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Public-private partnership in health care services

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Dedication

I dedicate this humble work,

To the one who has the warmest heart I ever seen, to my mother lhadja Houaria;

To the one whom I had been encouraged and had been pushed to realize the best, to my father lhadj Lakhdar;

To my big brother and my little sister and all Smahi family;

To all my friends whom I shared great moments with;

Last but not least, I wish I had a better achievement to dedicate to this person, so I dedicate this paper to my past grandmother whom I loved deeply and wiped deeply.

Smahi Mohamed Amine

Content

Summary

General introduction:

Today, all sectors and administrations are having a remarkable growth and evolution, that includes the health sector, health care is the world's largest industry and produces 9.8 percent of the world's gross domestic product.

Yet health systems in many countries, regardless of their level of income, are frequently described as "in crisis." The problems are particularly acute for publicly operated health services. As known, the health care system is divided to sectors, public sector financed by the government and the private sector financed by funds and investments. With the appropriate role and balance of the public and private sector in providing healthcare services to populations in low- and middle-income countries.

In recent years, disputes between the proponents of private and public systems have become particularly heated, as the global economic recession that began in 2007 has placed major constraints on government budgets—the major funding source for healthcare expenditures in most countries.

The nations acknowledged that they could not stretch themselves beyond a certain point in context to building capacities in the health sector domain. Therefore the need to engage in partnerships was felt.

Public-private partnerships are globally popular, but the concepts of partnership, the lessons learned from partnerships, and the novelties about the types of partnerships that currently make the illusion are still ambiguous.

Terminology:

Before going any further we must give a small definition of the commonly used terms in this dissertation which are public healthcare system, private healthcare system and the partnership between them.

Public health systems can be described as a network of entities with differing roles, relationships, and interactions.

All these entities contribute to the public's health and well-being throughout the community. The governmental public health department is a major player in the public health system, but they do not provide the full spectrum of essential public health services alone.

Private healthcare systems provided by entities other than the government. Ethical issues relating to private healthcare primarily concerns the argument that the seriously ill be entitled to spend money on saving their lives. On the other hand, private healthcare can sometimes be more efficient than public sector provision. Private operators may be more innovative in areas such as telemedicine, they can be more productive. The friendly behaviour of staff and doctors are the main reason for people relying on private health care centers.

Public-Private Partnerships in Health is the access to essential health services is an important aspect of development. Governments from both developed and developing countries are increasingly looking at public-private partnerships (PPPs) as a way to expand access to higher-quality health services by leveraging capital, managerial capacity, and knowhow from the private sector.

In many low-income countries in particular, health services are provided in crumbling facilities that are lacking basic sanitation, water, electricity, and functioning equipment and that experience frequent shortages of medicines and supplies. Low-quality services are inevitable. Similar problems occur at many public facilities in wealthy countries. Of course, the picture is more dire in

developing countries. To address these problems, a common response has been to spend more money on poorly functioning government-run services, encouraging them to do better what they have failed to do well in the past. Yet governments at all income levels find it difficult to finance capital spending through tax revenues; have a poor track record of managing infrastructure projects; and are challenged by the complexities inherent in providing health services. Most countries have engaged private capital, expertise, and innovation to strengthen public services in other sectors. However, investments in the health care sector in many countries have lagged behind this trend.

The lack of quality and services in health care systems in middle and low income countries has been noticed in a country of social healthcare system or as known a system funded by the government , and Algeria is one of these countries . so any necessary arrangement has been viewed should be taken under consideration in our country .

Research problematic:

After what was said earlier about public-private partnership in health care systems, we have the urge to ask some important questions that must be asked to form the main problematic of our research:

1- How can the private healthcare sectors extends in a governmental funded countries and what is the role of partnership in this case?

2- Is it possible to adopt public-private partnership system in Algeria, and does it have a positive impact on the Algerian' outputs in healthcare facilities?

Methodology of research:

To answer our problematic and verify the hypothesis which is improving the health of the poor by combining the different skills and resources of various organizations (public and private) in innovative ways; a descriptive and analytical methodology has been adopted.

First, a bibliographic and documentary research related to the different theoretic and conceptual aspects of the health system, as a level of change and new way of integration sectors which leads us to comparison between health system of many countries, and getting to their alliances.

Second part, has been divided into two sections. The first is a documentary research about partnership between the private and the public sector in general. The second is systematic review about partnership in health care locally and internationally, ending with mentioning past and current experiences of our idea worldwide.

Third part consists on the analysis of data provided by the employees of public facility and private facility, through a questionnaire for each employee and the comparison of the results with the effectiveness of application of new program as partnership.

PART ONE: ORGANIZATION AND HEALTH PLANNING IN SOCIAL SYSTEMS

Health planning is a tool for regulating the health system and especially for controlling and distributing the supply of care, which is an essential step in health organization. Its primary objective is the rational organization of the supply of care throughout the country to meet the health needs of the population.
In the first place, it would first be necessary to make a general overview of health planning, including its process and stages, and to study the different models of health planning adopted in several countries. Secondly, it is essential to analyze the Algerian health organization in order to understand how these principles work.

The aim of the analytical comparison of the study is to know the place of Algerian health care system worldwide, in order to embrace the partnerships in our country. in this case , there has been an analyze review of the Algerian and Moroccan and French health system and health planning and their capability of obtaining new ideas in mixed systems .

What is a health system?

"The health system is all the organizations, institutions, resources and people whose main goal is to improve health "[1]. To function, a health system needs staff, financial means, information, and supplies, means of transport and communication, as well as general guidelines. It must provide services that meet the needs, be financially and treat patients decently.

What is the organization of care?

The organization of a healthcare system is defined as all social actors intervening and interacting in the production and distribution of care, and the management of social protection are intimately linked. They are part of a global health system competition for the allocation of resources with other representative subsystems the general economy of a country (defense, industry ...)[2] .The components of the health care system are :

a) The demand for care: it depends on each individual belonging to the population. b) The supply of care: this is the result of the health professions and care establishments. Its changes are in line with medical advances (new diagnostic therapeutics) and the demographics of health professionals.

c) Financing and management of care: Although it is always the State (delegating sometimes its authority at regional / local level or national agencies) determines the public health policy and its framework of application, it exists important inter-country disparities in the management of health care systems. They result in varying levels of

[1] WHO, report, health system 2012 in www.who.int
[2] A. Duclos, S.GalandDesmé and C.Colin: "Organization of healthcare systems: networks and networks", Cours. In:lmm.univ-lyon1.fr/internat/download/item13.doc.p1

organization and skill levels. In addition, the mobilization of the funding resources of the system is strongly guided by the type of social protection enjoyed by the population.[3]

ALGERIAN HEALTH ORGANIZATION

In a health system, funding mechanisms, structures organizational structures, regulatory techniques and governance modes are combined interact to ensure balance and sustainability over the long term. In this section, we will analyze the Algerian health system in are together to detect the main dysfunctions related to its organization.

1. The organization of the Algerian health system

The organization of the national health system takes place at three levels:
the central level, the regional level and the wilaya level.

1.1. The central level:

The Ministry of Health, responsible for the design and the application of the health policy is the central agent in the health system Algerian. It comprises ten directorates (prevention, training, pharmacy and medicines, health structures, regulation and litigation and a general inspection ...).

And health institutes and agencies, responsible for evaluating the various resources put in work (human, financial and material). The main institutes are: Institute Pasteur of Algeria, National Institute of Public Health (INSP), National Laboratory for the Control of pharmaceutical products (LNCPP) ...

[3] Idem. p3.

1.2. Regional level:

There are five health regions in the country. Those are the Central regions (chief town: Algiers), East (chief town: Constantine), West (chief town: Oran), Southeast (chief town: Ouargla) and Southwest (chief town: Bechar). Each health region is under the aegis of a Regional Health Council (CRS) .[4]

1.3. The level of the wilaya:

Each wilaya is endowed with a Direction of Health and the Population (DSP), it plays a role of supervision, animation and coordination of health services at the level of the wilaya, its mission also lies in the collection and health data analysis; implementation of sectoral programs of action and their evaluation.

2. The organization of care

The organization of the Algerian health care system is based on four theoretical principles (the sanitary regionalization, the principle of integration, the prioritization of care and intersectionality), in this section we will focus on the principles of hierarchical care as well as the permanence of care which has a direct relation with the engorgement of emergencies and longer waiting times.

2.1. Prioritization of care

It consists in differentiating actions and care units according to their degree of complexity and technicality therefore needs to which they respond. She supposes the existence of extra-hospital lightweight structures capable of performing all functions

[4] CRS: it is an advisory body in charge of interministerial coordination, promotion and protection health of the inhabitants and also the development of regional health programs.

basic sanitary conditions. It is only on this condition that it will to decongest hospitals and also improve their functioning.

In addition, with the introduction of the principle of prioritization of care, access to specialized care of the public sector becomes selective, it must be done through the generalist in the basic structures which thus becomes the obligatory entry point. It is necessary to prioritize the care path of patients by:

- The hierarchy of care contributes to the rationalization of the use of resources available on a territory.

- The prioritization of care helps to reduce congestion and decongest hospital structures[5].

2.1.1. Attending physician:

It is the practitioner who consults the patient daily in case health problem, he orients his patient to specialists or to the hospital if it seems to him necessary. The goal is to avoid many patients unnecessary consultation and decongest SUH[6]. His missions are as follows:

- Participate in the provision of care in a given territory, ensuring the care medical first-aid;

- Refer the patient to the coordinated care path according to their need for care;
- Ensure or organize the detection and prevention of avoidable risks, accompanying and educating patients and contributing to the development of prevention and detection actions in the territory;

[5] Macroeconomic Course, Master II, Health Economics, 2013.
[6] "The Practicing Physician: A Practical Guide", 2013, in: www.linternaute.com/Practice Your Rights/Health Social security.

- Ensure the individualized application of long-term care protocols and contribute to the monitoring of chronic diseases, in cooperation with others stakeholders involved in the care of the patient;

- Participate in the permanent care of the territory of health[7]. In the UK Every GP (GP) has a list of 1500 to 2,000 people on average. It has a role of care but also of health promotion (consultation against tobacco, education of diabetics). It regulates access to medicine specialized.

Patients must first consult to access the specialist or the hospital. The patient can only be taken care of by the hospital directly in the context of the emergency.

Physicians are mainly paid by "capitation", paid by the health administration of their district. This is a quarterly payment calculated for each patient according to the age of the person, the mortality rate of the sector, and socio-economic indicators (level of poverty in the region, unemployment ...). The doctors' generalists are therefore independent; they exercise on a liberal basis, under contract[8].

2.1.2. Hierarchy of care structures

In Algeria, care is prioritized on four levels:

Level D: primary care that includes a set of units extra hospital (EPSP) located in the commune's administrative center. It understands:

- Polyclinics;

- care and consultation rooms

- Health center ;

[7] Hospitalization and Care Organization Department (DHOS), National Observatory of Demography Health Professions (ONDPS, General Assembly of Health Organization (EGOS), Synthesis of the work of the 2 national days ", 8 February and 9 April 2008, P9, in: http://www.sante.gouv.fr/IMG/pdf/synthese_egos.pdf

[8] L. Laplace, B. Kamendje and alt, "The French and English Health System: Comparative Evolution from the Middle of the '90s, Public Health 2002, P49, in: www.cairn.info/load_pdf.php? ID_ARTICLE = SPUB_021_0047

- dispensaries;

- maternity and child protection service;

- delivery clinics.

Level C: General care provided in a health facility Daira. It includes public hospitals in Daïra and Wilaya (EPH).

Level B: Specialized care provided in each wilaya health facility. It includes all Specialized Hospital Establishments (EHS).

Level A: highly specialized care that will be supported by highly technical, it includes the University Hospital Centers (CHU). In reality, the users do not respect this hierarchy, they address themselves directly to hospital emergency departments because of a small health problem and this comes down to failures of the structures of first resort (The absence of qualified personnel, the insufficiency technical platform and a guard system).

2.2. Permanence of care in primary care structures

The setting up of a guard system at the level of extra-hospital structures 24/7 is necessary, it allows users to directly address these structures in case of a health problem outside the hours of outpatient doctors and weekends. Extra-hospital emergency structures set up to lighten hospitals, for the most part continue to function like all other structures, the influx to hospitals for simple unscheduled consultations persists with all consequences of insufficient support for genuine emergencies and longer delays expectations.

In order to lighten hospitals and reduce waiting times, it is imperative to regulate access to hospital care by strengthening extra-hospital structures in terms of human and material resources and set up a system of guards, and then inform and oblige users to respect the hierarchy of care.

HEALTH PLANNING AND ACCESS TO CARE

Health planning is just one step in the public health action process. In fact, it is a method of solving problems, a decision aid for public action in the health field. In this section, we will try to analyze health planning in France in order to draw on experiences and lessons in the health field.

1. Health planning in France

Hospital planning [9] is not an old concept in France, since it was the hospital law of 1970 which established it for the first time, by drawing up a health map. The objective at the time was to put order in the somewhat anarchic development of the hospital park. To this purely quantitative orientation, the law of July 31, 1990 would add two other parameters: one qualitative and the other evolutionary. The main objectives of this reform:

♣ To adapt the supply of care to the health needs of the population and improve the quality of care;

♣ To increase the autonomy of the institutions and develop the responsibility of the hospital system actors;

♣ To improve dialogue and dialogue within the institutions;

♣ Establishing a better balance between the public service and the private sector. [10]

France has changed its public policies to regulate the supply of hospital care, which led in particular in 1991 to continue the development of health planning through

[9] It is a rational organization of the offer of hospital care on the whole territory to satisfy the health needs of the population.

[10] "Health organization: hospital planning", P1 in: www.unafam.info

regional health organization plans (SROS). Three generations of SROS have followed one another in 15 years (1991-2006)[11].

The purpose of the regional health organization plan is to anticipate and evoke the necessary changes in the provision of preventive, curative and palliative care in order to meet the needs of physical and mental health. It also includes the provision of care for the care of pregnant women and newborns. It encourages adaptations and complementarities of care provision and promotes cooperation between the two sectors (public-private). It sets goals for improving quality, accessibility and efficiency health organization.

1.1. The new French health system institutions

To organize the offer of care in France, several institutions have been created over each SROS:

1.1.1 The Regional Hospital Agency (ARH):

The ARHs are public interest groups associating the State and health insurance. They were created by the ordinance of 24 April 1996 and became operational during the first quarter of 1997. They are responsible for implementing, at regional level, the hospital policy defined by the Government, as well as for analyzing and coordinating the activity of public and private health establishments, to conclude with them multi-year contracts of objectives and means and to determine their resources. They develop, in partnership with all health professionals, the regional plans of the health organization which draw, every five years, the framework of the evolution of the supply of hospital care in adequacy with the whole system of health care.[12]

[11] Lernout Tiffany et al, "Three generations of regional health organization plans in fifteen years: a review and prospects ", Public Health, 2007/6 .p500 in: www.cairn.info

[12] "Agencies in the health system: A new institutional landscape »Adsp n ° 37 December 2001P23 .in: www .hcsp.fr

1.1.2 The Regional Health Agency (ARH):

The ARSs are Public State Establishments of an administrative nature (EPA) under direct ministerial supervision but with a share of autonomy. They intervene in prevention; care in the city and the hospital and in medico-social matters.

1.1.3 The Directorate-General for Health (DGH):

It must respond to the health needs of the population. In particular, she is responsible for issues relating to the demography of health professions and defines training needs.

1.1.4 The Direction of Hospitalization and Organization of Care (DHOC):

It is responsible for developing the policy of organizing the provision of care according to the objectives and priorities of the health policy. Among other things, it elaborates regulations for urgent medical assistance services (SAMU), mobile emergency and resuscitation services (SMUR) and medical transports. It assists in the definition of the orientations and the organization of the training of the medical and paramedical professions of which it determines the conditions of exercise. The DHOS is the interlocutor of the national bodies of the hospital public service.

