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Public-Private Collaboration in Health: Issues and Implementation

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During the 1980s, the so-called lost decade, many Sub-Saharan African countries went through a period of economic turbulence. For most, this was also when they embarked on structural adjustment programs aimed at a wide range of reforms. Such reforms, some of which are still being implemented, have not spared the health sector. Perhaps the best example of reforms in the health sector is policymakers' preoccupation with the issue of public-private collaboration in health. In the last five years or so, researchers have been exploring different aspects of this subject. Interest in this topic can be traced to an interregional meeting that the World Health Organization's Division of Strengthening of Health Services organized in July 1991 (WHO 1991).

Public-private collaboration is being extensively explored for a variety of reasons. One reason is the dwindling of resources in the health sector, combined with increasing demands on the sector. This is especially apparent in the area of human resources, largely doctors, which are concentrated in the private sector. Policymakers see public-private collaboration as one way to tap resources that have moved away from the public sector. Another reason is that with the implementation of various reforms in many countries, dual systems of health care provision are inconsistent with the many prescriptions in favor of market determination (for a full exploration of the market characteristics of the health sector see Bennett 1991). Yet another reason is that governments have come to recognize that the dual system of health care provision is promoting inequities by leaving large areas completely unserved by "free" public facilities introduced at independence. Finally, an epidemiological transition has taken place, with a shift from a prevalence of communicable diseases to noncommunicable diseases and injuries.[1]

After the decline in popularity of independence movements, the public sector is increasingly being perceived as inefficient. This dissatisfaction with the role of the government has also promoted collaboration with the private sector.

1. Although this transition may not have taken place in the developing countries, the pressure for greater private sector participation from international financial institutions and bilateral donors may have been motivated in part by this phenomenon (see Bennett 1991, p. 1).

Table 6.1. *The Public-Private Mix in Health Financing and Provision*

		Provision	
		Public	*Private*
Financing	*Public*	• Government funding and provision free at point of use	• Services contracted to private providers • Government subsidy to mission facilities
	Private	• Supplementary direct user charges • Private beds in public hospitals	• Private health care funded by private insurance • Health maintenance organizations • Services by nongovernmental organizations

Source: Adapted from Bennett and Ngalande-Banda (1994, p. 3).

This chapter examines these issues in the context of southern Africa. The discussion is intended to generate further debate of the issues surrounding public-private collaboration in the region. As this subject is new and complex, this chapter does not aspire to present all the different models of collaboration available.

Organization of Health Sectors

At the risk of overgeneralizing, health sectors in most countries in southern Africa are characterized by the presence of two health subsectors, namely, the traditional and the modern. Missionaries introduced modern health care as a complement to their religious activities. After gaining independence, most governments introduced a strengthened public sector presence in the modern health subsector, which has existed alongside the traditional subsector.

The private subsector as used here covers "all those organizations and individuals working outside the direct control of the state, that is, both for-profit private companies and individuals and nonprofit private organizations" (Bennett and Ngalande-Banda 1994). This subsector is extremely diverse and incorporates elements of both the traditional and the modern. Whereas it may have been correct to group all the religious missions' health facilities as nonprofit providers, recent changes in the health sector mean that some of these providers now have a for-profit orientation. This chapter does not cover the traditional subsector.

A useful way to characterize the different players in the health sector is to distinguish between their methods of financing and providing health services. This is done in table 6.1.

While the degree to which any of the four models may be present differs from one country to the next, all have some combination of the elements presented in table 6.1. Increasingly, however, countries are tending to embrace private financing and public provision, as evidenced by the number of countries currently contemplating the introduction of user charges in public hospitals.

A further development is the acceptance of private financing and provision as complements to public sector efforts, and it is this that has led to the growth in the private for-profit sector that is increasingly evident in a number of countries. The evidence indicates that this has been taking place in Tanzania after a period of being disallowed (Bennett and Ngalande-Banda 1994) and in Malawi following the amendment of the Medical Practitioners' and Dentists' Act.

