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Cost, Quality, and Accessibility: A Comparative Analysis of Business Profiles in Public and Private Healthcare Institutions - A Literature Review

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Abstract

Aims and Objectives: The main objective of the research is to study the differences between public and private healthcare institutions in terms of cost, service quality, and accessibility. **Methods:** The paper is a systematic literature review based on the PRISMA guidelines. The materials were searched in international scientific databases: PubMed, Elsevier, Scopus, and Google Scholar. The study includes an analysis of peer-reviewed international articles published in the last 10 years. Of the **182** records initially identified, **98** remained after removing duplicates and ineligible records. After screening titles and abstracts, **33** articles met the inclusion criteria and were used for the final synthesis. **Results:** The evidence synthesis showed that systems with strong public funding are more effective in reducing patients' out-of-pocket costs and ensuring financial protection. The private sector is distinguished by its promptness of service, reduced waiting times, and a patient-centered approach, although this is often associated with high costs and does not always translate into improved clinical outcomes. It was revealed that the creation of a unified e-health network significantly improves cost-effectiveness and

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collaboration between sectors. **Findings and Conclusion:** The study concludes that neither the public nor the private sector can achieve full efficiency and equity independently. A balanced hybrid approach is considered the optimal model for progress towards universal health coverage (UHC). It is recommended that public policymakers increase public funding, strengthen public-private partnerships (PPPs), and scale up electronic systems, ensuring equitable access to quality healthcare services and system sustainability.

Keywords: Universal health coverage; public and private healthcare; healthcare financing; quality of care; accessibility

Introduction

Universal health coverage (UHC) is widely recognized as a foundational objective of modern healthcare systems, reflecting the principle that all individuals should be able to access essential health services of adequate quality without experiencing financial hardship. Over the past decade, UHC has been positioned at the center of global health policy agendas; however, recent evidence indicates that progress toward this goal has slowed, while inequalities in access and financial protection remain widespread (World Health Organization & World Bank, 2023). These challenges have renewed attention to the organization, financing, and governance of healthcare systems, particularly the respective roles of public and private healthcare institutions.

International comparisons demonstrate that rising healthcare expenditure alone does not guarantee improved population health outcomes or equitable access to care. Several high-income countries with substantial healthcare spending continue to face unmet medical needs, affordability barriers, and disparities in service utilization among different socioeconomic groups (OECD, 2021). These patterns suggest that system performance depends not only on the volume of resources invested but also on how healthcare services are financed, delivered, and regulated. In this context, the balance between public and private healthcare provision plays a critical role in shaping cost containment, quality assurance, and accessibility.

Public healthcare systems are typically designed to promote equity and financial protection through tax-based or social health insurance financing mechanisms. Such systems emphasize universal entitlement, preventive care, and standardized clinical protocols, aiming to ensure population-wide access to essential services. In contrast, private healthcare institutions often operate within market-oriented frameworks that prioritize efficiency, competition, and patient choice. While private providers may offer greater responsiveness, shorter waiting times, and enhanced patient experience, concerns persist

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regarding higher service costs, fragmented care, and unequal access, particularly in the absence of strong regulatory oversight (Kruk et al., 2018).

The coexistence of public and private healthcare institutions is especially prominent in mixed healthcare systems across Europe and in many low- and middle-income countries. In these settings, insufficient public financing frequently increases reliance on out-of-pocket payments, exposing households to financial hardship and limiting access to necessary care (Thomson et al., 2024). At the same time, unregulated expansion of private healthcare provision may contribute to cost inflation without corresponding improvements in clinical outcomes or population health. Evidence suggests that ownership status alone does not determine performance; rather, governance arrangements, pricing regulation, and quality monitoring systems are decisive factors influencing outcomes across both sectors (Moscone et al., 2017).

Understanding how public and private healthcare institutions differ with respect to cost structures, quality of care, and accessibility is therefore essential for informed health policy and system reform. Although a substantial body of research has examined these issues, existing findings are often fragmented and context-specific, leading to inconsistent conclusions. Systematic synthesis of this evidence is needed to clarify common patterns and inform policy decisions aimed at advancing universal health coverage.