1.1.5 The Regional Directorates for Health and Social Action (RDHSA) and the Departmental Directorates for Health and Social Action (DDASS):

These are the closest guardians of UAS. At the regional level, the DRASS ensures the prevention of the emergence of health risks. At the departmental level, the DRASS has a role of control and risk management[13].

1.2. The Creation of The Diagram Region of the Sanitary Organization

The Regional Scheme of Care Supply (RSCS) is in France the pivot of health

[13] Bruno Garrigue, "PARAMEDICALIZATION STATE OF PLACES FOR THE FUTURE" P19, In: staff.afisar.fr

planning. It defines the needs for infrastructures, means and activities of care which make it possible to respond optimally and satisfactorily to the health objectives of a region. It organizes functional links between health care institutions and plans overall and qualitative public health. In 15 years, there are three generations of Regional Scheme of Care Supply:

1.2.1. First Generation Regional Scheme of Care Supply:

The Regional Health Organization Plan Its mission is to geographically distribute facilities and care activities; to foresee and bring about the necessary evolutions of the supply of care, with a view to optimally satisfying the demand for health care[14]. The new contribution of the first-generation SROS was the transfer of power from the departmental level to the regional level. Thus, emergency reception services (UAS) must be implanted in a health facility including medical services. versatile or internal medicine, cardiology, visceral surgery, orthopedic surgery and gyneco-obstetrics.

1.2.2. Second-generation :

The second scheme of the health organization covering the period (1999-2004) provides for forward planning of the French health system organization at the regional level. At the time of its development, each region identifies the specific health needs of the local population and defines the priorities that will be implemented for the next five years. Its objectives are: to improve the consideration of health needs and to promote the coordination of care.

In the field of emergency, SROS carry out the geographical distribution of emergency sites, their identification and coordination. They organize prehospital regulation for optimal regulation of vital emergencies and for better participation of city doctors in the emergency[15].

[14] Lernout Tiffany et al, "Three generations of regional health organization plans in fifteen years: a review and prospects ", Public Health, 2007/6 .p503 in: www.cairn.info

[15] Second generation regional health organization plans (SROS II) .in: www.sante.gouv.fr.

1.2.3. Third-generation SROS:

SROS III was developed in conjunction with other reforms (Hospital Plan 2007,T2A), where the health card was discontinued. It seeks to simplify hospital planning. It encompasses preventive, curative, palliative and community-based care, mental and physical health, medico-social and social work. The development of third-generation SROS is based on priorities, namely:

• Better assessment of health needs;

• Greater consideration of the territorial dimension;

• A closer association of institutions, professionals, elected representatives and users[16].

The SROS III is based on a regulation of the activity and no longer on a programming of the beds (the quality of care). Whereas in SROSI and II, the health map and indexes were defined at national level, in SROS III, it is the HRHs that define the health territories and set quantified targets for the provision of care for the five years to come up.

1.3. The contribution of SROS to the organization of the emergency system

The implementation of regional health organization plans has led the French health system to guidelines in the organization of emergency services and this with the aim of improving access to care, ensuring access to care , for all non-scheduled and urgent care needs (ordinary emergencies and life-threatening emergencies), through a relevant network of the territory, taking into account the structures of emergency medicine, SMUR and SMUR antennas. More concretely by:

¬ The mesh of emergency medicine structures makes it possible to respond to local needs.

¬ SMURs make it possible to organize access to specialist care sectors[17]. It also improves the quality and safety of care by ensuring the distribution and coordination of missions carried out by EMS in the regional territory.

[16] "The health of tomorrow in Limousin, a shared vision: SROS 2006-2011" .in: www.sante-limousin.fr

[17] «Directorate-General for Caregiving Methodological Guide for the Development of the SROS-PRS» version 2.p58 in: www.sante.gouv.fr

¬ The implantation of the UAA in the most important public hospitals, on the other hand the Units of Proximity Reception, Orientation and Treatment of Emergencies (UPATOU) are divided between the public and private sector.

¬ The reduction of waiting times by setting up a National Mission of Expertise and Hospital Audit (MEAH) that studies with emergency services, she first observed what is spent in these services, measured the times, found the conditions of the passage, highlighted the organizations associated with these times of passage, and finally she helped the professionals to develop tools to reduce the times of passage, in order to assess wait times in the latter.[18]

Health planning in Morocco

In Morocco, the supply of care (public-private) knows a rapid development which leads to anarchy in its distribution, which has led to a situation dominated by imbalances and dysfunctions, the most important of which are:

§ Poor geographic distribution of available resources;

§ insufficient performance of health facilities;

§ lack of complementarity between the various stakeholders in the sector

§ the provision of care does not meet the needs of the population[19].

It is in this context that Morocco has put in place a new health regulatory tool.

1. A new tool for planning and regulating the supply of care

Morocco has embarked on a major reform project where planning occupies a preponderant place, and this by setting up new tools for its technical and institutional anchoring. In this context, the Regional Plan of Care Supply is both a tool for planning the supply, regulating expenditure and consolidating the regionalization policy.

[18] BLICICHNER G. (2003): "Reducing the time spent in emergencies". Compendium of good practices organizations, France, p. 6.in: www.anap.fr

[19] "National Forum on the health map: technical note" .in: www.health.gov.ma

1.1. The need for the implementation of the Regional Plan of Care Supply

It is through the Health Sector Management Support Project (PAGSS), which is the result of cooperation between the EU and Morocco in the field of health, that was first Regional Diagram of Care Supply in the Eastern Region.

The Regional Plan of Care Provision originated in France as a planning tool for the hospital supply, its implementation in Morocco requires some adaptations to take into account:
• the pyramidal nature of the Moroccan health system, which means that health coverage does not only include hospitals, but also the network of basic health care facilities;
• the inadequacy of health coverage, which means that the Regional Plan of Care could also target the extension of infrastructure and not just the organization of care;
• the need to consolidate health coverage gains and capitalize Morocco's experience in public supply planning, particularly that relating to the basic health care network (Health Cover Extension Plan) (PECS))[20].

1.2. General principles

The Regional Plan of Care must meet a number of principles:

a) Globalism: The principle of globalism aims at the integration of all components of the care supply:

- The three levels of use of care: primary, secondary and tertiary;
- The different types of care services: preventive, curative and promotional;
- The different components of healthcare provision: infrastructures, equipment, human resources, ..etc ;
- the different sectors of medical activities: public, private for-profit or non-profit.

b) Integration: The SROS should aim at building an integrated regional health system characterized by:

- A functional complementarity of the different components of the supply of care;
- An absence of overlap between the levels of recourse to care;

[20] "Methodology of elaboration of the regional plan of the supply of care", November 2004, Edition 2005, P 9, in: www.santé.gov.ma

- The availability of a system of referral and referral of patients between different health facilities[21].

c) Equity: this is a principle relating to medical coverage. SROS must be one of the instruments that ensure equity in the provision of care.

d) Proximity: This principle reflects the desire to allow physical accessibility to care. It assumes the use of a territorial analysis of access to care. The geographical dimension is therefore present in all SROS initiatives.

e) Sustainability: the Regional Plan of Care Supply offers justifications for a possible redeployment or mobilization of means and resources. To be viable, it must take into account resource mobilization capabilities[22].

2. The stages of development of the Regional Plan of Care Supply

The development of SROS has gone through different phases. We will report here the most important steps:

2.1. Upgrade Phase: This step includes the preparation of an enabling environment for the support project and the technical implementation of the Regional Plan of Care Supply. In this phase, two actions have been identified:

- Prepare managers and this through a 7-day training on change management.
- Conduct of an epidemiological study in the eastern region.

2.2. Regional diagnostic step: this includes the diagnosis of the Western Region health system (RO) in the form of a document prepared by the technical assistant responsible for the care sector.

2.3. The Regional Plan of Care Supply framing step:

This is marked by the following events:

- Drafting of a scoping document of SROS by the regional technical advisor. The latter had proposed a methodology for the development and general organization of the Regional Plan of Care Supply at the level of the RO region;

[21] Barreh Adaweh Ibrahim, "Organization Model of the Health Care Provision of a Health Region", presented brief for the degree of master's degree in health administration in public health, option administration Kingdom of Morocco, July 2008 .in: www.memoireonline.com

[22] "Methodology of elaboration of the regional plan of the offer of care". Idem. P18.

- The preparation of a report on the preparation and execution the Regional Plan of Care Supply by the technical assistant responsible for the latter.

2.4. Training stage: A five-day training course was consolidated by an internship in Europe carried out by a representative team of the different actors involved in the process, with the aim of training them in the following areas: the government, the council Regional Council of the College of Physicians.

3. Difficulties encountered in the development the Regional Plan of Care Supply in Morocco

The regional health organization plan approach is easier conceptually and it becomes complex and difficult at the time of its application, which has created several difficulties and obstacles to its development, namely:

- the Regional Plan of Care Supply in Morocco had no regulatory basis, that is to say that legal support is not defined as that of France[23].

- The validation of the stages of the Regional Plan of Care Supply and of the various works of development of the latter, delays at the level of the central administration. This causes a delay in the progress of the Regional Plan of Care Supply.

- A lack of training in health planning for the actors concerned is raised as the main problem to the implementation of SROS in Morocco.

- A lack of consultation between the actors. Indeed, the steering committee, bringing together all partners and representatives of the Ministry of Health in the Eastern Region, has never met until now. This is due to the lack of formalization of the SROS approach by the Ministry of Health[24].

[23] Sabrina OUHEB (2012) "Trial of analysis of the determinants of inter-hospital transfers of patients in primary and secondary care structures: Case of the Wilaya of Tizi-Ouzou". Master's thesis in economics, economics option health, Abderrahmane University MIRA de BÉJAÏA, P16

[24] AZIZ Yahya (2004): "Analysis of the process of elaboration and implementation of the Regional Plan of Care Supply" SROS ": case of the Eastern region". Bachelor's degree, National Institute of Health Administration, Kingdom of Morocco p69, In: www.health.gov.ma

To avoid these problems and to successfully develop the regional plan of the health organization, the leaders proposed the following recommendations:

- A legal framework that institutionalizes the SROS and regulates the health region.
- The need for a study on the health needs of the population concerned.

- The provision of an information system that is relevant to the profile of those responsible for providing them with reliable and complete data.

- The setting up of a steering committee which has a set of competent and well-trained managers.
- A simple methodology adopted by all stakeholders with a system of consultation and validation at the different key stages of the development of Regional Plan of Care Supply[25].

[25] AZIZ Yahya, (2004): "Analysis of the process of elaboration and implementation of the Regional Plan of Care Supply" SROS ": case of the Oriental region" .Idem. p73.

Conclusion

Everywhere in the world, we recognize today the limits of the health. France has questioned its health card as a tool for health planning since it only takes into account the quantitative aspect of the offer of care.

The establishment of the Regional Plan of Care Supply added a qualitative aspect and corrected the limits of the health map. In addition, the Regional Plan of Care Supply has set up audit and monitoring institutions (ARH, DRASS ...) whose mission is to control the activities of all institutions.

Morocco has implemented the regional health organization scheme for the first time in the West regions, however, the Moroccan the Regional Plan of Care Supply do not rely on any regulatory base as well as the lack of training for the relevant stakeholders in health planning is one of the factors of non-success of the Regional Plan of Care Supply in Morocco. In Algeria, health planning relies exclusively on the health map, which only takes into account the quantitative dimension and deals only with the geographical division of the supply of care and the quantitative distribution of equipment. The offer of private care is not integrated into the health map, especially through the lack of cooperation between the two sectors, which makes them competitive.

The Algerian health organization accuses many dysfunctions, to correct these anomalies, it is necessary to set up sustainable policies adapted to the means of the country.

As pointed , it has been establishes a descriptive review about Algerian , Moroccan and French health organization in order to review a comparative analysis between health care systems . in general , our study was based on how to integrate social systems in order to see if partnership is possible according to governments planning .

Additionally, partnership is likely face challenges to coordination as well as potential conflict over how to pursue goals, because partnership demand two parties or more rather than a systematic program that need to be pursued.

Finally, the main purpose of the examination of other countries health care system is the manage the alliances between systems before the alliances between sectors, which will leads us to applying a theory which is public-private partnership.

PART TWO: PUBLIC-PRIVATE PARTNERSHIP IN HEALTH CARE

The World Health Organization defends the objectives of universal coverage of health systems to make sure that everyone can get the services they need and are protected from the associated financial risks. Governments are increasingly engaging and interacting with the private sector in initiatives collectively referred to as public-private partnerships (PPPs) to enhance the capacity of health systems to meet this goal. Understanding the values that support collaborators and demonstrating commitment for building relationships were found to be the main abstracts in building effective PPPs; however, there remain many research gaps.

Challenges to sustainability within the health system include health system fragmentation, manpower constraints and investments in technology advancement, which put pressure on the financing capacity of the health systems to meet demands. Different forms of interactions and modes of collaboration between the public and private sectors, known as public-private partnership (PPP), have been increasingly studied as a means of mobilising resources to enhance health system capacity and sustainability. The private sector includes for profit organisations and corporations, not-for-profit nongovernmental organisations (NGOs).

However, applying the term 'partnership' to characterise the relationship between government and non-government actors is problematic because the term suggests an equal status and authority for the actors involved[26] .

Thus, in the health sector, the World Health Organization (WHO) describes partnership as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles". In this definition, agreement on key principles is considered crucial, as well as maintaining a balance of power between the parties, to enable each to retain its core values and identities .

In the global context, diverse forms of public-private interactions include modes of collaboration such as contracting public services, privately financing infrastructure properties and even funding corporate social responsibility projects with co-regulatory mechanisms. Most of these interactions and arrangements are not new, and they are currently grouped under the term of PPP[27].

To understand ppp in health much better , we'll get into reviewing internationally public-private partnership.

Public – private partnerships (PPPs), defined as cooperative institutional arrangements between public and private sector actors,

It have gained wide interest around the world. But few people agree on what a PPP actually is. Some see it as a new governance tool that will replace the traditional method of contracting for public services through

competitive tendering. Others see PPPs as a new expression in the language of public management, one intended to include older, established procedures of involvement of private organizations in the delivery of public services Yet others view PPPs as a new way to handle infrastructure projects, such as building tunnels and renewing harbors. Then there are also a number of people who seem to use the terms "contracting" and "public – private partnership" almost interchangeably. [28]

[26] Martens, J., 2003. Dialogue on Globalization: the Future of Multilateralism after Monterrey and Johannesburg. Friedrich Ebert Stiftung, Berlin

[27] Kickbusch, I., Quick, J., 1998. Partnerships for health in the 21st century. World Health Stat p.69

[28] Linder , Stephen . 1999 . Coming to Terms with the Public – Private Partnership: A Grammar of Multiple Meanings . *American Behavioral Scientist* 43 (1): 35 – 51

The benefits or otherwise of private service provision versus government service provision and intervention in the economy have driven an important continuing debate. There is a certain amount of neologism attached to the use and discussion of PPPs, though. That is, PPPs are hailed as the main alternative to contracting out and privatization, and thus they are seen as a qualitative jump ahead in the effort to combine the strong sides of the public sector and the private sector. Many articles and papers are devoted to the study of PPPs because the concept promises a new way of managing and governing organizations that produce public services. Yet history indicates that there has always been some degree of cooperation between the public sector and the private sector The stories of private contracting in the public sphere are numerous: Mathew the private tax collector from the Bible; the private cleaning of public street lamps in 18th-century England; the private railways of the 19th century; or the fact that 82 percent of the 197 vessels in Sir Francis Drake's fleet, which successfully conquered the Spanish Armada in 1588, were private contractors to the Admiralty[29].

