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Public-Private Collaboration in Malawi

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Malawi is a landlocked country in southeastern Africa. It covers an area of 118,500 square kilometers and has a population of approximately 11 million people. Malawi's health status indicators are poor, with an infant mortality rate of 134 per 1,000 live births, an under five mortality rate of 234 per 1,000 live births, and a maternal mortality rate of 620 per 100,000 live births. The leading causes of death are nutritional deficiencies, pulmonary tuberculosis, pneumonia, anemia, meningitis, malaria, diarrhea, and measles. More than 30 percent of hospital admissions are currently due to HIV/AIDS and related diseases. Although deaths from AIDS are not reported as such, AIDS is probably among the top three causes of death (MOPH 1996).

The main health providers in Malawi are the Ministry of Health and Population (MOHP), which provides 60 percent of hospital beds; the Christian Health Association of Malawi (CHAM), which provides 30 percent of hospital beds; and others who provide the remaining 10 percent of beds. In addition, about 1,000 traditional birth attendants are scattered throughout rural areas along with some 18,000 traditional practitioners with no formal links to the MOHP. Health care in Malawi is delivered at four different levels: community rural health facilities, district hospitals, central hospitals, and special hospitals that provide health care to the mentally ill and to leprosy patients.

The philosophy of health care provision in Malawi is the primary health care approach based on the Alma Ata declaration. The primary health care concept and strategy are rooted in the community, and the emphasis is on outreach activities. Given the poor health situation in Malawi, the diverse nature of what has to be done to improve people's health status, and the multiplicity of health providers in the country, this chapter summarizes the methods used for collaboration in the health sector and describes the country's experience with these methods. The chapter discusses collaboration between public and private nonprofit organizations, public and private for-profit providers, and public providers and traditional healers.

Background

The provision of health care in Malawi was started by missionaries at a time when the colonial government was busy trying to develop the structure of a modern state system centered on political, administrative, and economic aspects that favored settlers' interests (Ngalande-Banda and Simukonda 1993). The pressure on the government to provide some social services, including health care, is believed to have come both from

Africans organized in native associations and missionaries. Thus by the 1930s the government had embarked upon a program of setting up district hospitals (Ngalande-Banda and Simukonda 1993). Missionaries (pioneers in this activity), the people themselves, and the government (despite its major preoccupation being to set up the structures of government) all saw the need for collaboration in the provision of health services. Thus the provision of district hospitals by the government at this early stage can be construed as complementing mission activities in providing facilities for patient referral as well as providing health services in areas that missionaries could not reach.

From the late 19th century to 1964, the government established 21 district hospitals, the special hospitals, and a number of dispensaries and health centers, along with a central referral hospital in Blantyre and a general hospital in Zomba. The government commenced the training of nurses, medical assistants, and other cadres. During the same period, various missionary establishments also expanded their services, covering wider geographical areas and establishing hospitals as well as training schools for nurses and paramedics where these were lacking. Local government authorities, estates, and other government bodies, such as the military, established their own health care units (Ngalande-Banda 1995).

No records of the forms of collaboration that existed then are available, but it is safe to conclude that this was informal, with no demarcation of the various roles and with no written policies in place. One thing that is clear is that although collaboration was informal, it was accepted by both the government and the missionary establishments. Evidence of this is that, for example, the government took it upon itself to provide specialist medical care and public health care early in Malawi's history, complementing health services the missionaries started. Note that before independence, any collaboration that existed was only between public and missionary hospitals, and no collaboration existed between public providers and traditional healers. Private for-profit organizations were not yet in place.

Current Collaboration between Health Providers

The period from 1964, the year Malawi gained its independence, to 1992 saw the growth of health service provision on all fronts. This partly reflects the fact that African countries, including Malawi, adopted social welfare systems that in many ways replicated the systems of their former colonial rulers or new ideological mentors. The growth was also partly due to the policy of the new government. During this period the missionary health services grew tremendously. For these providers to interact well with the government and with each other, they formed a charitable organization called the Private Hospital Association of Malawi, which later became the Christian Health Association of Malawi, incorporated in 1966 pursuant to the provisions of the Trustees Incorporation Act. The overall objective of this body was to develop mutual cooperation among its members to obtain an optimal level of health services delivery and patient care, to act for the benefit and welfare of the people of Malawi generally, and to facilitate cooperation between the government and CHAM members.

