in Hre & Byo
 - Curative and no preventive services
 - Facilities not built for purpose
 - Interventions of low CE ratios – high health cost but no improved health for users
 - Price colluding & industry entry barriers
 - Poach experienced public sector workers
 - Vertical and duplicated services
 - Adverse selection MedAid – formal sector only (80% in informal sector)
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How they rate: not for-profit

- Operate in remote rural areas
 - Serve about 70% of rural population
 - Curative and preventive services
 - District & Provincial roles assumed
 - Train own human resources – not Drs
 - Service needs of poor as Govt. agents
 - Fee structures based on ability to pay
 - Feedback & consult with Govt routine
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Private sector diversity & influence on health policy

- No formal statement for security of status and relationship with public sector.
 - Too amorphous and mosaic to effectively influence on health policy
 - Legislated professional bodies to self regulate – GPs & Nurses (HPC affiliation)
 - No sector voice – professionally polarised
 - Aid Unit – for coordinated financing
 - Non-uniform fees – resistance to national standards by diverse professions.
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Implications to managing equitable health systems

- Underlying assumptions in favour of private sector are not always correct
 - Even in free markets, interventions to drive up standards and equity are necessary.
 - Evidence: Missions (private not for-profit) have better claims for support.
 - Empirical evidence needed to justify redirecting resources to for-profit sector.
 - Strategies to fund Excess Supply - to hold down health costs for increased access?
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