In recent history, the commercial company Falck (at one stage a part of the global company Group 4 Securicor) has partnered with the Danish public sector for nearly 100 years. We might view many of these arrangements as early cooperative forms of partnership. Throughout this time, arguments about efficiency, service quality, and accountability in the two sectors have been well rehearsed. These days, public – private partnerships have become a central tenet of "third way" governments.

[29] Wettenhall , Roger . 2003 . The Rhetoric and Reality of Public – private Partnerships . *Public Organisation Review: A Global Journal* 3 : 77 – 107

1- Public – Private Partnership defined

Public – private partnerships defined as cooperative institutional arrangements between public and private sector actors, have got massive interest around the world. PPPs are also seen as financial models that enable the public sector to make use of private finance capital in a way that increases the possibilities of both the government and the private establishment.

PPPs are contractual arrangements of varied nature where the two parties share rights and responsibilities during the duration of the contract. Different forms of PPPs may exist involving various combinations of public and private sector finance and exposure to project risk. The various arrangements often reflect the different appetites for risk and the role of the private party varies based on the sector and the nature of the market. This guide focuses on those PPPs that involve significant private financing because these are usually more complex to prepare and imply a greater involvement from both parties throughout the life of the project.[30]

2- Privatization and Management Contracts

PPPs are often confused with privatization. There is a clear difference between these two forms of private sector engagement: privatization involves the permanent transfer of a previously publicly owned asset to the private sector, Whereas a PPP necessarily involves a continuing role for the public sector as a "partner" in an ongoing relationship with the private sector[31].

Under a PPP, accountability for provision of the service is clearly in the hands of the public sector, and there is a direct contractual relationship between the government and the private sector provider. With privatization, immediate accountability for providing the service may often transfer to the private provider (although ultimately

[30] Edward Farquharson, Clemencia Torres de Mästle, E.R. Yescombe, and Javier Encinas**,** How to Engage with the Private Sector in Public-Private Partnerships in Emerging Markets, 2011, p9

[31] When privatization is partial rather than total, the public sector may remain involved in the firm depending on the degree of control actually transferred to the private sector

the citizen may hold government accountable): if the telephone in a privatized telecommunications utility does not work, the citizen will normally complain to the private provider, but if a PPP hospital is closed, the citizen will still hold the government immediately accountable.

These distinctions can be important when governments seek to engage public understanding of and support for PPPs and begin to identify the skills and processes needed for the very different PPP processes. Some governments have deliberately sought to brand their PPP programs to distinguish them directly from privatization and in some cases even from previous forms of concessioning. In Mexico, for example, certain PPP projects are referred to as projects for the provision of services (PPS), and in Peru PPP projects have been branded in the legal framework as co-financed concessions.

Other forms of private sector involvement may entail shorter-term management contracts or (longer-term) lease or afterimage arrangements with limited private sector investment. Management of rural roads and water and sewerage projects often use this approach. Urban water utilities in developing countries, for example, may involve leases or afterimage contracts, where the private sector enters into a long-term arrangement with the public authority to operate and maintain a facility and implement an investment program in the utility, although the public sector retains the responsibility for financing the investment. These projects share some common characteristics with the capital-intensive PPPs discussed in this guide, and many of the steps described may be equally applicable to preparing such projects and attracting good operators. However, the transfer of risks to the private sector is more limited, with implications for the incentives and nature of the partnership. In particular, while the private party's profit may be at risk under a management contract, only limited private sector capital is at stake, and therefore important disciplinary mechanisms found in capital-intensive PPPs, such as the lenders' due diligence and subsequent

exposure of capital investment to performance risk, are absent or at least considerably reduced.[32]

3- Role of Public-Private Partnerships

Many governments turn to the private sector to design, build, finance, and/ or operate new and existing infrastructure facilities in order to improve the delivery of services and the management of facilities hitherto provided by the public sector. Governments are attracted by the benefits of mobilizing private capital: the estimated demand for investment in public services shows that government and even donor resources cannot fill the investment gap alone, and so harnessing private capital can help to speed up the delivery of public infrastructure. PPPs, in particular those with long-term contracts, can bring significant benefits for governments in the delivery of public services, such as the following:

3.1- Greater efficiency in the use of resources.

By allocating the management of risks optimally between the public and private sectors, a well-managed PPP preparation and bidding process can enable a more efficient use of resources over the lifetime of the asset, as the private partner has an incentive to consider the long-term implications of the costs of design and construction quality or the costs of expansion in the case of existing facilities. At the same time, the long-term nature of the contract can generate greater certainty (or even a reduction) in the price of service delivery, in real terms. This is especially the case for those PPPs, where the public sector is purchasing a service on behalf of the taxpayer: known prices have clear value within a highly constrained public sector budgetary system, as they greatly reduce the likelihood of surprises down the line. This also ensures budgeting for proper long-term maintenance of assets, which is often omitted in traditional forms of public sector procurement to the detriment of the asset and the taxpayer.

[32] Edward Farquharson, Clemencia Torres de Mästle, E.R. Yescombe, and Javier Encinas**,** How to Engage with the Private Sector in Public-Private Partnerships in Emerging Markets, 2011,idim p10

3.2- Capital at risk to performance.

The explicit exposure of capital to long-term performance risk gives the private party an incentive to design and build the asset on time and within budget and to take into account the costs of longer-term maintenance and renewal. It underpins the required allocation of risks.

3.3- Quality assurance and scrutiny.

The PPP process usually involves a much greater level of quality assurance than the standard public procurement process as the public authority prepares its projects and engages with the market. The public authority will face scrutiny by parties outside government, such as lenders and investors, whose capital will be at risk over the long term, depending on the performance of service delivery.

3.4- The more open scrutiny

The more open scrutiny of the long-term commitment required of a PPP usually requires information about the true long-term risks and therefore costs to deliver the public service. This scrutiny can generate a more informed and realistic debate on project *selection* and a focus on *outputs* and even *outcomes.* Such additional quality assurance and scrutiny are often absent in conventionally procured projects.

These benefits have important implications for PPP policy even where the availability of long-term private funding is more constrained. In other words, there are some fundamental policy drivers to use PPPs even if, at times, private financing is constrained. Looking ahead, good PPP structures can endure and can simply adapt to changes in the market.

PPPs therefore can make governments think and behave in new ways that require new skills. They can be a tool for reforming procurement and public service delivery and not merely a means of leveraging private sector resources. PPPs are also more than a one-off financial transaction with the private sector. As a consequence, they need to be based on firm policy foundations, a long-term political commitment, and a sound and predictable legal and regulatory environment. Sophisticated private sector partners

understand this and will look for these factors when deciding whether or not to bid for a project. The other challenge for governments, especially in emerging markets, is the fact that resources are usually less readily available for activities that lay the *foundations* for a successful PPP than for project-specific procurement activities. However, without the right policies, institutions, and processes, the transactions that follow will often fail. Most forms of PPP involve a contractual relationship between the public and private parties (for example, a concession). The long-term nature of these contracts can create a strong long-term mutuality of interest: they differ from traditional (input-based) procurement contracts, under which the client government will often be tempted to micro-manage the decisions of project implementation and so carry much of the associated risk. Contractors seldom miss the opportunity to increase their prices, which are linked to inputs, and so this style of contract is often associated with a short-term "claims culture."

Early evidence of operational contracts in more mature PPP programs shows that in many cases the parties recognize this mutuality of interest without adversely affecting the mechanisms in the formal contract that determine performance (Ipsos Mori Social Research Institute 2009).[33]

4- Legal and Regulatory Framework

With regard to the payment of PPPs, private investors will seek clarification on the government's commitment to adopt a pricing policy that ensures the financial viability of the contract (accompanied by the adoption of transparent subsidies if the government decides that not all consumers can afford to pay cost recovery rates). In addition, regulatory frameworks may be needed in many infrastructure sectors where purchasing power parities are likely to be used.

In some cases, sectors may be subject to reform and the signing of a contract may be preceded by the adoption of a broader sectorial framework. When the regulatory framework and institutions are already in place, private investors will always assess

[33] **Edward Farquharson, Clemencia Torres de Mästle, E.R. Yescombe, and Javier Encinas,** How to Engage with the Private Sector in Public-Private Partnerships in Emerging Markets, 2011, ibidim, p3

characteristics such as technical capacity and independence of regulators, predictability of decisions and transparency of operations. The existence of clear monitoring mechanisms is also important to supervise the project after signing it Private investors will always review the legal and regulatory framework and its ability to ensure the effectiveness of long-term PPP contracts. Legislation may be needed to allow a private company to charge and collect user fees. Specific laws may be needed to allow the public sector to conclude contracts with private bodies to provide services provided by the State only. For example, considerable efforts were needed to introduce major reforms to allow private sector, as this increases the predictability and transparency of all concerned. In short, governments need to lay the foundations for private sector involvement by developing an appropriate legal, regulatory, institutional and contractual framework.[34]

It may also depend on whether the Government is already engaged in comprehensive sector reform (often involving PPP) and has developed regulatory frameworks for the sector. Alternatively, there may be countries where the opportunity to do one or more PPPs occur before a legal and regulatory decision is taken. The frame is in place. In this case, these leading transactions - just fine Organizer - can be the first steps in building a broader framework, That specific provisions could be incorporated into the frame. It is also true that while specific conditions may vary Should be taken into account, countries can also benefit from them Legal and regulatory solutions used in markets Running PPP programs, where the private sector is already familiar These approaches. [35]

It is often necessary to strike a balance between a fixed legal and regulatory framework flexible and flexible framework able to respond to evolutions in best practices over time. In general, investors have a strong preference for certainty, detail and clarity in the legislative framework, provided that it is a good frame. However, as a warning, very detailed legislation on PPPs or sectorial legislation has sometimes

[34] **Edward Farquharson, Clemencia Torres de Mästle, E.R. Yescombe, and Javier Encinas,** How to Engage with the Private Sector in Public-Private Partnerships in Emerging Markets, 2011, ibidim, p4

[35] For more information on contracts, laws, and regulations for PPPs in infrastructure, visit the Web site of the PPP Infrastructure Resource Center for Contracts, Laws, and Regulations: http://www.worldbank.org/pppiresource.

been developed from the beginning step of a PPP program without contribution of real project experience (operating either nationally or internationally). This legislation has sometimes proved impractical and difficult to change. It can sometimes be better to set out basic principles (based on the best practice) in the framework legislation and to use rules or administrative regulations to establish more detailed rules that can respond, in a logical and coherent manner, and in a consultative manner, to the inevitable changes of policy and market (as long as it does not lead to a host of conflicting and arbitrary rules and regulations).

That said, the experience of developing countries with weak institutions and weak institutional capacity have shown that in some case, leaving too much discretion to design and modify specific rules and regulations can lead to ineffective results, because government officials managers do not have the technical expertise to develop or supervise them appropriate external consultants who can advise them. So, there may be a case in these circumstances to have less flexibility and instead of establishing clear but stable rules that would benefit from the growing body of international experience in regulating infrastructure sectors and the implementation of PPP programs.

It is important to remember that private financings - bondholders and equity investors - require contractual and, where appropriate, regulatory certainty as a precondition for participation in a PPP in which their capital is exposed to risk (which is normally the case). Governments sometimes prepare standard or standardized project agreements that set out the obligations of public and private parties in great detail, reflecting the fact that the two parties share the risks. This may take the form of mandated contracts that are not open to negotiation (an approach currently used, for example, in India), or perhaps a more exegetical document, ie a document that sets out and explains the basic principles with only certain key terms and mandatory conditions (the UK government adopts this approach with its standardized form of Private Financing Initiative Contract). At the other extreme, contracts can be negotiated separately for each project. The latter approach can result in more time and money, as well as the likelihood that rights and obligations, and therefore the distribution of risks, will vary

from contract to contract. more than they need: this could also reduce the transparency of the process and leave too much room for ad hoc negotiations for lack of a clear reference framework. In fact, many risk allocation issues will be similar across projects, and it is preferable that the public sector adopt a consistent approach and a clear framework for contracting, solicitation and disclosure. evaluation of offers from investors and interested operators . The unification of some forms enables the public sector to negotiate as a whole - and therefore more effectively - on key issues and to ensure a level of consistency across contracts. At the same time, standard contracts, with key terms locked, can hold back the essential innovations and adjustments required by market, policy or sector specific issues, and therefore a disciplined centralized process of review and time-to-time review is also important.

There is a balance to be achieved between the advantages and limitations of giving greater flexibility to bidders or operators, which will often depend on the sector in which they operate and the nature of the contract. The balance also depends on the PPP eligibility of a given country or sector. The costs of preparing and managing a PPP project will have a direct impact on the benefits PPP can offer as an alternative.

Standard guidance and sector-specific model contracts can help improve this value for money, as these measures can be used to identify lessons learned from closed projects related to subsequent projects. Can also promote a common understanding of the main risks faced by PPP projects and reduce the duration and cost of negotiations - reducing transaction costs to implement a PPP project and improving the quality of contracts. However, using standardized contracts to transfer experience from the former to the latter.

It is difficult to achieve at the beginning of the purchasing power parity program or before implementing some Pathfinder projects; therefore, an important team of consultants with international experience and a full understanding of the legal framework can play an important role. It may be wrong to consolidate contracts (authorization) before accumulating sufficient experience and disseminating good practices among government entities involved in the preparation and equivalence of

procurement offers. At the same time, the wait may not be long to adopt standardized contracts is optimal, where the public sector will give up the advantages that some standardization can provide. The broader procurement law may also have an impact. In many countries, particularly in Latin America, the Procurement and Jurisdiction Act, and therefore the new PPP legislation, will likely require the Procurement Authority to submit a model contract to bidders who will not be open to negotiation as soon as the procurement process begins or after which the bidders are on the list. In such cases, where structured dialogue with bidders is limited or prohibited, the process of consultation before the bidding process will be of paramount importance if the public sector wishes to take into account innovations and requirements of the private sector. In these countries detailed preparation of the project requires early action. The Implementation is required to determine the detailed scope of the project, identify the outputs, identify the risks and allocate them, and market probes, which are discussed later in this manual, before the bidding process begins and before the views of the private party in the known situation competition. The role of advisors in the development of a reasonable risk matrix will be of particular importance, as will the use of model guidelines and conventions, which call for a strong and PPP unit. Once the contract is signed, it is generally good practice, and for transparency, to make the contract available to the public through, for example, publishing the contract on the PPP website (subject to any sensitive issues).

5- Public–Private Partnerships as Organizational and Financial Arrangements

Develop public-private partnerships because they can benefit the public and private sectors. The inference is simple - both public and private have specific characteristics, and if these characteristics are combined, the end result will be the best of all. There is agreement in the literature that risk sharing is the main consideration of both sectors in combining these qualities. In addition to uncertainty in the future, another

component is the knowledge that everything cannot be written in a detailed contract [36]Cooperation may require some new products or services that no one has ever thought of whether public institutions and private organizations have adhered to them. Finally, a partnership involves a commitment that may continue for a number of years.

More formally, Dutch public administration specialists [37]define PPP through an institutional perspective as "sustainable collaboration between public and private actors involved in the development of products and services and the exchange of risks, costs and resources associated with these products" (2001, 598). This definition has many advantages: first, it highlights the cooperation of some durability. Cooperation can occur only in short-term contracts. Second Infrastructure projects include many forms of contractual arrangements. These arrangements include BOT and BOOT, as well as so-called sale and re-lease agreements under which local governments sell their premises, lease under a contract of 20 or 30 years with a financial institution. Not surprisingly, with a general infrastructure, there is a narrower definition of PPPs. It focuses on risk sharing as an essential element and other factors of participation. The Parties shall form a partnership together and on an equal footing shall bear some of the risks involved. There can be several types of risk. Third, they produce something common (product or service), and perhaps implicitly, each of which has everything to take advantage of a joint effort. [38]

For example, Campbell [39]simply points out that "a PPP project usually involves the design, construction, financing, maintenance (and sometimes running) of public infrastructure or utilities by the private sector under a long-term contract." The broader interpretation of the partnership that maintains the organizational aspect

[36] Williamson , Oliver . 1985 . *Th e Economic Institutions of Capitalism* . New York : Free Press .