CHAM was established as an ecumenical organization that brought together Roman Catholics under the Episcopal Conference of Malawi and Protestants under the Christian Council of Malawi. It now has 148 church-related member health facilities that vary both in size and in the scope of services offered. The services offered are mainly curative and facility based, although more recently they have emphasized preventive services and primary health care.

CHAM's executive committee implements policies and decisions through the association's secretariat. Under the executive committee are subcommittees responsible for planning, administering grants, training, organizing health service delivery, and managing personnel and drugs. The MOHP is not represented on the executive committee or on any of the other subcommittees. Even though the MOHP is represented on the council, it does not have a decisive influence on CHAM's policies because of its nonvoting membership status.

NGOs in the health sector do not fall under CHAM. They work independently of each other without any unifying body and each deals with the MOHP separately. Local authorities' health facilities operate maternity units, dispensaries, and health centers throughout the country. They provide only 3 percent of the services and have no unifying body. Other health providers, such as private for-profit organizations that came into being after independence, are organized through the Medical Council of Malawi. Traditional healers have an association, the Herbalist Association of Malawi, but not all healers recognize it.

The government has long recognized the need for collaboration in service delivery between the MOHP and its partners, especially CHAM. The National Health Plan of Malawi for 1986-5 states:

> Special attention needs to be drawn to the coordination of the future activities of all health providers, especially CHAM, with those of MOHP. CHAM receives a subsidy from MOHP each year. CHAM training centres are an important source of manpower for the sector as a whole. The magnitude of the CHAM contribution to health services and training of health manpower coupled with the significant financial contribution that the MOHP makes, requires that close cooperation and coordination should take place.

In pursuit of this policy, since 1986 the MOHP has explored ways to improve collaboration in the health sector. The MOHP started by conducting a joint MOPH and local authority study on improving local authority health services. The study examined ways to rationalize and consolidate service delivery at the health center level. Among the recommendations were providing financial support to local authority health units, exchanging staff, having the MOHP supervise local authority health units, and providing in-service training. These recommendations are already being implemented.

Next was a joint MOHP-CHAM study with the objective of improving coordination and collaboration between the MOHP, CHAM, and other providers. As a precursor to this study, the MOHP was reorganized in 1987 to allow decentralization of responsibilities and functions to the regions and districts. The study revealed the following shortcomings:

- Poor communication between CHAM and MOHP headquarters
- Poor coordination within CHAM
- Poor coordination between all providers
- Disparities in health service utilization
- Poor patient referral system
- Poor supervision of facilities and services
- Lack of a legal framework for government financial assistance to CHAM.

Following the revelation of these shortcomings, recommendations were made and are presently being implemented, for example:

- A draft agreement between CHAM and the MOHP has been prepared that spells out the clear obligations of both parties and empowers the government to audit CHAM's accounts.
- Health delivery areas have been set up to facilitate supervision and patient referrals in a manner that eliminates duplication and waste of the sector's resources.
- The government is collaborating with CHAM to improve the quality of nurses' training schools by seconding nurse tutors to assist in CHAM schools.

As noted earlier, the Medical Council of Malawi oversees collaboration between public and private for-profit organizations. This collaboration is presently limited to maintaining standards of care and organizing patient referrals from private to public units. Public collaboration between the public sector and traditional healers is not good, because not all traditional healers recognize the Herbalist Association of Malawi. However, public providers and traditional birth attendants do collaborate in providing family planning services, and the MOHP has a unit responsible for traditional birth attendants.

Lessons Learned

From the foregoing pages, clearly the need to collaborate in the provision of health services in Malawi has always been present. All parties have been involved in the collaboration to varying degrees. The question now is how effective has this particular method of collaboration been, what lessons were learned, and how this collaboration can be improved.