Resource Mobilization and Distribution

The role of mobilizing resources is best left to the government, which has the necessary instruments of coercion, persuasion, legislation, and regulation, coupled with the means for enforcement. However, the government

does not always achieve the optimal distribution of resources. Even though Sub-Saharan Africa as a whole receives funds from donors equivalent to 10.4 percent of its health expenditure, resources are unequally distributed throughout economies, especially within health sectors.

After several decades of independence, many countries still have areas that the public sector does not serve. This unequal distribution has placed a great deal of pressure on governments to accept some partnership with private providers, such as missions, which have tended to locate in remote areas. The unequal distribution of health facilities is prompting governments to explore ways to reduce inequity by granting concessions to private providers.

Approaches and Options

Public-private collaboration can be in provision, in financing, or in some combination of the two. Historically, in southern Africa the private sector has, in most instances, been providing modern as well as traditional health care longer than the public sector. In addition, because the private sector may be endowed with facilities absent in the public sector, collaboration can enable the public sector to gain access to superior facilities. In some countries the best hospitals may belong to the private sector. For these and other reasons, the most commonly used method of collaboration as it relates to sharing facilities is contracting.

With dwindling financial resources, another form of collaboration now commonly found in the region is based on financing. Under this arrangement, the private sector is called upon to help finance health care through insurance schemes or payment of user fees. Other more complex arrangements can also be found that combine aspects of both provision and financing.

Contracting

Contracting or outsourcing is a way to combine public financing with private provision (McPake and Ngalande-Banda 1994). Just as with other types of contracts, this arrangement makes use of a normal market exchange that is formalized in advance by a contract that specifies the services to be provided and the fees to be paid. The provider of the service could be another public institution; however, public health sectors are increasing contracting out to private institutions.

The best examples of contracting out are found in the areas of nonclinical services. The argument is that the health sector should concentrate on providing medical care rather than ancillary services such as catering, laundry, and security. The private sector can undertake these activities more readily, because monitoring and evaluating performance is easier in these fields, unlike in clinical services, where establishing the expected and actual quality of the outcome is difficult. Health policymakers also believe that these activities can be outsourced without compromising the quality of health care. There are indications that these arrangements are either contemplated or currently practiced in Lesotho (catering and security services), Nigeria (laboratory services), Uganda (catering, elevator services, and the management and maintenance of steam and boiler houses), and Zimbabwe (laboratory and equipment maintenance).

In other contexts, the public sector contracts out certain services as a way to combat the brain drain from the public sector. In Namibia, private general practitioners are contracted to provide surgery in remote rural areas for an agreed fee (Bennett and Ngalande-Banda 1994). Elsewhere, doctors are permitted to admit private patients in public hospitals in return for attending to public patients.

Health Insurance

Governments are increasingly trying to cope with resource constraints in the health sector by resorting to expenditure sharing between the public and private sectors. One way they do this is by introducing insurance schemes. Insurance schemes are also used to spread the cost of the risk of falling ill.

The most common of the different types of insurance schemes are (a) social health insurance, which is also referred to as national health insurance, especially where it covers the whole population; (b) employer-based schemes; (c) community-based health insurance; and (d) private health insurance. (For a discussion of these schemes see Bennett and Ngalande-Banda 1994.)

Besides offering the opportunity to spread the cost of the risk of falling ill, insurance schemes may have the added flexibility that expenditures against unpredictable illnesses can be met at the time that the household has the financial means to do so. This is especially true in the case of community-based schemes, to which contributions can be solicited at the time that most households are likely to be able to afford the premium payments, such as during the harvest.

Other Forms of Collaboration

A third approach that a country can use is to recognize fully the strengths and weaknesses of different providers and financiers in the health sector and to attempt to build a viable system based on the sharing of responsibilities. In many Sub-Saharan countries, mission hospitals and ministries of health have developed lasting relationships where the latter pays the salaries of staff working for the former, for instance, in Ghana, Malawi, Namibia, Tanzania, and Zimbabwe. This is essentially a way to safeguard the financial viability of the mission facilities. Other forms of collaboration involve paying lump sum grants (subsidies), seconding health personnel, providing relief from duty and taxes on imports (Bennett and Ngalande-Banda 1994), cooperating in staff training, and carrying out research and developing policy (in the case of South Africa).