[37] Van Ham , Hans , and Joop Koppenjan . 2001 . Building Public – Private Partnerships: Assessing and Managing Risks in Port Development . *Public Management Review* 4 (1): 593 – 616 .

[38] Savas , E. S . 2000 . *Privatization and Public – Private Partnerships* . New York : Chatham House .

[39] Campbell , Greg . 2001 . *Public Private Partnerships — A Developing Market?* Unpublished manuscript .

but considers it from an inter-organizational perspective is the design of policy networks as special arrangements for public-private cooperation.

Table 1: A Typology of Public – Private Partnerships Based on Financial and Organizational Relationships

Finance/ Organization	Tight Organizational Relationship	Loose Organizational Relationship
Tight financial relationship	Joint-venture companies Joint stock companies Joint development	BOOT, BOT, Sale and-lease-back
Loose financial relationship	Policy communities	Issue networks

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In general, PPPs appear to have at least two dimensions. The first dimension is financing: how do public and private actors contribute financially to purchasing power parities?

The other dimension is the organization: what is the precision of the organization of public actors and private actors?

There are also many other uses of the PPP concept. Osborne[40] points out that, in addition to being the cornerstone of New Labor's stakeholder community in the UK, PPPs has become a tool for delivering public services and developing civil services. Community in post-communist systems such as Hungary, as well as a mechanism to combat social exclusion and promote community development within the framework of EU policy. In the United States, purchasing power parity is traditionally associated with urban renewal and the economic development of the city center. Purchasing power parities "were central to national and state governments' efforts to renew local urban communities, as well as community-led attempts to address the government crisis in local companies ".

[40] Osborne , Stephen . 2001 . *Public – Private Partnerships: Theory and Practice in International Perspective* . New York : Routledge

The concept of public-private partnership seems to involve at least five arrangements:

1- Institutional cooperation for joint production and risk sharing - An example of this institutional importance is the Dutch Ports Authority.

2- Long-term infrastructure contracts focusing on the precise definition of results in long-term legal contracts,

3- Policy networks with a focus on stakeholder relationships,

4-Civil society and community development in which the symbolic partnership of cultural exchange is adopted, as in Hungary and Europe,

5- Urban renewal and economic development of US city centers, for example, follow a set of measures for local economic development and urban renewal.[41]

It is clear that families of public-private partnerships cover a wide range of governance types, rather than the experience of the UK or US PFIs in procurement. Although they are not exclusive, they seem to cover very different areas, with emphasis on different properties or general mechanisms.

Each PPP family has different effects from conventional contracts: long-term effects, potentially greater role in infrastructure decision-making, higher cash flow, and greater transfer of risk to all aspects of the partnership. Each can have different accountability implications to ensure that this type of governance maintains public accountability at a high level.

[41] Weihe , Guri . 2005. Public-Private Partnerships. Addressing a Nebulous Concept, Working Paper No. 16, Copenhagen, International Center for Business and Politics, Copenhagen Business School.

Public-private partnership in health care

PPPs have become a common approach to health care problems worldwide, and recently there has been enthusiasm for using PPPs to improve the delivery of health and welfare services for a wider range of health problems.

The World Health Organization (WHO) has played a significant role in formulating health policies and prescribing standards of health care, welcomed and encouraged partnerships between the state and the market in financing, provisioning, and researching health care.

Furthermore, with growing financial pressures on service providers, public and private community leaders were looking more and more at these types of partnerships as a way of tackling a broad range of community health needs and rationalizing the allocation of local health care.

Moreover, the rapid change in the provision of health care, due mainly to ageing populations, medical-technological developments, and policy changes, meant that governments around the world were dealing with problems such as booming health care costs and decreasing governmental budgets.

For many governments, PPPs between health care providers and the private sector represented a way of coping with such problems. This development conveniently overlooked the emerging evidence that questioned the myth that competitive markets facilitate increases in cost containment, equity, or efficiency in health care markets.

PPPs in the health sector can take a variety of forms depending on the degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, risks, and rewards, as might be defined in a contract or manifested through a different arrangement.

PPPs, when appropriately structured and implemented, help address specific cost and investment challenges, deliver improvements in service efficiency, and enhance service quality. However, the structuring and implementation of PPPs may not be easy, as in many cases they may not be the most effective or efficient option available. For this reason, a careful evaluation of the conditions for success and sustainability is

required on a case-by-case basis so as to assess the costs and benefits and the likelihood of success of such an approach.

A- Effectiveness

While PPPs can provide a mechanism for achieving the comparative advantages of public and private sectors in mutually supportive ways, several issues are critical and need to be carefully considered when implementing a PPP.

Despite the involvement of the private sector in PPP projects, the government needs to continue playing the role of regulator, especially in health care sectors, where accountability is critical and the public interest is at stake.

In particular, the public sector should continue to set standards and monitor product safety, efficacy, and quality, and ensure that citizens have adequate access to the products and services they need. In other words, PPPs do not imply 'less government' but a different governmental role[42].

Moreover, because of the stronger position of the private partner in such partnerships, more active government participation is often needed.[43]

In analysing the poor–reach health disparity in developing countries, explains that one of the major areas requiring attention is the inefficiency of the pharmaceutical distribution system. In this context, partnerships between the public and the private sector have a contribution to make in improving the health of the poor by combining the different skills and resources of various organizations (public and private) in innovative ways.

However, in order to be beneficial, the public sector should continue to:

- Fund fundamental research;
- Set standards for product safety, efficacy, and quality;

[42] Jamali, D. (2004) Success and Failure Mechanisms in Public Private Partnerships (PPPs) in Developing Countries. Insights from the Lebanese Context. International Journal of Public Sector Management, 17:5 p414–30.

[43] Scharle, P. (2002) Public–Private Partnership (PPP) as a Social Game. Innovation: The European Journal of Social Sciences, 15:3 pp227–52.

- Sstablish a system whereby citizens have adequate access to health product and services;
- Use public resources in an efficient manner;
- Create environments in which commercial enterprises are appropriately motivated to meet the needs of the entire population.

Another important element considered fundamental to PPPs' effectiveness is the regulatory framework in which they take place. The establishment of a transparent and sound regulatory framework as a necessary precursor to private sector participation.
Regulation provides assurance to the private sector (protection from expropriation, respect of contract agreements, etc.) and to the public sector as well, by ensuring that essential partnerships operate efficiently and optimizing the resources available to them in line with broader policy objectives.[44]
The PPP project where there is not enough emphasis on the extent and nature of stakeholders' involvement. The importance of stakeholders' involvement has been found in the asymmetri- -cally distributed in the partnership, and that there is greater reliance on informal mechanisms of coordination. However, for PPPs to be effective, it is important to reduce the power asymmetry between partners and to rely on informal mechanisms of coordination and trust.

PPP effectiveness can be achieved by addressing the way contractual arrangements are structured and the degree of flexibility they generate. Moreover, they identified certain features that appear to be particularly significant in determining the flexibility of PPPs in health care, such as knowledge and expertise, combined with competent management of the contractual arrangements; the contract; the way the project is financed; and the existence of a dependency between the funding for the clinical services and the expenditure of the health authority on PPPs. They conclude by suggesting that health authorities should address those determinants in order to

[44] Di Lodovico, A. M. (1998) 'Privatization and Investment Under Weak Regulatory Commitment'. Unpublished PhD dissertation, University of California, Berkeley, CA.

prevent the development of hospitals that lack the ability to respond adequately to the uncertainties associated with their immediate contexts.

Despite the increasing attention paid to PPP effectiveness in the health care sector, few studies provide a protocol for evaluating PPP effectiveness, mainly because there is a lack of firm evidence of the effectiveness of PPP projects.

It has been pointed out a number of elements that should be considered when evaluating the effectiveness of a PPP. It has been proposed a protocol for evaluating the effectiveness of a PPP as a means of improving health worldwide.

There are seven principal aspects to the protocol:

1. The relationship between the public and private sectors.
2. The nature of the partnership between public and private sector participants.
3. The financial arrangements of the PPP project.
4. The government policy enacted to promote partnership efforts.
5. Identification and quantification of PPP outcomes.
6. Assessing issues of equity.
7. Identifying the potential weakness of the analysis.[45]

PPP effectiveness is not always guaranteed, because of the complexity of PPPs, during the implementation phase several issues can arise. With the implementation of PPPs for hospital building, the issues have been summarized in elements which are:

1. COSTS:

The costs involved in PPPs are frequently underestimated. Moreover, it is difficult to make accurate cost comparisons between the cost of PPPs and more conventional methods.

2. QUALITY:

Usually when a problem arises in PPPs, there are trade-offs between three variables: cost, time, and quality. While cost and timing seem to be fixed in PPP contracts,

[45] Barr, D. A. (2007) A Research Protocol to Evaluate the Effectiveness of Public-Private Partnerships as a Means to Improve Health and Welfare systems Worldwide. American Journal of Public Health, 97:1 pp19–25

concerns arise concerning the quality of projects and many hospitals built under PPPs in the United Kingdom have experienced such problems.

3. FLEXIBILITY:

While the delivery of health care is changing rapidly, partly in response to altered demands on health-care systems, PPP contracts are often specified in very great detail, with large penalties for introducing changes and elements of flexibility.

4. COMPLEXITY:

PPP projects involve many different types of stakeholders. They also require the active participation of universities and research funders. The difficulties in reaching an agreement with all of these stakeholders, combined with the high costs of the projects, have led to the collapse or to the failure of many projects in the United Kingdom and worldwide. These experiences raise questions as to whether this model can be simplified sufficiently for use with very complex projects.

B- Benefits

Partnerships between the public and the private sector are often seen as offering innovative methods with a good chance of producing the desired outcomes. One primary benefit is that each sector contributes what it most has to offer, and the combination of these skills, abilities, and powers has the potential for producing the best results. Yet neither the public nor the private sector is capable by itself of solving the numerous problems the health sector is facing worldwide. In contrast, PPPs combine the best of both worlds: the private sector with its resources, management skills, and technology; and the public sector with its regulatory actions and protection of the public interest.[46]

[46] UNECE. (2008) Guidebook on Promoting Good Governance in Public-Private Partnership. Geneva: United NationsEconomic Commission for Europe

This balanced approach is considered particularly beneficial in the delivery of health care services.

PPPs can produce innovative strategies and positive consequences for well-defined public health goals, and they can create powerful mechanisms for addressing difficult problems by leveraging the ideas, resources, and expertise of the different partners.[47]

PPPs in the health sector can not only fill the gaps in the spread and prevalence of the health care infrastructure, it also offer a range of other potential benefits, such as:

– Enabling existing health infrastructures to be used with enhanced efficiency.

– Health, poverty alleviation and development programmes run primarily by governments can be speeded up with PPPs.

– The primary constraint in relation to the effective execution of the developmental efforts is improper communication and government work culture, which leads to the demotivation of the programme execution teams and beneficiaries as well. Motivation can be restored by PPPs (and this is the first level of achievement to be achieved).

– Some parts of the population, i.e. those living in the country and the poor, need to be considered as markets and their status as a market can be established through a PPP.

The relatively new trend in global health care of cooperation between the public and the private sectors also opens up significant possibilities for tackling problems that previously seemed intractable, particularly those requiring increased research and development on drugs and vaccines for diseases that disproportionately affect the poor.[48]

For example, several partnerships are achieving positive results in the fight against infectious diseases. Partnerships with the private sector have also demonstrated an ability to advance public health messages and create industry incentives for the development of healthier products, but also risks for the public sector and for public health[49].

[47] Reich, M. R. (2002) Public–Private Partnerships for Public Health, Cambridge, MA: Harvard Center for Population and Development Studies

[48] Buse, K. and Waxman, A. (2001) Public-Private Health Partnerships: A Strategy for WHO. Bulletin of the World Organization, 79:8 pp748–54

[49] Barlow, J. and Köberle-Gaiser, M. (2009) Delivering Innovation in Hospital Construction: Contracts and Collaboration in the UK's Private Finance Initiative Hopitals Program. California Management Review, 51:2 pp126–43.

This means that PPPs need to be carefully implemented if the expected benefits are to be reaped. for example, using a multiple-case study on six hospitals built under Private finance initiatives (PFI) in the United Kingdom, found that to be beneficial a PFI needs a rigorous risk analysis and optimal risk allocation; synergies through improved integration of design, construction, operation, and maintenance; and a focus on whole-life costing and long-term performance management. Furthermore, they state that consideration needs to be given to whether the PPP will deliver the desired benefit in terms of stimulating innovation in new hospital schemes. Finally, it has been argued that major improvements in health systems require an approach that simultaneously addresses not only infrastructure and financing, but also access, service delivery, and management, to achieve better patient outcomes.[50]

C- Public interest

One of the main concerns relating to PPPs in health care sector is their impact on public interest. This is understandable, as the private partner may not necessarily have public interest as a primary goal.[51]

PPPs either can be interpreted as purely commercial ventures with an economic interest or can be seen as public policy in action. This means that partnerships can play out at any point along a spectrum from integrity–trust to unethical, scheming–political behaviour.[52]

For example, PPPs in the UK, National Health System are driven by a questionable politico-economic rationale.

In England they are associated with reduced health system capacity. Indeed, PPPs have reduced the provision of health services, harming the public interest. This is due to the underfunding generated by the cost of PPPs, which creates pressure for cuts in service provision in order to reduce deficits.

[50] Sekhri, N., Feachem, R. and Ni, A. (2011) Public–Private Integrated Partnerships Demonstrate the Potential to Improve Health Care Access, Quality, And Efficiency. Health Affairs, 30:8 pp1498–507

[51] Friend, J. (2006) Partnership Meets Politics: Managing within the Maze. International Journal of Public Sector Management, 19:3 p261

[52] Johnston, J. and Gudergan, S. P. (2007) Governance of Public–Private Partnerships

Despite the potential that exists in collaborating with the private sector, certain measures must be taken at a global level to assist global partnerships and set a framework within which efforts at the country level can emanate.

As a first step there is a need to develop a set of global norms and ethical principles. It is critical that the driving principles of such initiatives be rooted in the benefit for the society rather than the mutual benefit for the partners and that they should centre on the concept of equity in health.[53]

The implementation of a PPP requires critical policy reflection, especially when the interactions between public and private sectors are likely to positively and negatively impact the achievement of health for all. It requires adopting the well-proven policy paradigm in which public–private relationships are seen as potentially problematic interactions between two separate spheres. It means being very clear about the aim of private partners, which is to generate a profit for their companies. It is about asking Who wins what?, Who risks what?, and about exercising appropriate caution in order to preserve the public interest.

D- Efficiency and value for money

The divergent goals of PPP public and private sector partners is the key factor that brings into question the necessity of assessing project efficiency at microeconomic level when judging the success or failure of a PPP.

The main reason for starting a PPP is the cost saving that arises from delivering a project via PPP rather than traditional methods. These savings can result from the greater innovation and efficiency of the private sector compared with the public sector.[54]

The private sector generally achieves higher operational efficiency in asset procurement and service delivery by applying its expertise, experience, and innovative

[53] Nishtar, S. (2004) Public–Private Partnerships in Health: A Global Call to Action. Health Research Policy and Systems, 2:1 pp5–12.

[54] Grimsey, D. and Lewis, M. K. (2004) The Governance of Contractual Relationships in Public Private Partnerships. Journal of Corporate Citizenship, 15:1 pp91–109.

ideas/technology. Overall project cost savings can be achieved by striving for the lowest possible total lifecycle costs while maximizing profits[55].

Value for money (VFM):

It is the optimal combination of whole lifecycle costs, risks, completion time, and quality in order to meet public requirements, In another important consideration, especially for the public sector, There are six determinants of VFM:

– Risk transfer.

– Long-term nature of contracts.