This study addresses this need by conducting a PRISMA-based systematic literature review comparing public and private healthcare institutions across three key dimensions: cost, quality of care, and accessibility. By synthesizing evidence from peer-reviewed international studies, the review aims to provide a comprehensive and critical assessment of how different healthcare models influence system performance and equity. The findings are intended to support evidence-based policy recommendations for countries with mixed healthcare systems, including Georgia and similar contexts. Cost, Quality, and Accessibility-Increased funding is a critical factor in the comparative analysis of business profiles between public and private healthcare institutions. A study conducted in Georgia, aimed at healthcare system stakeholders and policymakers, evaluated cost dynamics across numerous services over a 10-year period. The findings demonstrated the significant impact of funding on service quality. Consequently, the study provides recommendations to ensure adequate resources for high-quality healthcare services. Specifically, the government should increase healthcare funding, improve health insurance coverage, and foster public-private partnerships among healthcare providers. These measures are essential for enhancing both the quality of healthcare and the accessibility of services (Abashidze-Gabaidze et al., 2023)

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Impact of E-Health Systems-Recently, there has been growing interest in the creation of a unified electronic healthcare network. This development has demonstrated significant improvements in service quality, cost-effectiveness, and the reduction of out-of-pocket expenses within healthcare systems. These findings are supported by a literature review that deeply evaluated the positive impact of e-health on healthcare services. The review specifically highlighted the positive dynamic and collaborative influence of e-health, facilitating seamless continuous collaboration between public and private institutions. Furthermore, research has confirmed that e-health contributes to improved health outcomes for all, offering accessible and scalable solutions that enhance general well-being. (Abashidze-Gabaidze, Gakharia, et., al 2025)

Methods

Design/methodology/approach - The authors conducted a review of the literature in databases using keywords. The selection of sources includes scientific articles based on different methods and contexts. Literature Selection Methodology-The literature was sourced from international peer-reviewed journals, including those indexed in Scopus and Elsevier. Initially, **182** records were identified through databases and register searches. After removing duplicates and ineligible records, **98** articles were screened, of which **33** met the criteria for a comprehensive review. Following a rigorous evaluation by two independent reviewers, a final selection of thirty-three articles was made. These articles fully meet the specific inclusion criteria and requirements established for this literature review

This study was conducted as a PRISMA-based systematic literature review (Refer to Prisma Figure N1 and Prisma flow diagram Figure N2). following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses framework to ensure transparency, methodological rigor, and reproducibility. The review aims to synthesize existing evidence comparing public and private healthcare institutions with respect to cost, quality of care, and accessibility.

Data Sources and Search Strategy

A systematic literature search was performed using internationally recognized academic databases and search engines, including PubMed and Google Scholar. These sources were selected due to their extensive coverage of peer-reviewed research in healthcare systems, health policy, and health economics. The search strategy employed combinations of keywords related to healthcare ownership and system performance. Core search terms included: public healthcare, private healthcare, healthcare costs, quality of care, healthcare accessibility, universal health coverage, out-of-pocket payments,

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health system performance Boolean operators (AND/OR) were applied to refine search results. The search was limited to English-language peer-reviewed journal articles published within the last two decades to ensure relevance to contemporary healthcare systems.

Eligibility Criteria: Explicit inclusion and exclusion criteria were applied to identify studies relevant to the research objectives.

Inclusion criteria: Peer-reviewed journal articles-published in English, Studies comparing public and private healthcare institutions or systems, Research addressing at least one of the following dimensions: cost, quality of care, or accessibility, National, regional, or international comparative studies, Full-text articles available in English

Exclusion criteria: Editorials, commentaries, opinion papers, and non-peer-reviewed publications, Studies focused exclusively on a single provider type without comparative analysis, Articles lacking clear methodological description or outcome reporting, Studies not addressing cost, quality, or accessibility outcomes

Study Selection Process

The initial search across databases and registers identified **182** potentially relevant records. After removing **84** duplicates and ineligible records, **98** titles and abstracts were screened to exclude clearly irrelevant studies. Full-text versions of the remaining articles were then assessed against the predefined eligibility criteria. Studies that did not provide comparative evidence between public and private healthcare institutions or did not address the review's analytical dimensions were excluded (**n=65**). Following this rigorous screening process, a final sample of **thirty-three (33)** studies was selected for inclusion in the systematic review.