In almost all cases where appropriate umbrella organizations exist, such as nonprofit organizations that manage mission health facilities, an important motivating factor for their establishment is the receipt of certain incentives, for example, public subsidies and tax exempt status. In return, the organizations have to meet specific conditions or agree to certain undertakings. In the case of Tanzania, for example, audited accounts must be provided to receive any assistance, while in Malawi subsidies for salaries are only for local staff (Bennett and Ngalande-Banda 1994). Note that suitable umbrella organizations are most prevalent in the nonprofit subsector as opposed to the for-profit subsector.

Implementation Mechanisms and Strategies

The last section touched upon some of the ways in which countries have fostered collaboration. The most common and successful conduit seems to be organizing a number of providers into umbrella organizations. Running parallel to this is the carrot and stick mechanism (Bennett and others 1994). What this means is that the government can foster collaboration by granting incentives (the carrot) or by setting regulatory mechanisms (the stick). Almost all countries use these approaches in various forms; however, some common steps are involved in successful implementation of these mechanisms.

Identifying and Phasing in Public-Private Collaboration

One important step toward successful collaboration is recognizing what is possible. The first step is to take stock of what institutions are available in the country to assess possible kinds of collaboration. Countries have found the easiest form of collaboration to be between the ministry of health and local government facilities in the provision of preventive primary health care services. In Malawi, for instance, these two facilities tend to be within close proximity to each other.

Financial collaboration requires there be some minimum support structures. Many countries do not have structures that can support insurance schemes or the introduction of user charges. They should therefore evaluate what forms of financial collaboration can work, and perhaps attempt this type of collaboration later.

Collaboration in service provision can also become tricky. For contracting to work, for example, the country needs to have some providers who have the infrastructure to support the scheme. This is important, because otherwise contracting could result in the deterioration of services, or even in acute shortages.

Requisites for Success

One of the important attributes of the private sector that could benefit the public sector through public-private collaboration is that people tend to perceive private providers as more efficient than public providers. They believe that, in general, private facilities are better managed, private providers allocate resources optimally, and services are superior than those public facilities provide. Nurturing this perception through collaboration is important for both collaborators. Thus designers of collaboration mechanisms should pay close attention to clear contract terms, appropriate pricing, and standards for quality monitoring.

By contrast, in some instances people view private providers as too preoccupied with making profits, and this perception should be downplayed through collaboration. For example, if collaboration results in the introduction of fees at public facilities, health care consumers will have to be convinced that the benefits of public provision, namely, universal coverage, will be retained in the process of collaborating with the private provider.

The success of collaboration will also depend on how well the collaborators' intentions are communicated to the community. Depending on the social marketing done, people can view a community-based insurance scheme either as a way in which the government is reneging on its responsibility to care for the poor, or as a way in which it is spreading the risk away from the poor. Thus each collaborative scheme must be evaluated on the basis of its implications for the users, and appropriate steps must be taken to ensure that its beneficiaries understand such implications.

Bottlenecks to Overcome

Collaboration encounters three main bottlenecks that it must overcome: capacity, availability of collaborators, and harmonization.

Many developing countries lack the capacity to manage collaboration. Successful collaboration in provision requires managerial skills that are often in short supply in the health sector. In addition, because of resource constraints, collaboration has to take place amid shortages, which requires ingenuity on the part of all those collaborating, but especially the government, which must also regulate. Similarly, financial collaboration requires the existence of financial systems to handle the complex accounting and auditing procedures required. In the case of insurance mechanisms, for example, both the health care provider and the insurance provider must adhere to certain accounting, reconciliation, and auditing procedures. Furthermore, the government needs considerable capacity to regulate insurers and monitor their behavior to avoid such problems as risk skimming and cost spirals associated with fee-for-service third party payers.