– Competition.

– Performance measurement and the use of an output specification.

– Performance measurement and incentives.

– Private party's management skills.

Often when the government approves a project in which it is seeking to involve the private sector through a PPP, private sector bids are assessed against public sector benchmarks to determine VFM. The public sector comparator is the tool most commonly used by the public sector to show how much it would cost the government to build the asset through public funding, which is then compared with how much it would cost to build the asset as a PPP.

The main reason and justification given by governments for entering into PPPs is to secure VFM and if this objective is not achieved, the arrangement will have no legs to stand on. It is therefore essential to plan and design the partnership so as to achieve VFM assurances, and this must be the guiding principle for government's right from the start.[56]

A novel feature of the VFM technique is that apart from the expected financial costs, it also includes the costs of some of the risk associated with the project. Since some of the risks are to be transferred to the private sector, the PPP option should provide a

[55] Cheung, E, Chan, A. and Kajewski, S. (2005) Enhancing Value for Money in PPP Projects: Findings from a Survey Conducted in Hong Kong and Australia Compared to Findings from Previous Research in the UK. Journal of Financial Management of Property and Construction, 14:1 pp7–20.

[56] Sethumadhavan, T. (2010) Public Private Partnership (PPP) and Accountabilty Concepts. Indian Journal of Public Audit and Accountability, 3:3 pp1–9.

greater VFM than a publicly financed alternative where the public sector bears all the risks.[57]

Despite the importance of assessing VFM before starting a PPP project, some authors have reported that this is often not carried out. For example,[58] in analysing six PPPs in the Italian health sector, found that;

(a) in the majority of cases, recourse to a PPP was not due to an evaluation demonstrating that it would be more advantageous than traditional public financing, but because the public sector lacked the necessary resources to carry out the investment;

(b) the failure to use methodologies such as VFM is often the consequence of the behaviour of politicians at the regional administration level;

(c) analysis of the private partner selection process for the PPPs in question showed that the most common economic criterion included in the call for bids was the financial contribution of the private partner to the PPP.

Furthermore, describing the microeconomic argument for PPP solutions stated that the cost-efficiency case for PPP appears weak, since public finance is always cheaper than private finance. Moreover, they underlined that to be VFM a PPP must more than offset the higher cost of finance through better management of risk by the private sector. While in theory it is possible that the private sector will be able to provide this, there is clearly a need for proper evidence to be supplied in support of this analysis. However, the evidence base on PPP performance and efficiency is still poor.[59]

E- Partners

In the absence of viable and efficient alternatives for implementing large investment projects, the use of PPPs seems inevitable. However, one major disadvantage to them is the constant conflict of interest between the PPP partners. By definition, PPPs

[57] Edwards, P. and Shaoul, J. (2002) Controlling the PFI Process in Schools: A Case Study of the Pimlico Project. Policy & Politics, 31:3 pp371–85.

[58] Barretta, A. and Ruggiero, P. (2008) Ex-ante Evaluation of PFIs within the Italian Health-Care Sector: What is the Basis for this PPP? Health Policy, 88:1 pp15–24.

[59] Hellowell, M. and Pollock, A. (2009) The Private Financing of NHS Hospitals: Politics, Policy and Practice. Journal of the Institute of Economic Affairs, 29:1 pp13–19.

involve a partnership between two structurally different organizations with different strategies and operational goals.[60]

While the partners belonging to private sector aim either to maximize their profit margins or to enhance the performance of their own business, the partners belonging to the public sector aim to optimize the social, political, and budgetary objectives.

The major risk related to the relationship between partners is the creation of unbalanced partnerships. Becker and Patterson[61] reported that unbalanced partnerships are not to be expected and should be avoided. An unbalanced partnership may result from one or more of the following conditions:

– In certain cases of fraud or abuse of office, public officials abrogate their responsibilities for participation, oversight, or leadership.

– Public officials may not have the experience or training to be an effective partner in such relationships. They may defer inappropriately to the substantive or negotiating expertise of the private partner.

– The roles of the partners may not be clearly defined.

– The public partner may attempt to be the general partner when, in fact, it should be the limited partner.

Given the importance of PPP partners, the selection of the right partners is critical. But which criteria should be used for the selection of candidate companies? Although there is no single and clear answer, it is fundamental that the public sector ensure that the selection process for partners is fair and transparent. In the absence of such a process, not only may the right partner not emerge to undertake the tasks, but also the entire process may get bogged down in avoidable disputes, litigations, etc., which will impede the progress of the projects.[62]

[60] Zhang, Z., Wan, D., Jia, M. and Gu, L. (2009) Prior Ties, Shared Values and Cooperation in Public–Private Partnerships. Management and Organization Review, 5:3 pp353–74.

[61] Becker, F. and Patterson, V. (2005) Public Private Partnerships: Balancing Financial Returns, Risks and Roles of the Partners. Public Performance & Management Review, 29:2 pp125–44.

[62] UNECE. (2008) Guidebook on Promoting Good Governance in Public-Private Partnership. Geneva: United Nations Economic Commission for Europe.

F- Public-private partnership for hospitals

The provision of health care in almost all countries involves a form of public-private partnership. In countries where care is primarily provided through the public system, many inputs, such as medicines and support services, come from the private sector. In countries with special facilities often, the state influences its composition through regulation and financial incentives. In hospitals, the situation is more complex because of many of the functions performed by these institutions: training of health professionals and research and development, for example, activities financed from the public sector to varying degrees.[63]

Although, even the concept of public-private divide is problematic. States often limit the number of private sector contractors to determine the location of firms. In addition, there is a difference between for-profit companies that run hospitals as a business among many non-profit organizations only available to provide health care.

From this state , we will examine the construction of how to run hospitals by our theory:

The model in which the public authority contracts with a private company for the construction or management of a hospital is inevitable, especially in countries where national health services are provided. for example, Australia has the most diverse range of models, with differing versions in several states.[64]

In the United Kingdom, The Private Finance Initiative (PFI) is a design, build, finance and operate (DBFO) model. It has been the primary means of financing major capital investments in the health, during the past two decades. This arrangement allowed the government to stay within the targets of public sector borrowing. The actions taken by the British National Statistical Office to redefine this expenditure should remove one of the main reasons for the continuation of the DBFO model in one fell swoop.[65]

In the British model, a construction company typically creates a "special-purpose vehicle" to bid with a health organization to create and provide non-clinical services to

[63] McKee M, Healy J, editors. Hospitals in a changing Europe. Buckingham: Open University Press; 2002.

[64] Bloom A. Hospital co-locations: private sector participation in the hospital sector. In: Bloom A (editor) Health reform in Australia and New Zealand. Melbourne: Oxford University Press; 2000.

[65] Atun RA, McKee M. Is the private finance initiative dead? BMJ 2005; 331:792-3.

the hospital. A successful contractor will enter into three types of outsourcing: one with banks to finance the project, one with a construction company to build the hospital and the other with a utility management company to manage it for the duration of the project. Contract, usually 30 years. Throughout the duration of the contract, the health care provider agrees to pay a certain amount of revenue and the contractor undertakes to maintain the hospital's fabric in good condition and to manage the facilities.[66]

A unique model has been developed at Alzira Hospital in Valencia, Spain, which is managed by a private consortium responsible for the health care of a specific population for an annual payment.

There is still relatively little experience in these hospital models, but governments have not yet conducted rigorous assessments. Thus, the logic of these models compared to the traditional model of presentation is very controversial, but it is possible to identify many of the keys that have emerged. These are cost, quality, flexibility and complexity.

Hospital care inevitably involves many public-private partnerships. We have studied here the situation in which governments contract with the private sector to manage the hospital and sometimes to build it.

The theoretical justification for private financing of public utilities, despite discussion, is now widely accepted. However, the practical results do not seem to meet the expectations of privately financed companies. In general, the new facilities are more expensive than those purchased by traditional methods. If the public sector is successful through privately financed development, it may have to pay for a collapse project later.

Compared to the traditional system, new facilities are likely to be created on time and within budget; but these gains often appear to be at the expense of quality. The need to minimize risk to the parties means that it is very difficult to maintain facilities in a rapidly changing world. Finally, although standard public hospital purchases are now established, their complexity is increasing, especially for very large enterprises.

[66] Lethbridge J. European works councils and the healthcare sector. London: PSIRU; 2004.

It is impossible to say whether the model of public-private partnerships is flawed or whether the difficulties encountered in this type of activity are the result of implementation errors.

Reasonable explanation is that the additional complexity of public-private partnerships makes everything but the simplest projects simply very difficult. The uncertainty about the role and value of public-private partnerships in health care must be addressed.

G- Future partnership

Partnerships between public / governmental entities, Private / commercial entities and civil society contribute to improving the health of the poor by combining different skills and resources from different organizations in innovative ways. Public bodies clearly benefit from their collaboration with the private sector in areas where it lacks experience and expertise, for example in product development and production, processing, marketing and distribution.

However, there are areas, such as public health policy development and regulatory approval, where the concept of partnership with for-profit institutions is inappropriate. The objectives of the partnerships must therefore be carefully examined and clarified. The partnerships seem very justified: the traditional methods of self-employment have a limited impact on the problem, agreed objectives can be agreed by potential collaborators;

Complementary complementary experience exists in both sectors, achieving long-term interests for each sector (i.e. benefits for all parties), and experience and resource contributions are reasonably balanced .

Public-private partnerships should not replace actions on responsibilities elsewhere: public sector agencies should continue to: fund basic research, set standards for product safety, efficiency and quality, and implement place systems for citizen access Adequate access to health products and services, efficient use of public resources and creation of environments in which business is the motivation to meet the needs of the entire population.

A constructive analysis of the relevance, governance, accountability, processes and benefits of partnerships can only be achieved when the analysis topics are properly identified. This analysis requires taking into account different partnership arrangements, particularly as regards the legal situation.

Public-private partnerships should be viewed as social experiences to learn how to deal more effectively with intractable health problems. There is no formula for construction; it is unlikely that we find the universal application. Criticized partnerships30, but we must not forget that without them, few new things can happen to fix them.

Public-private partnerships can be useful but not a panacea. In the poorest countries, action is needed to overcome market failures and poor distribution systems that limit availability and access to medicines and lead to health inequities. Some measures taken by the public sector alone mobilize new resources, promote demand.

Enable market mechanisms to address health needs in a large number of countries and develop them within countries. Similarly, for-profit companies in the private sector can take unilateral; Build a better foundation for building partnerships.

On the basis of these actions, collaborative efforts between the public and private sectors will bring added value, It is relatively easy to identify the elements of an appropriate strategy in relation to the difficulties of implementation. It is necessary for all players, including those who do not trust them.

With those who need cooperation, take a long-term perspective. Implementation requires a long-term commitment. The responsibility for finding new and more effective ways of addressing health problems, if not more, lies with the public sector and with government and intergovernmental agencies, as in the private sector, where it is responsible for public health.

H- Public-private partnership experiences

In order to extend the private sector complementary to the public sector, experiences of public-private partnerships has been shown and applied in many country or regions. In this section, we are going to examine and describe past experiences of public-private partnership.

Turkey

Turkey has launched an ambitious public-private partnership program in recent years. According to the World Bank (without a year), Turkey alone accounted for 47% of the number and 46% of the monetary value of PPP contracts delivered in the Eurasia region in 2008-2013. A large part of this PPP program belongs to health facilities that will be built and operated in the big cities. PPP's health care program aims to create thousands of hospital beds and increase the number of hospitals per bed from 30 to 80 square meters to 150 to 200 square meters over the next few years. By the end of this program, hospitals operating in PPPs will be operated by 25% of all public, private and academic hospitals. Projected PPP investment in the health sector exceeds € 30 billion, 75% of which was signed in 2011-2014. P3s in health care will largely be linked to existing public hospitals, outdated and obsolete. The PPP model allows the private sector to design, finance, build and operate health facilities over a long period of time and to provide certain medical assistance services such as laboratories and imaging services in these facilities for five years, such as considered by the Ministry of Health.

Although the political will to achieve PPPs in the health sector is strong, the first contract was presented at the 2009 tender, four years after the adoption of the Parity of Authorities Act. in 2005. Twenty contracts were awarded, six only financial closing contracts in mid-2016, despite the service charges that the Ministry of Health intends to pay to the operator to cover the services provided. Investment and debt, thus facilitating the financing of purchasing power parity. In addition, none of the PPP

projects awarded were launched, indicating an inefficient procurement process. As proposed by the United Nations Economic Commission for Europe (UNECE) (2008), purchasing power parity (PPP) is needed to meet general governance standards, which should include the effective functioning of institutions, enabling procedures and processes around purchasing power parity. This chapter states that the Turkish PPP program in the health care field has not followed this proposal with difficulty, thereby inadvertently hindering the successful and timely implementation of the PPP. It is a well-known fact that if the first button is put in a bad folder, each button will be an error. The first part of the PPP legislation to establish rules and procedures for the provision of a sanitation system was poorly designed and aging, so the steps followed were in the wrong direction. The following section reviews policies on health reform and PPP policies in Turkey. Rules and procedures for PPP contracts are then reviewed in the health sector. A PPP request is critically evaluated and then conclusions are presented.

India

In India, an analysis of cooperation between the State and the private sector in the health field often appears in national health programs. Most of these cooperatives were in the nature of a supportive role in community mobilization and education with limited service delivery. Since the first plan, the government has sought support and cooperation from "for-profit" and "non-profit" areas in malaria control and family planning programs. Initially, the Government sought to support non-governmental organizations at the primary level to mobilize and educate the community. But later, these cooperatives extended to the profit sector and many other programs. Summarizes the nature of public-private partnerships and cooperation in the health sector over the past six decades and shows that most of them have taken place in the Family Protection Program. Private and non-governmental cooperatives have increased awareness and demand for family planning services significantly through community mobilization. Only a small proportion of practitioners and private clinics provided birth control and abortion services. The State provided subsidies and cash incentives to these sectors to provide services. Over the past two decades PPP concept has been introduced into health programs. The difference between purchasing power parities in the 1990s and previous forms of cooperation is that the previous concepts shape both partners equally and are arbitrated through an official memorandum of understanding, while in the second the role of non-state actors was marginal. a program. In the mid-1980s, purchasing power parity was introduced in many child-funded programs of child diseases, reproductive health and child health, mainly from the World Bank, which provided the rationale and guidelines for the preparation and maintenance of the program Partnerships. The design of these partnerships is inspired by new public administration practices and techniques (NPM) that prefer to move from traditional management to public administration based on market economic efficiency concepts.

Spain Alzira model

The Spanish National Health System (NHS) is respected internationally. For example, the donor-to-member system is an international reference model and Spain ranked seventh in the international health care classification.[67] Under the Franco regime, it was a system that was tested from about 20% of the population in the 1940s to about 80% in the 1970s. A democratic constitution in 1978, followed by the Public Health Act in 1986, led to the creation of a global health system. In 2002, the gradual transfer of responsibility for health care from the Department of Central Health to the autonomous regions.

In each autonomous region, the Spanish NHS operates on a two-tier system. Each district is divided into health zones divided into basic health zones. Each health district has a specialized, hospital and ambulatory care hospital. Primary health care centers exist within the community in each basic health area and provide easily accessible basic health services.

Health financing is part of the existing regional funding system (Lopez Casasnovas et al., 2005). The central government imposes certain legal and financial restrictions and the Ministry of Health retains the role of coordination and governance, despite Lopez Casasnovas and others. This is weak. Political accountability is ensured by regional parliaments, with increased financial accountability after the 2002 changes by setting minimum health expenditure (Lopez-Casasnovas et al., 2005). The mandate means that the autonomous regions show differences in health expenditures because of differences in clinical practice and health care priorities.