Results:

Data were extracted from each included study using a structured approach, capturing information on study design, geographic context, healthcare system characteristics, and key findings related to cost, quality of care, and accessibility. Due to heterogeneity in study designs, outcome measures, and settings, a narrative synthesis method was employed. The synthesized evidence from the **33 included studies** was organized into three analytical domains:

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Table 1: Comparative Summary of Public vs. Private Healthcare Systems

Domain	Key Findings from Reviewed Literature (n=33)
Cost & Financial Burden	Public systems show higher capacity for risk pooling and lower out-of-pocket (OOP) payments. Private care is associated with higher prices and increased financial risk.
Quality of Care	Private sector excels in responsiveness and patient satisfaction. Public sector performs better in standardized protocols, maternal health, and chronic disease management.
Accessibility & Equity	Private providers concentrate in urban/wealthy areas. Public systems remain the primary source of care for rural and low-income populations.

Discussion

Healthcare financing and cost containment are central determinants of equity and sustainability within health systems. A consistent finding across the reviewed literature is that the relative roles of public and private healthcare institutions significantly influence overall expenditure levels and the financial burden borne by households. Systems characterized by strong public financing mechanisms—such as tax-based or social health insurance models—demonstrate greater capacity to pool risk and limit out-of-pocket (OOP) payments (Wagstaff & van Doorslaer, 2003; World Health Organization, 2010).

International evidence highlights that reliance on private financing is often associated with higher healthcare prices and increased financial risk for patients. Comparative analyses across OECD countries indicate that higher healthcare spending in market-oriented systems is driven primarily by price levels rather than superior outcomes (OECD, 2021). Furthermore, in low- and middle-income contexts, private sector care frequently results in higher OOP payments without corresponding improvements in clinical effectiveness (Basu et al., 2012).

Regarding the quality of care, the widespread assumption that private institutions inherently provide superior services is challenged by empirical evidence. While private providers often excel in service responsiveness and patient satisfaction (Berendes et al., 2011), public institutions frequently demonstrate stronger performance in clinical adherence, preventive care, and population-based health outcomes (Kruk et al., 2018). Governance strongly mediates these differences; robust accreditation and accountability mechanisms are critical determinants of quality regardless of ownership status (Smith et al., 2009).

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Finally, the literature underscores that the expansion of private provision, in the absence of robust public oversight, is liable to exacerbate disparities in healthcare accessibility. Private providers tend to concentrate in urban and economically advantaged areas, contributing to "two-tier" healthcare systems (Le Grand, 2007; OECD, 2019).

Policy Implications and Future Directions

The findings of this review suggest that progress toward universal health coverage requires a shift from binary debates about ownership toward integrated governance frameworks. Policymakers should prioritize the expansion of public financing to mitigate financial hardship caused by out-of-pocket payments, while simultaneously implementing robust price regulations for private providers. Furthermore, the integration of unified e-health networks is critical for enhancing collaboration between sectors, reducing service fragmentation, and improving overall cost-effectiveness. Future research should focus on longitudinal assessments of public-private partnerships in low- and middle-income contexts to identify scalable models for equitable healthcare delivery.

Conclusion

This systematic literature review demonstrates that neither public nor private healthcare institutions alone can fully achieve efficiency, equity, and sustainability in healthcare delivery. Strong public financing is fundamental to reducing financial hardship and ensuring universal access, while private healthcare providers can contribute to service responsiveness and innovation when appropriately regulated. Based on the synthesized evidence, several key policy implications emerge. Health systems should prioritize expanding public financing to reduce reliance on out-of-pocket payments, implement effective price regulation and strategic purchasing mechanisms, and enforce unified quality standards across public and private providers. In addition, incentives for private sector engagement in underserved and rural areas may help address geographic inequalities, provided that such participation aligns with public health objectives.