As concerns the availability of collaborators, successful examples of collaboration in many developing countries involve the nonprofit and public sectors. Where private providers are unwilling to form an umbrella organization, successful collaboration often becomes a problem. Simukonda (1992) lists some of the philosophical problems that can contribute to the failure of social welfare agencies to get organized. Note that in many developing countries the private sector is both extremely small and lacks the capacity to get organized.

A final consideration is the need for harmonization. This can take many forms. One area of harmonization that is proving important for collaboration in many countries is the need to harmonize user fees between private and public providers. Many countries have as many as three different fee structures: one for the private for-profit subsector, one for the private nonprofit subsector, and one for the public sector. In Malawi the harmonization of user charges has been under discussion since the early 1990s, and does not seem to be any closer to being resolved now than then.

Economic Impacts on Efficiency, Equity, and Sustainability

The previous section noted that people tend to perceive the private sector as more efficient than the public sector. This is because the private sector responds to market signals, although such a response can produce undesirable effects in health care. However, another reason is that the private health subsector is significantly

more decentralized than the public health subsector. This being the case, individual units are considerably more accountable than their public subsector counterparts.

One of the impacts of collaboration is that it can engender a move toward decentralization of decisionmaking and resource utilization. This can improve the efficiency of the entire health care system. Another avenue through which efficiency can come about is by accelerating the introduction of user fees systemwide, the effect of which, at least in theory, is greater allocative efficiency.

Public-private collaboration can also foster equity. In many countries, particularly in rural locations, vast areas are either not served by health care facilities or, where they are, the facilities are of different types. In many rural areas the only health facilities are mission facilities, which charge for their services, while in other areas services are free. Collaboration, in so far as it would require harmonization, would either require payment for all services or all services would be completely free.

A final impact is on sustainability. As much as most newly independent African governments wanted to be able to provide their populations with free health care, the majority have not been able to do so. They are increasingly having to rely on cost recovery from users, and to guarantee a reasonable quality of care, the resources of the public and private sectors have to be pooled. The most direct way to achieve this is through direct payment for actual services received, as is done through user fees.

Collaboration can also have a negative impact on sustainability when private providers take advantage of contracting arrangements to introduce cost-push elements into the system. This is common in the case of for-profit providers who can take advantage of loyalties established with consumers to inflate contract prices. Perhaps the best examples of such behavior can be found in insurance markets.

Broader Systemic Impacts

To the average user of the health care system, the impact of collaboration may be to simplify information that has to be processed on population characteristics, epidemiological profiles, disease burden, use, ability to pay, availability of providers, fees, entitlements, and so on. The health sector is notorious for imperfections in information flows. Through collaboration consumers could access this information by interacting with the system at any one point. For example, in some Sub-Saharan African countries patients can access both modern and traditional forms of health care without leaving a public health facility. Similarly, in many countries in the region, babies born in any type of health facility have equal access to immunizations through collaboration between the public and private providers. Such collaboration can improve on the reach of medical interventions within the community by being able to work through any system available.

The effect of collaboration on decentralization was mentioned earlier. Collaboration will not only ease the management of the health system at the local level, but also at the central level, where some easing of congestion will take place. In a number of countries free services seem to encourage overutilization of the services. Collaboration would standardize the level and quality of services, provide more resources to the sector, spread the consumers (and the rate of utilization), and curb unnecessary consumption.

One problem associated with private sector providers is that they place too much emphasis on curative rather than on preventive care. To overcome this, governments have provided such preventive measures as vaccinations and family planning interventions to private providers at no cost. With collaboration, providing such services through a shared cost structure may become easier.

Conclusion

Public-private collaboration is a complex and evolving research field. The complexity comes about because the roles of both governments and the private sector are changing all the time. It also comes about because the provision of health care in the region has always been divided among many providers. Furthermore, the emergence of HIV/AIDS in southern Africa as the main killer disease of the 1990s is also adding to this complexity.

This chapter has surveyed some of the issues that require attention in efforts to foster greater collaboration. Many countries are experimenting with a number of different models, and this chapter could not possibly do justice to all those efforts. The author hopes that this chapter will stimulate the sharing of specific country experiences, which will enrich the analysis.

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