Our case study is a PPIP: a ten-year contract was signed in 1997 between the Government of Valencia and RSUTE, a special vehicle, for the creation of a hospital and the management of clinical and non-clinical facilities in the city from Zira. The shareholders of RSUTE were first, the health insurance company Adeslas S.A. (51%), as a technical provider of health services required by the conditions of purchase to

[67] Sanchez Bayle M, Beiras Cal H. The People's Campaign against Health Care Counter-Reforms in Spain. Journal of Public Health Policy 2001;22(2):139 .

benefit from the project. It was closely linked to the Spanish regional savings banks, the majority of its shareholders being Agbar S.A. La Caixa, Spain's leading savings bank, was one of the controlling shareholders. Secondly, Bancaja, CAM and Caixa-Carlet regional savings banks were jointly controlled by Ribera Salud S.A (45%), the project's financial partner. Finally, construction companies Dragados and Lubasa obtained a 2% stake. The project was to be financed by collecting 204 D per person per year in the health region concerned, paid by VDoH and above the Consumer Price Index (CPI) each year. The contract was awarded in 1997 and opened on 1 January 1999. Following the losses, the contract was terminated in March 2003 and immediately replaced by a second contract awarded to Ribera Salud II Temporal Union of Empresas (RSUTE II) in the case where the refinancing transaction was effective. The second decade extended its mandate to not only manage the La Ribera hospital, but also primary health care in the surrounding area.

A critical analysis of the underlying financial reality of the 'Alzira model' disrupts the NPM discourse of success. This model is not a true partnership between the public and private sectors, but rather a political partnership between the regional government and the regional savings banks. It is this political relationship which locks in the savings banks as indirect long term shareholders in the UTE, rather than their investment in the concession as proponents of this model claim.[68] Within Spain, Ribera Salud S.A. has become the main player in the PPIP market. It has been successful in winning another four Valencian hospital contracts paid for by capitation fee, in each case partnering with a health insurance company. In a further consortium with Adeslas, it has also been awarded a contract in Madrid. Its strength as a player in the healthcare market can be measured by the fact that it no longer needs to partner with health insurance companies, instead seeing itself as the specialist healthcare member of a further consortium set up to bid for a hospital PPP.

There are wider global implications for this. The 'Alzira model' has been replicated in Spain and more recently in Portugal as well as in developing countries. Evaluation of

[68] Kinlaw H. Public–private investment partnerships in health systems strengthening. In: Report on Wilton Park conference 909; 2008, Available at: www.wiltonpark.org.uk/documents/conferences/WP909/pdfs/WP909.pdf.

these other contracts needs to establish whether our findings in relation to Alzira are also repeated in these other cases. Whilst the other Spanish and Portuguese cases may be subject to the same benign political regime, this is unlikely to be the case for other countries, particularly developing countries where stricter criteria will be imposed by organisations such as the World Bank and where private sector partners will not be bound by close political relationships. Thus risk transfer and affordability could become issues.

Organisations such as the Global Health Group based at the University of California are actively promoting the 'Alzira model'. As well as the concerns raised by Jean Perrot of WHO's department of Health Systems Financing that developing countries would struggle with such complex projects[69], we would add our concerns that this model, if applied in a true commercial environment, will not prove viable or affordable in the long term.

[69] Bes M. Spanish health district tests a new public–private mix. Bulletin of the World Health Organisation 2009;87:892–3.

Africa

These days health care delivery cannot be limited to just national frontiers. Africa is developing centers of excellence that can serve populations of the entire continent, and beyond. A couple of examples were given previously for Mali and Kenya .

Another example is South Africa, where a private service provider, Netcare, sells services to England for ambulatory eye care clinics. Netcare personnel go to England a few months at a time and return enriched by the experience. Thus, human resources and technical plateau problems should start to be analysed on a regional and global basis, no longer solely on a national one.

Examples of partnerships with professional associations

In Uganda, the Market Day Midwives project, a joint effort between SOMARC (Social Marketing for Change) and the Uganda Private Midwives Association, set up midwives in community markets as a distribution system for family planning. SOMARC provided each midwife with a sales booth, training through Service Expansion and Technical Support, and a uniform, and sold products to midwives at wholesale prices (Futures Group International 1995).

Then, in January 2001, the Summa Foundation created a US$175,000 revolving fund to provide microcredit to private healthcare providers (nurses, midwives, and doctors) to expand or improve their practices. Commercial Market Strategies Uganda provided training in business skills, marketing, and credit management alongside this, and has produced a business handbook for private health providers. The 3-year, USAID-funded project is expected to provide training and funds to 280 private healthcare providers.

In Kenya, Futures Group Europe initiated a small network of 38 private sector midwives to provide a range of reproductive healthcare advice and services. In addition to free contraceptive and vaccine supplies, the Ministry of Health supplied the midwives with free bed nets and malaria treatment, with the sale of the bed nets providing a revolving fund for the midwives. Such projects seem to have potential, but are generally small scale; long-term sustainability, once donor project funding has ended, is uncertain. These types of pilots have

tended to focus on the low-technology end of activity, on ambulatory care and normal delivery.

The Burkina Faso experience with public-public contracting

There appears to have been growth in some output indicators during the period of the program (e.g., immunization coverage), while others remained static (e.g., assisted deliveries and use of curative care services). However, methodological limitations make it difficult to link the program to either of these phenomena. Some evidence suggests that deficiencies in the health system's delivery structure may also have influenced performance during this period. Greater attention needs to be paid to incorporating a systematic research evaluation component into programs of this kind. Research is necessary to examine the effect of institutional capacity and delivery structure variables on a variety of health system performance outputs that are linked to individual/household behaviour change and ultimately to improved health status outcomes. Scientific evidence that performance-based management programs in the public sector can contribute to improved health system performance is urgently needed.

The foremost challenge for the immediate future is whether this model—implemented with Bank financing—can be replicated by governments with the support of a bilateral donor. It is essential that the legal framework within which the program was implemented—in particular, a waiver to the existing law of finance—be re-evaluated. Procedures and requirements will also need to be simplified. Priorities, as articulated in the performance indicators, will need to be re-examined to ensure compatibility with the new health sector development plan.

A better balance must be achieved between financial and technical performance auditing.

Increased engagement of technical managers of vertical disease-control programs at central level also must be obtained. To achieve better efficiencies, greater decentralization of program oversight and management responsibilities should be

considered. Support to health facility-community management committees came late in the program and should therefore become a primary focus of attention. Institutional capacity is necessary but not sufficient in itself to achieve improved health system performance. There are a considerable number of delivery structure problems.

An important lesson learned from this first experience is that decentralized management programs are likely to achieve only partial success without concurrent policy reforms and capacity building at central level in a wide range of systems, such as planning, budgeting, and health information. Those lessons can also be applied to public-private partnerships.

Zimbabwe

In Zimbabwe, the Ministry of Health has maintained a long-standing contract with Wankie Colliery, a 400-bed hospital, to provide the services of a district hospital. Patients who are characterized as "government responsibility" (patients exempt from user fees at public hospitals) may be treated at the hospital on a fee-for-service basis. A government official stationed in the hospital certifies the eligibility of the patient, the patient is treated, and the hospital sends the bill for treatment to the Ministry of Health.

The original contract was signed in the 1950s, without a competitive tendering process and prompted by the lack of government hospitals in the area. The contract does not specify charge rates, although a fee-for-service system has operated since the inception of the contract. There is no formal monitoring of quality of services or operation of the contract.

An analysis of this contract by McPake and Hongoro in 1995 revealed several important lessons. Because there was no competition and the government did not retain its capacity to offer services, the monopoly position of Colliery in the district was entrenched, rather than challenged by the contract. This and the failure of the government to appropriately screen patients for their ability to pay and need for hospital services led to excessive provision. The contract did not manage to contain

costs, a result of overuse and the fee-for-service nature of the contract. Approximately 70% of provincial non-salary recurrent expenditure was allocated to the hospital, yet the hospital was accessible to only a minority of the population.

The absence of skilled personnel to appropriately monitor the contract and screen patients was an important constraint affecting the outcome of the arrangement. The contract was ultimately terminated due to disagreements over revisions (Mills 1997).

Conclusion

As a clarification of our project, time and effort must be spent laying the foundations for successful PPPs, in particular to accomplish the following:

• Establish and clarify the policy framework, as the private sector needs to understand the drivers that lie behind the projects.

• Establish a clear legal and regulatory framework, as PPPs depend heavily on contracts that are effective and enforceable.

• Ensure consistency, as well as clarity, of the policy and legal framework, which reduces the uncertainty for investors.

• Use legal terms and approaches, where possible, that are familiar to the international private sector, if they are to be sought as partners.

• Draw up investment plans, which can be useful to demonstrate high-level political support, to indicate the potential flow of future projects, and to explain how projects fit together within the context of national or regional economic plans.

• Avoid sending out wish lists of disconnected projects that are not part of a coherent program.

• Establish a clear PPP process map, including quality assurance and approvals processes.

• Adopt the appropriate institutional solution, so that governments can effectively perform the specialized functions needed to manage successful PPP programs. When creating a PPP unit, ensure that it has the relevant commercial and legal skills needed to be a key source of support for policy makers and public bodies developing and sponsoring projects. (Taking these crucial steps will send a powerful message of consistency and credibility to the private sector about the public sector's competence and seriousness of intent.)

• Capitalize on the experience of others who have managed the process, as the private sector takes considerable comfort from working with public officials who have been through the process before.

The decision to adopt PPP must be political, first. The government must consider the political and social implications of PPP and whether there is sufficient political will to implement PPP.

Next, consideration needs to be given to the institutional, legal and regulatory context - the extent to which government institutions have the needed skills and resources, the financial and commercial markets have needed capacity and appetite, and laws and regulations encourage or enable PPP – and whether changes need to be made to the institutional, legal and regulatory climate in order to provide the right context for PPP. Once these basic issues have been addressed, those designing the PPP solutions available to policymakers must consider the most commercially and financially viable and appropriate structures.

This must involve consideration of cost benefit, value for money, the sources of finance, the commercial arrangements, the nature of investors and government participants, and a variety of other circumstances that need to be addressed in the design of appropriate PPP structures. This latter process is where a robust classification model can help.

Partnerships between the public and the private sector have a contribution to make in improving the health of the poor by combining the different skills and resources of various organizations (public and private) in innovative ways.

However, in order to be beneficial, the public sector should continue to:

- fund fundamental research;
- set standards for product safety, efficacy, and quality;
- establish a system whereby citizens have adequate access to health product and services;
- use public resources in an efficient manner;
- Create environments in which commercial enterprises are appropriately motivated to meet the needs of the entire population.

Part three: Preparation and implementation of the survey on the level of a private facility and a public facility

In order to complete our project and extend the study, will embark a survey on the level Dr. benzerdjeb hospital establishment in Ain temouchent and the private clinic "IBN SINA" in the same city, Starting at first with a brief introduction of both facilities, which will be followed by interests concerning our theory and then an analysis and interpretations of results, built from employees' answers.

A- The hospital establishment "Dr. benzerdjeb":

"Dr. benzerdjeb " hospital is one of the rarest institutions at the level of Algeria, here cares functions related to the protection of public health. It is as governmental term with commercial entity , it deals with private and public industrial enterprises granting them health conditions and materials. It has been lunched at 2006 as one of the seventh hospital establishment with same status. It has been ranked on 2018 as the first best hospital in Algeria.

B- The private clinic "IBN SINA":

The clinic "IBN SINA" is situated in Ain Temouchent city, owned by Doctor BEN AMMAR. It has been launched earlier this year; it has occupied multiple posts from

doctors, nurses, and administrators, providing responsive healing environment and improving the quality of life for all members of our community.

Methodical choice:

We chose the statistical method to be able to measure and display the results in the form of tables and graphics, interpreting the results to test assumptions at the beginning of the study.

The tool used in our survey is a questionnaire which represents a list of questions in writing requests for information gathering, we have used this tool due to get effective forms of results. Set up the questionnaire has ensured the selection of interpreting simple questions and easy to get clear answers.

The purpose of the study:

The purpose of this study is to learn how to perceive all employees and personnel stuff to apply partnerships at the level of the facilities than areas than the system.

Retrieving the questionnaire:

We didn’t have difficulties at the restorations of questionnaires from respondents, where we collected 47 replies of total 50.

Analysis and interpretation of results

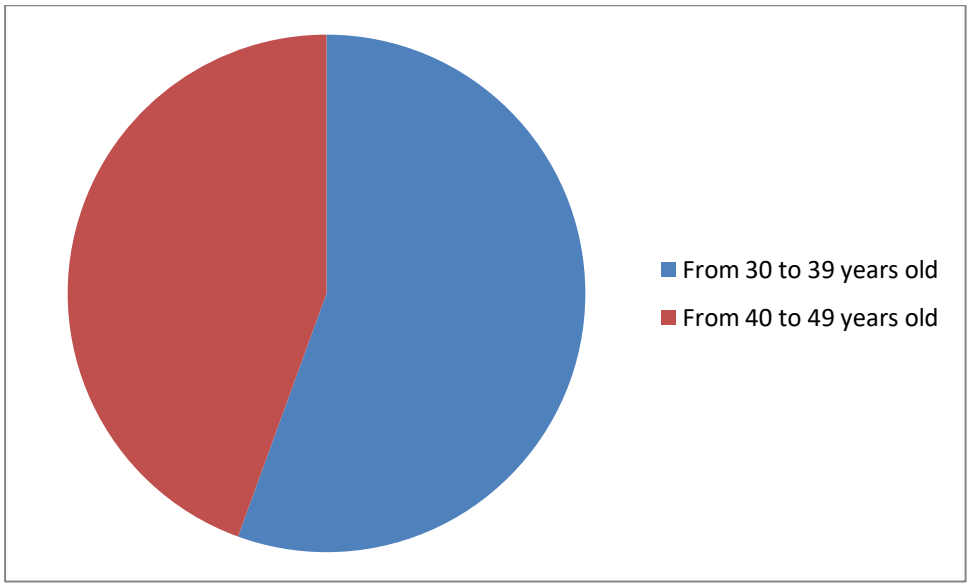
1. Identification of population sampling

1.1. Gender

Table n01: the distribution of member by gender.

gender	member	Percentage
males	31	65,95
females	16	34,04
total	47	100

Graph n 01:



Source: the graphs was formed by us from the results of the questionnaire

As shown in the table and graphic, we've got 65, 95 of the sampling are males, in other hand, the rest of the repliers are females.

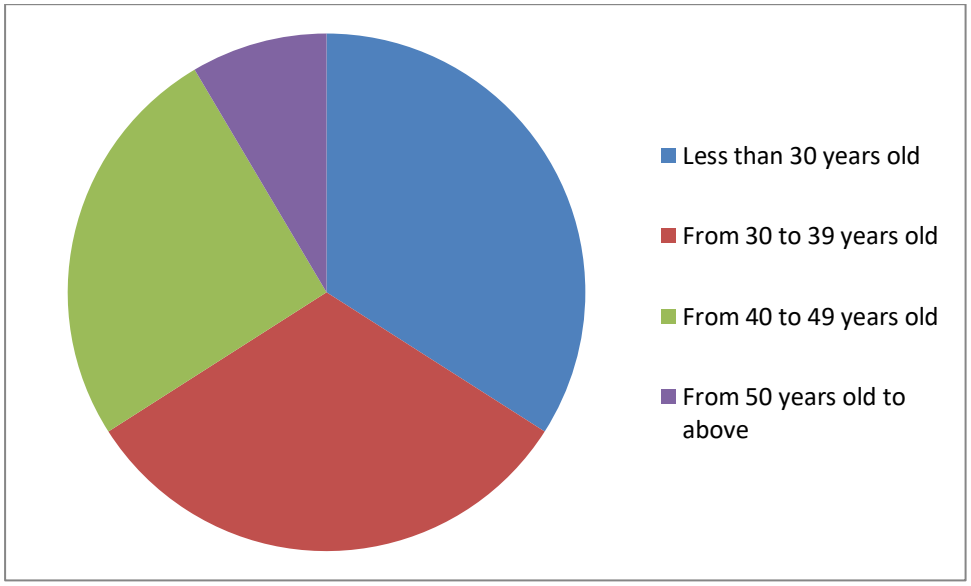
1.2 Age range

Luckily, our investigation has touched almost all age groups and we distributed a questionnaire to all employees in various fields in order to reach the largest possible results.