For countries with mixed healthcare systems, including Georgia, these findings highlight the importance of balanced reforms that integrate private healthcare institutions within robust public financing and regulatory frameworks. Such an approach offers the most promising pathway toward advancing universal health coverage while maintaining efficiency, quality, and equity in healthcare delivery.

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AI Statement

We utilized AI technology (ChatGPT) in a limited way to correct grammar, improve clarity, and improve readability of the manuscript we rewrote and edited for this article, as well as providing us with suggestions regarding formatting, but we did NOT use any AI to design or collect data, analyze data, interpret results, or draw conclusions in this article. All contents of the manuscript were thoroughly reviewed, rewritten, and verified by the authors. The authors accept responsibility for the accuracy, originality, and final format of the manuscript.

Conflict of Interest: The authors reported no conflict of interest.

Data Availability: All data are included in the content of the paper.

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Appendix: Prisma Figure N1

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Cost, Quality, and Accessibility: A Comparative Analysis of Business Profiles in Public and Private Healthcare Institutions Literature review	points to its main topic
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Describes a brief overview of the article
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	introduction
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	introduction
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	introduction
Information sources	6	Specify all databases, registers, websites, organizations, reference lists, and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	introduction
Search strategy	7	Present the full search strategies for all databases, registers, and websites, including filters and limits used.	introduction
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if	introduction

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Section and Topic	Item #	Checklist item	Location where item is reported
		applicable, details of automation tools used in the process.	
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	introduction
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g., for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	introduction
	10b	List and define all other variables for which data were sought (e.g., participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	introduction
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	methodology
Effect measures	12	Specify for each outcome the effect measure(s) (e.g., risk ratio, mean difference) used	N/A

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Section and Topic	Item #	Checklist item	Location where item is reported
		in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g., tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	N/A
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as managing missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	introduction
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	N/A
	13e	Describe any methods used to explore probable causes of heterogeneity among study results (e.g., subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A

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Section and Topic	Item #	Checklist item	Location where item is reported
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	The selection process is detailed in the PRISMA flow diagram (Figure 1). From 182 initially identified records, 33 studies were included after removing duplicates and applying exclusion criteria
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Excluded reports and the specific reasons for their exclusion (e.g., mismatch in study design or population) are summarized in the Results section and the PRISMA flow diagram (n=65) p.3 Paragraph 4
Study characteristics	17	Each of the sites includes studying and presenting its characteristics.	Characteristics of the 33 included studies, including geographic context and study design, are summarized in the Results section, Page 4, Paragraph 1 and Table 1.
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Methods section, Page 3, Paragraph 2
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimates and its precision (e.g., confidence/credible interval), ideally using structured tables or plots.	Results section, Pages 4-6, organized by thematic domains. Table N 1
Results of syntheses	20a	For each synthesis, briefly summarize the characteristics and risk of bias among contributing	A narrative synthesis of the 33 studies is presented in the Results, organized by

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Section and Topic	Item #	Checklist item	Location where item is reported
		studies.	cost, quality, and accessibility. Summary findings are provided in Table 1. Results section, Page 4, Paragraph 2; Narrative synthesis across three domains
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g., confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Data extraction and synthesis
	20c	Present results of all investigations of probable causes of heterogeneity among study results.	Cost and Financial Burden
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Quality of Care
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Accessibility and Equity
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Accessibility and Equity
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Discussion section, Page 7, Paragraph 1
	23b	Discuss any limitations of the evidence included in the review.	Discussion section, Page 7, Paragraph 4
	23c	Discuss any limitations of the review processes used.	Discussion section, Page 7, Paragraph 5