Since before independence to the present, the approach to collaboration followed what one could call a "big brother approach," where the MOHP has consistently assumed the big brother role. The MOHP has always taken a major and leading role in implementing collaboration, for example, in providing almost all specialist medical care, training all registered nurses (and recently doctors) without any contribution from other providers, paying local staff salaries and wages in all CHAM health units and providing drugs, and providing in-service training to CHAM staff members and local authority staff members. The MOHP has provided this assistance every year, and at the same time, allowed these providers to charge fees for their services and keep the revenue. Sometimes the MOHP has had to do this when its own health units have been facing crippling recurrent cost problems. Some view this situation as unfair.

The implication of the big brother approach is that any part of the health sector facing problems has tended to look to the government to provide solutions. For example, whenever they face a funding shortfall, CHAM and local authorities look to the government for assistance. The result is that providers are not equal partners, with all the attendant problems of feeling left out of policy decisions and suspecting the government's motives when it takes a certain course of action. Despite the good intentions of all parties concerned, the big brother syndrome has not helped to strengthen collaboration.

To address this problem, the government has formed the Health Sector Coordinating Committee, which brings together all major health providers, the Ministry of Finance, and the Department of Personnel Management and Training. The committee has met several times, but its effectiveness is limited because the MOPH lacks a desk officer to follow up on issues raised. Similarly, CHAM and other providers have no specific officer to follow up on matters. The result is that what is discussed is rarely incorporated into policy changes.

Thus the type of collaboration that exists between health providers in Malawi is mainly with respect to the provision of services. Because health services in government health units are still free at the point of consumption, there is no collaboration in the setting of patient fees.

Future Collaboration

Based on the lessons learned, future collaboration needs to focus on the following:

- Collaboration in the provision of health services should be strengthened through
  - Providing a desk officer in the MOHP to act as a gateway into the MOHP for all other providers, including NGOs, and to provide planning officers responsible for planning in all major providers except the MOHP
  - Operationalizing the health delivery area concept to streamline the referral of patients and supervision of health services provision.
- Further collaboration among providers will always have limited success, particularly in the referral of patients, supervision, and quality improvement, as long as the MOHP continues to provide free medical services to most patients. The government has already worked out ways to introduce cost sharing, and is now working out the necessary mechanisms, such as the need to retain fees collected at the collecting units and how such funds should be used.
- Collaboration in health planning needs to be introduced. Gone are the days when health planning was merely planning civil works, such as hospitals and health centers. Planning needs to deal with resources in the sector and how best these can be allocated equitably to improve people's health

status. The need to collaborate in planning and developing human resources for the sector and the expansion of financial resources is particularly urgent.

- The 1980s witnessed growth in the number of NGOs involved in the provision of health services and of private practitioners. Thus to facilitate effective collaboration, the laws and regulations that govern the provision of health services need to be reviewed.

Conclusion

Collaboration is unavoidable in the health sector in Malawi; however, current collaborative relationships require improvement if Malawi is to achieve further progress in the provision of health services. While various significant achievements in collaboration have been accomplished, especially from 1964 to 1992, more work remains to be done. While consensus generally exists on the areas that require collaboration, all parties concerned should develop mutually agreed on and effective mechanisms for collaboration in the future.

Immediate attention should be paid to policy formulation. The present form of collaboration is limited to material and financial support and service provision; it does not come into play in analyzing problems that affect health provision. This is unfortunate considering that primary health care as a strategy adopted by the MOHP emphasizes the need for coordination and collaboration within the health sector, as well as between the health sector and other sectors. This recognizes that health as defined today cannot be provided by one type of provider alone or by the health sector alone. The MOHP needs to open its doors to allow other providers, including NGOs not affiliated with churches, to participate in policy analysis and formulation. Likewise, these other partners also need to open their doors for the MOHP to appreciate, for example, the amount of resources they bring into the sector. Without this transparency and involvement in policy analysis, plans and policies made for the sector will remain unrealistic. The MOHP is about to start preparing the new national health plan to cover the next ten years. This is an opportunity to begin collaboration in policy formulation.

For other areas of collaboration, such as referral of patients, the MOHP will have to establish preconditions, such as the introduction of cost sharing, for this type of collaboration to be effective. We note that the mere creation of health delivery areas will not help much. In conclusion, we believe much can be done to improve the approach to collaboration if future actions are based on what has gone before.

References

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