Table n02: The distribution of age

Age range	Member	percentage
Less than 30 years old	16	10,63
From 30 to 39 years old	15	31,91
From 40 to 49 years old	12	25,53
From 50 years old to above	4	08,51
Total	**47**	**100**

Graphs n02



Source: Source: the graphs was formed by us from the results of the questionnaire

Graphic number 02 and table number 02 shows us that there's diversity of the sampling.

PS: the source table and graphic number 02 ware made by us from the results of the questionnaire

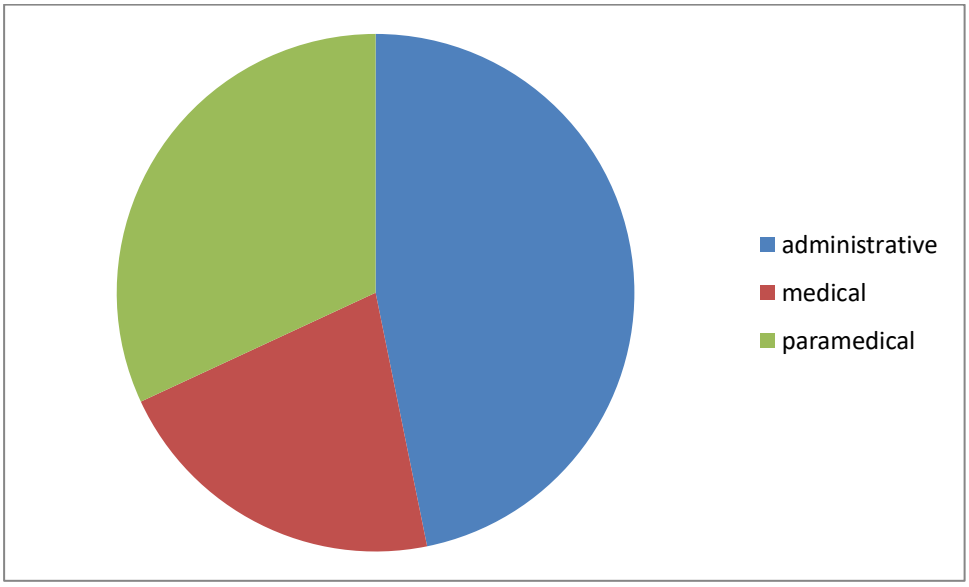
1.3. The distribution of field

We distributed a questionnaire to all employees in various fields in order to reach the largest possible results.

Table n03:

Field	**member**	**Percentage**
Administrative	22	46,80
Medical	10	21,27
Paramedical	15	31,19
Total	**47**	**100**

Graphs n03:



Source: the graphs was formed by us from the results of the questionnaire

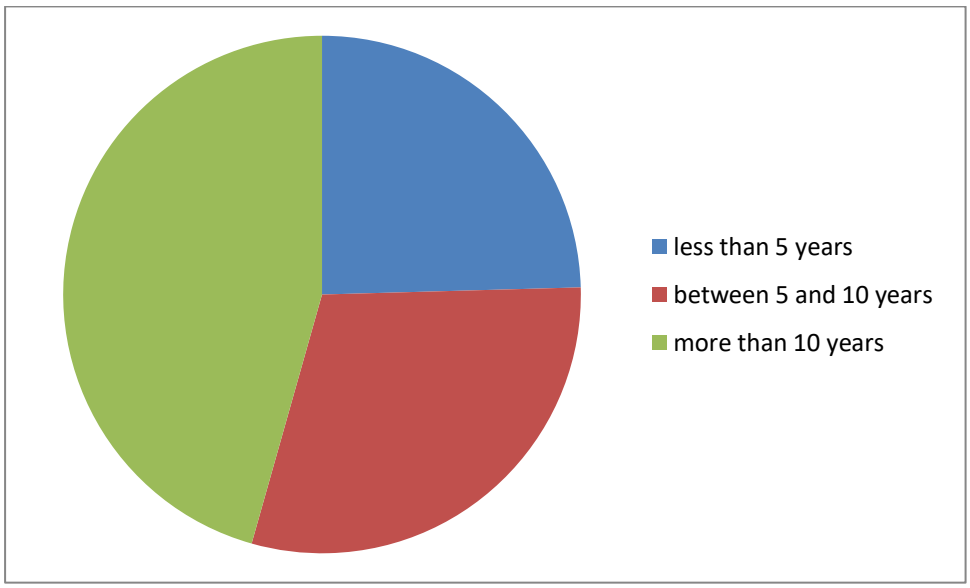
1.4. The distribution of experience

We ensured with the distribution of questionnaires to touch individuals who exercise at the level of the hospital for several years, but we had to take newcomers opinion in the matter.

Table n04:

Experience	**member**	**Percentage**
Less than 5 years	**14**	**29,78**
Between5 to 10 years	**17**	**36,17**
More than 10 years	**26**	**55,31**
Total	**47**	**100**

Graphs n04:



Source: the graphs was formed by us from the results of the questionnaire

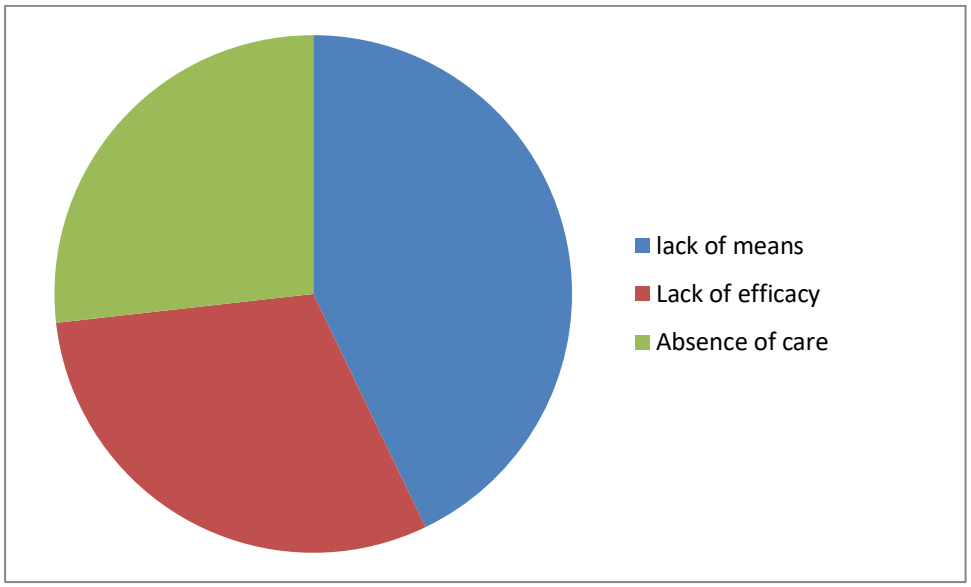
According to the results, the answers were perfect, we had replies from both genders, all age ranges, and all fields; luckily the variables were close.

Question 01: what is your assessment of the hospital organization in the public sector?

Table n05:

answer	member	Percentage
Good	21	44,68
Average	16	34,04
Bad	10	21,28
Total	47	100

Graphs n 05:



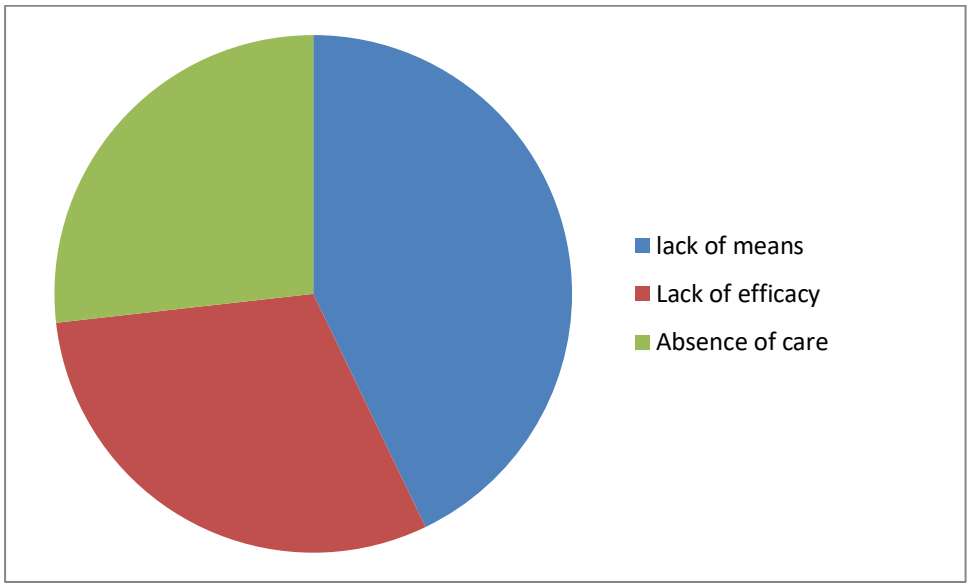
Source: the graphs was formed by us from the results of the questionnaire

By this question, we wanted to know the fact about organization in a public hospital, even that we gave the questionnaire to employees in a private clinic. Knowing that a private clinic is more organized that the public, the results more surprising taking the fact about the reality of organization in Algeria. Gathering the replies, we found that 44.68% of employees are satisfied of the organization in the public facility, 31.04% were at average, while the rest said that the organization is bad.

Table n06:

answer	member	Percentage
Good	08	17,02
Average	15	31,91
Bad	24	51,06
total	47	100

Graphs n06:



Source: the graphs was formed by us from the results of the questionnaire

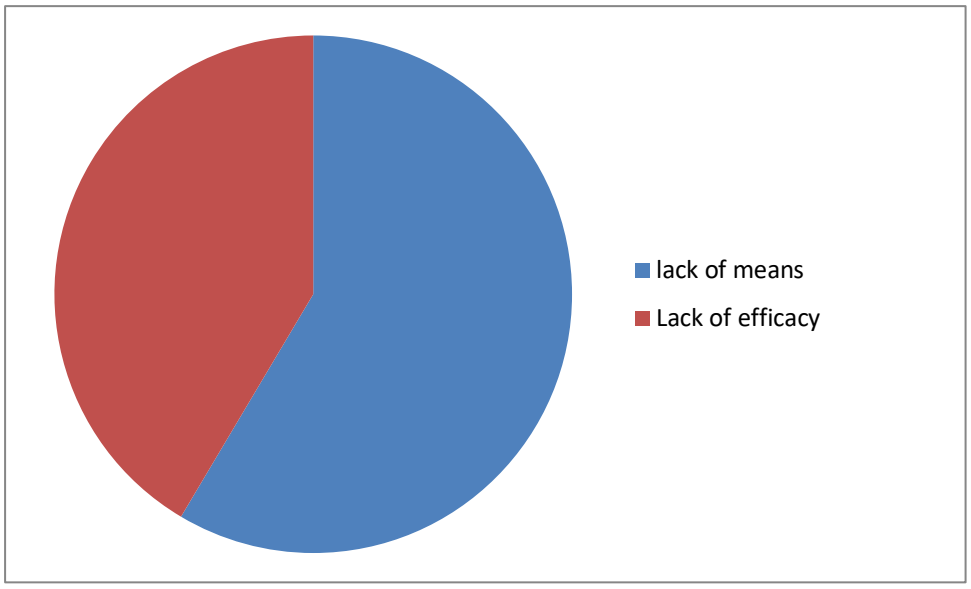
As expected, the time waiting is an issue in hospitals since the negative answers were represented by 51.06% from total replies, 31.91 were as average, and the rest said it is not an issue. As the matter of fact, this question must be asked to patients and not employees, we asked them the question so we could know their idea about the systematic organization which is ran by the hospital or the clinic.

Question n03: what are the reasons of the lengthening of the waiting times?

Table n 07:

Answer	member	Percentage
Lack of organization	22	46,80
lack of means	25	53,19
total	47	100

Graphs n 07:



Source: the graphs was formed by us from the results of the questionnaire

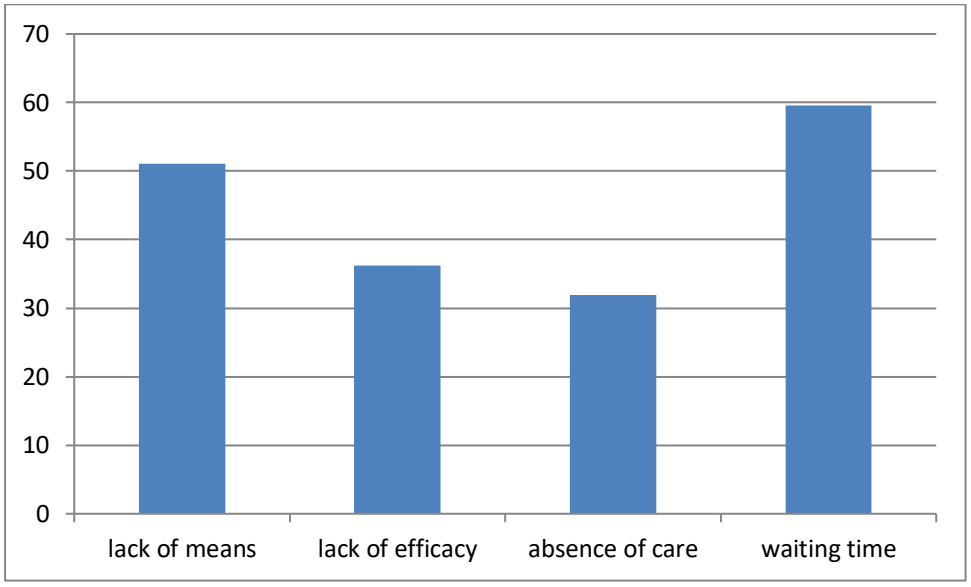
In the previous question, we found that time is an issue in hospitals, our query were about the reasons. According to replies of the questioners, the problem of the the lengthening of the waiting times is due to lack of organization presented by 46.8% and lack of means presented by 53.19%.

Question n04: why do patients go to the private sector rather than the public, besides emergencies? (Multi responses)

Table n 08:

answer	member	Percentage
Lack of means in the public facilities	25	51,06
Lack of efficacy	17	36,17
Absence of care	15	31,91
Long waiting times	28	59,57
total	/	**100**

Graphs n 08:



Source: the graphs was formed by us from the results of the questionnaire

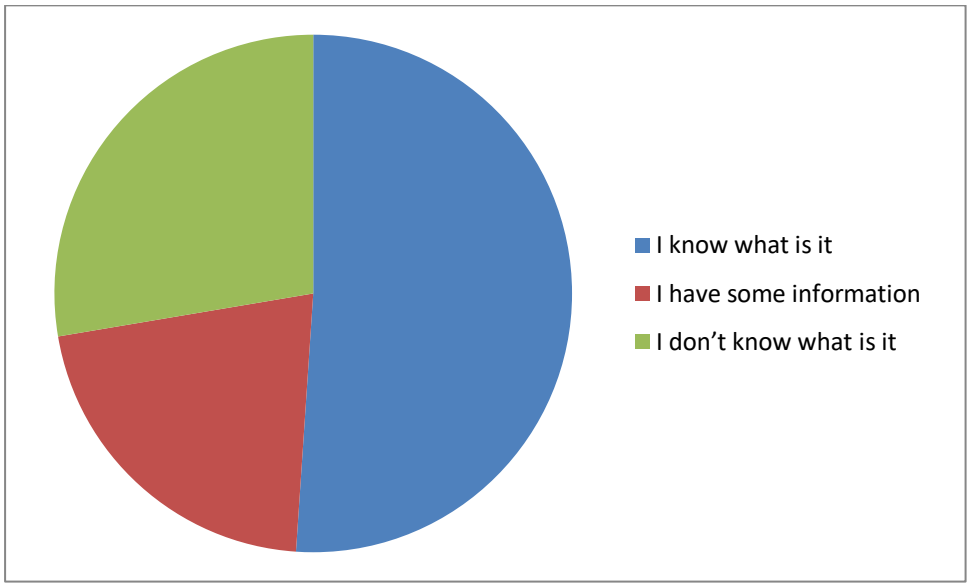
This question was asked to know the importance of the private hospitals over the public. The survey indicated multi replies in each icon, over half of the employees saw that patients reach the private clinic in order to seek materials and win time, 36.27% said efficacy in the privates are better than the public. The third suggestion (absence of care) was more human, because neither doctors nor employees would say that the crisis in the public hospitals would be due to absence of care.