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Section and Topic	Item #	Checklist item	Location where item is reported
	23d	Discuss implications of the results for practice, policy, and future research.	Conclusion section, Page 8, Paragraph 2.
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	N/A (The review protocol was not registered in a public database)
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	N/A
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N0 Page 8 (No financial support was received)
Competing interests	26	Declare any competing interests of review authors.	N0 Page 8 (Authors declare no competing interests).
Availability of data, code, and other materials	27	Report which of the following are publicly available and where they can be found template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	references

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372: n71. doi: 10.1136/bmj. n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

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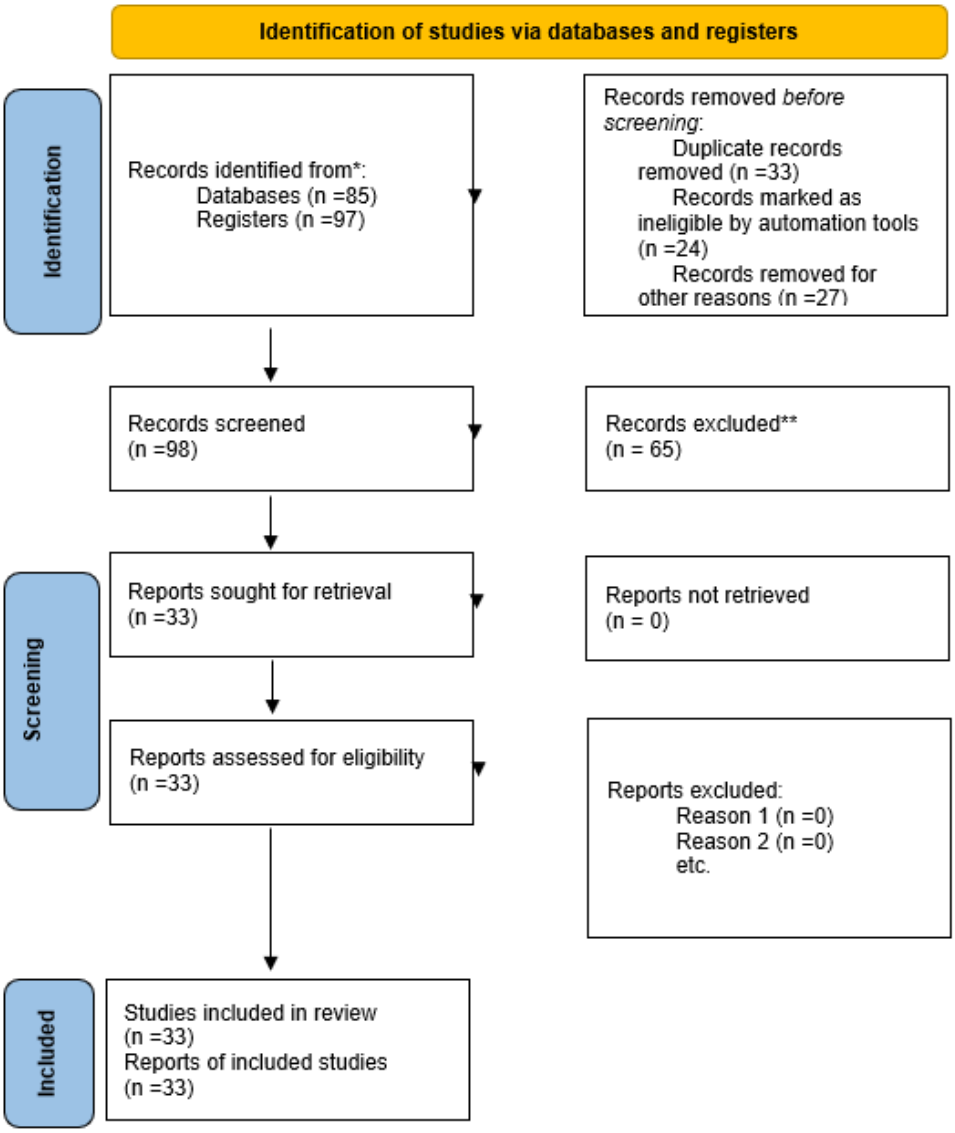

Figure 2: Prisma flow diagram