Question n05: what do you know about public-private partnership?

Table n09:

Answer	Member	Percentage
I know what is it	**24**	**51,06**
I have some information	**10**	**21,27**
I don't know what is it	**13**	**27,65**
Total	**47**	**100**

Graphs n 09:



Source: the graphs was formed by us from the results of the questionnaire

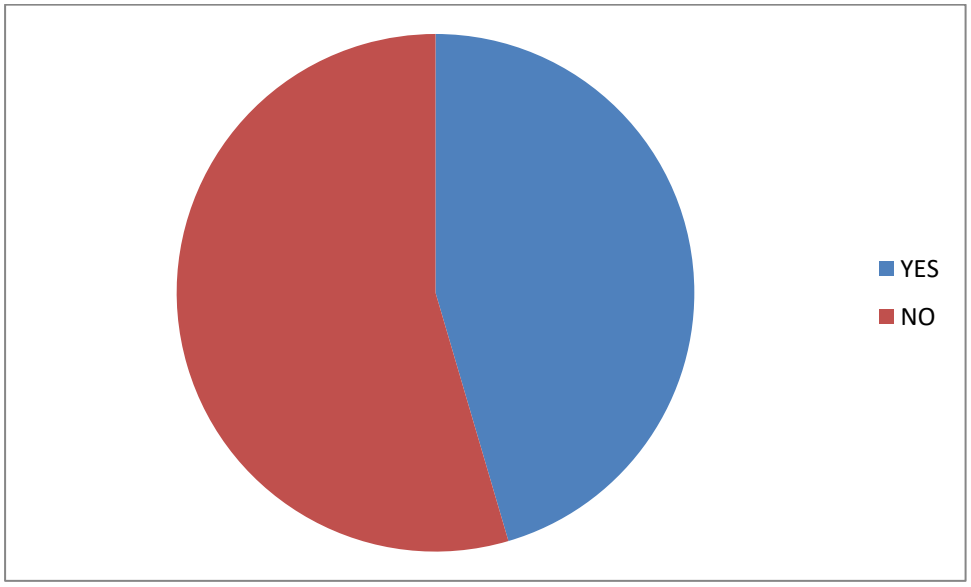
It appears that half of the sample knew what PPP is, represented by 51.06%, 21.27% had some information about it while 27.65% didn't hear about this system.

Question n06: do you support the application of public-private partnership in all administrative decisions of Algerian's hospitals?

Table n 10:

Answer	Member	Percentage
Yes	18	38,30
No	29	61,70
Total	47	100

Graphs n 10:



Source: the graphs was formed by us from the results of the questionnaire

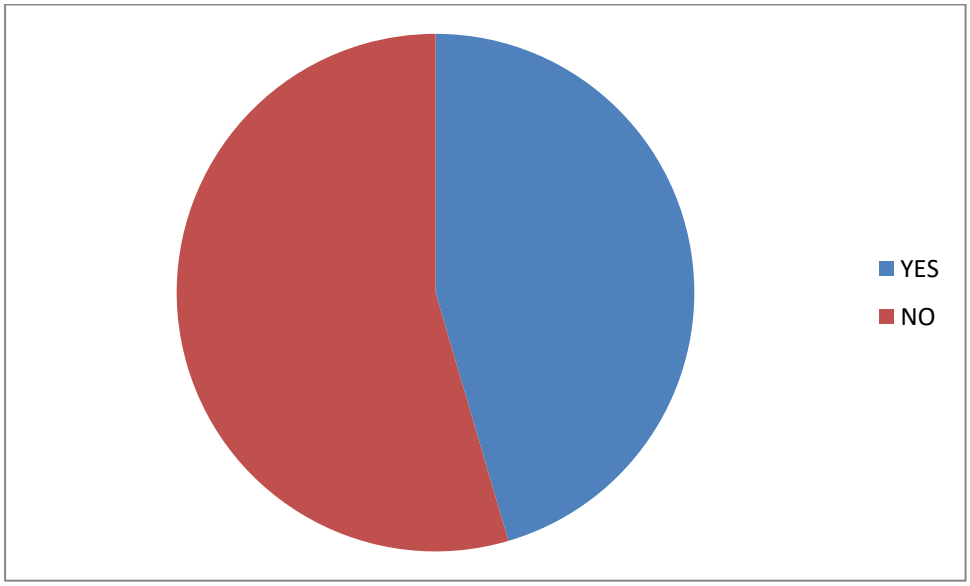
In this question we asked the sample about the application of PPP in administrative decisions, 61.70 % shown their negativity, we can deduce from their reply that each sector attends to be independent from the other.

Question n07: Do you take responsibilities for the decision you participated in concerning the merge of public and private sectors?

Table n 11:

Answer	Member	Percentage
Yes	16	34,05
No	31	65,95
Total	47	100

Graphs n 11:



Source: the graphs was formed by us from the results of the questionnaire

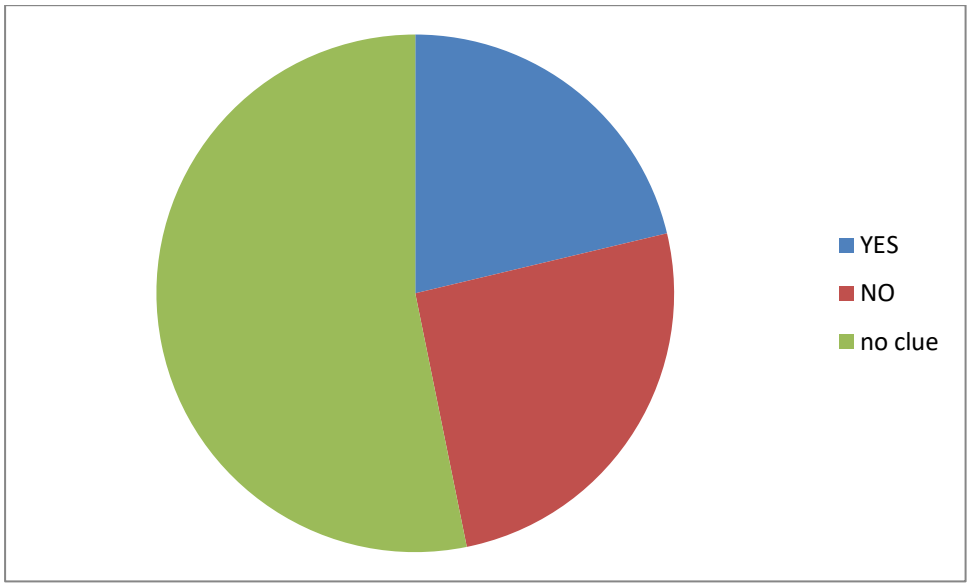
The current question was about taking responsibility in case of the merge between public and private facilities, as indicated from the results 65.95% said that they will not take responsibility in the merging. Our only regret was not asking about the reasons of the negation or acceptance.

Question n08: Is the Algerian population ready to adopt the culture of partnerships?

Table n 12:

Answer	Member	Percentage
Yes	10	
No	12	
No clue	25	
Total	47	100

Graphs n 12:



Source: the graphs was formed by us from the results of the questionnaire

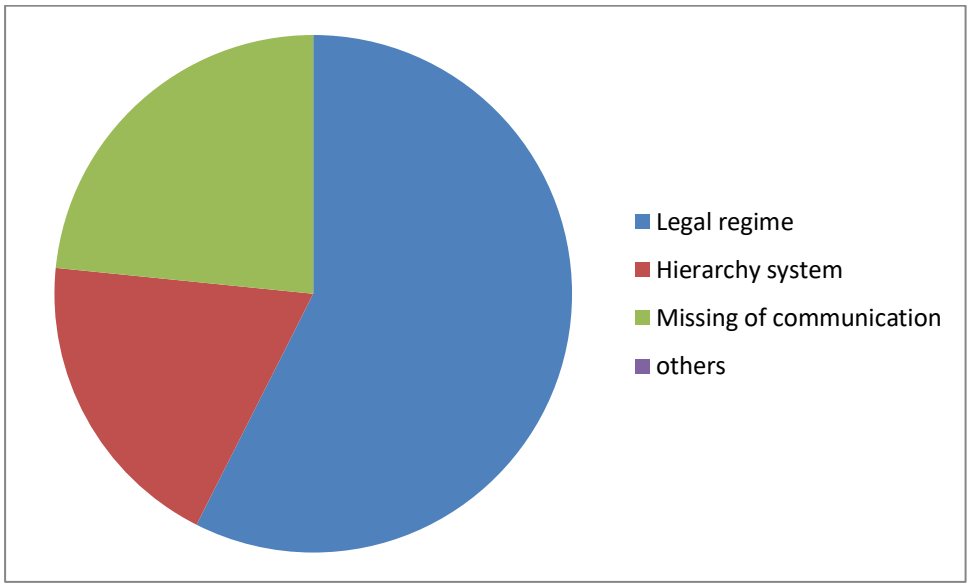
As indicated by the results, the majority of the repliers have no clue about the reaction of the population concerning the application of PPP.

Question 09: what are the possible failures reasons of public-private partnership in Algeria?

Table n 13:

Answer	Member	Percentage
Legal regime	27	57,45
Hierarchy system	9	19,15
Missing of communication	11	23,40
Other reasons	0	0
Total	47	100

Graphs n 13:



Source: the graphs was formed by us from the results of the questionnaire

This was the most important question in the survey, because it concerns the application of our theory. As indicated from the results, 57.45% have doubt in PPP because of legal regime, 29,25% answered as it might be the reason of the failure on hierarchy system, while missing of communication was the third reason and was affirmed by 23.45% of the sampling.

CONCLUSION

The most important thing we can deduce from this statistical data is the diversity of answers, and because of the correlation of the question. The rapprochement of the answers was surprising, taking as granted the application of a new whole system in a social country which the majority of the budgets is financed by the nation treasury.

Among the difficulties impeding the application of public-private partnership within the administration's legal system and legislative department, add some mirrors who responded with the authority to issue administrative decisions because they reaper sent the hierarchy programs. These are the most important reasons that we told the employees and workers concerning the application of PPP models as a mechanism too eases health staff members.

General conclusion

Public-private partnerships (PPPs) are an important tool for governments seeking to expand and improve the provision of infrastructure and other social services for their citizens. As such, they can help to boost economic growth and development and to fight poverty. PPPs have been used in developed countries in a wide range of sectors, and they are increasingly being seen as part of the menu of solutions to the lack of infrastructure service provision in developing countries. However, PPPs can fulfil this role only if they appropriately combine the interests of the two partners—that is, the interests of the government in expanding and improving services for citizens that are sustainable and achieving value for money and the interests of private investors in obtaining a reasonable return on their investment for the risks they are being asked to bear.

PPPs have become a common approach to health care problems worldwide, and recently there has been enthusiasm for using PPPs to improve the delivery of health and welfare services for a wider range of health problems. That's why PPPs in the health sector can take a variety of forms depending on the degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, risks, and rewards, as might be defined in a contract or manifested through a different arrangement.

In another hand, there's some difficulties impeding the application of public-private partnership within the administration's legal system and legislative department, add some mirrors who responded with the authority to issue administrative decisions because they reaper sent the hierarchy programs. These are the most important reasons that could lead into the failure of the partnership, and that's what has been resulted from the data collected from employees opinions in Algerian facilities.

Appendixes

Questionnaire

01/ Gender

Male ☐ female ☐

02/ Age

- Less than 30 years old ☐
- From 30 to 39 years old ☐
- From 40 to 49 years old ☐
- From 50 years old to above ☐

03/Field

- Administrative ☐
- Medical ☐
- Paramedical ☐

04/ Experience

- Less than 5 years ☐
- Between5 to 10 years ☐
- More than 10 years ☐

Q1 : what is your assessment of the hospital organization in the public sector?

- Good ☐ - Average ☐ - Bad ☐

Q2 : what is your assessment of waiting time in a hospital establishment?

- Good ☐ - Average ☐ - Bad ☐

Q3: what are the reasons of the lengthening of the waiting times?

Lack of organization ☐ -lack of means ☐

Q4: why do patients go to the private sector rather than the public, besides emergencies?

- Lack of means in the public facilities ☐
- Lack of efficacy ☐
- Absence of care ☐
- Long waiting times ☐

Q05: Are tariffs of health care appropriate according to purchasing power of citizens ?

- In public facility : yes ☐ no ☐

- in private facility: yes ☐ no ☐

Q06: what do you know about public-private partnership?

- I know what is it ☐
- I have some information ☐
- I don't know what is it ☐

Q07: do you support the application of public-private partnership in all administrative decisions of Algerian's hospitals?

- Yes ☐
- No ☐

Q08: Do you take responsibilities for the decision you participated in concerning the merge of public and private sectors?

- **Yes** ☐
- **No** ☐

Q09: is the Algerian population ready to accede the culture of partnership

- Yes ☐
- No ☐

Q10: what are the possible failures reasons of public-private partnership in Algeria?

- Legal regime
- Hierarchy system
- Missing of communication
- Other reasons

PS: the questionnaire was in Arabic

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Abstract

Despite the limited experiences and the lack rigorous evaluation of Algerian health care system, the appearance of public-private partnership is a special phenomenon, to insure effectiveness and efficiency and good quality.

Public–private partnerships have become popular worldwide as a way of improving health care service delivery, Its need has aroused against the backdrop of inadequacies on the part of the public sector to provide public good on their own, in an efficient and effective manner, owing to lack of resources and management issues. Our research was made to capture if Algerian health care system is ready to adopt the partnerships of both sectors.

Résumé

Malgré les expériences limitées et l'absence d'évaluation rigoureuse du système de santé algérien, l'apparition de partenariats public-privé est un phénomène particulier, destiné à assurer efficacité, efficience et qualité.

Les partenariats public-privé sont devenus populaires dans le monde entier comme moyen d'améliorer la prestation de services de soins de santé. Son besoin s'est fait sentir dans le contexte des insuffisances du secteur public à fournir le bien public de manière efficace et effective, en raison de: manque de ressources et de problèmes de gestion. Notre recherche visait à déterminer si le système de santé algérien était prêt à adopter les partenariats des deux secteurs.

ملخص

على الرغم من التجارب المحدودة وعدم وجود تقييم صارم لنظام الرعاية الصحية الجزائري ، إلا أن ظهور شراكة بين القطاعين العام والخاص ظاهرة خاصة ، لضمان الفعالية والكفاءة والجودة الجيدة.

أصبحت الشراكات بين القطاعين العام والخاص شعبية في جميع أنحاء العالم كوسيلة لتحسين تقديم خدمات الرعاية الصحية ، وقد أثار حاجتها على خلفية أوجه القصور من جانب القطاع العام لتوفير الصالح العام من تلقاء نفسها ، بطريقة فعالة واكثر كفاءة ، وذلك يعود إلى نقص الموارد وقضايا الإدارة. تم إجراء بحثنا لمعرفة ما إذا كان نظام الرعاية الصحية الجزائري مستعدًا لتبني شراكات القطاعين.