Involving private voluntary health care providers in Better Health for Africa

Contribution to the study day on health reforms, Royal Tropical Institute, Amsterdam, 10 May 1996

In Better Health in Africa the World Bank promotes a prominent role for International and National Non Governmental Organizations, including confessional institutions, in the execution of the basic package of services and public health tasks.

As a staunch supporter and worker for NGO health care organizations I greatly welcome this important change in view of this renowned institution and the implicit recognition for the potential that these organizations have towards improving health care provision to the people of Sub-Saharan Africa. Depending in the country you look at, they provide 40-60% of health services used.

However, we should remember that the subject of achieving closer collaboration between public and private not-for-profit/voluntary health care providers is not new. Past attempts have had limited success. Failures have strengthened feelings of competition and have even sometimes fostered mistrust and hostility.

It is at district level that confessional institutions are more present. Since WHO started to promote the district approach to ensure the implementation of Primary Health Care, new attempts to establish a closer collaboration between public and private non profit are being tried. However, progress is slow and difficult.

The aim of this paper is therefore to show that we all need a clearer view on the ultimate goal of closer collaboration in order to assist the development of consistent policies and feasible strategies.

The World Bank defines NGOs as 'private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect environment, provide basic social services, or undertake community development'. In wider use the term NGO can be applied to any non-profit organization which is independent from government.

As in Sub-Saharan Africa Church-related/confessional or social organizations constitute the largest group of NGO health care providers and as my work experience is mainly with them, I deliberately narrow the definition of NGOs to this group. This narrowing-down coincides with the definition, also used by the World Bank and others, of private non-profit or private voluntary/mission health facilities/providers.

The essential arguments in 'Better Health in Africa'

The World Bank promotes the prominent role for NGO health care providers under two main objectives:

* Institutional reform and management
Collaboration with NG0s should be encouraged to ensure Institutional Pluralism in support of decentralization and in a wider context to broaden civil society.

As they have enormous potential, Governments should provide an enabling legal environment to ensure establishment and registration.

* Mobilizing resources

Increased NGO health sector involvement can ease the pressure on the public budget, certainly within strategies that mobilize out of pocket payment of households for quality health services. Also the private market is generally perceived as more efficient and thus subsidizing private voluntary organizations for specific public health tasks and/or contracting these tasks to them can enable the public sector to improve cost-effectiveness.

Though the reasons for a larger role of the private non-profit sector are not listed explicitly, these can be deducted from the general reasons for proposing the present Health Reforms for Africa:

- Reduction of the Government's direct engagement in provision of health care means other parties have to be sought to ensure the execution of tasks and duties.
- The enormous budgetary constraints force the Governments to determine priorities, improve cost-effectiveness and seek additional funding.
- Community participation and ownership is recognized as the most valid way to ensure responsiveness to household and community needs and ensure accountability. Public and Private sectors come together at this level and the community needs clear working relations.
- Decentralization is the central axis of the Health System Reforms proposed. The proposed 'District Health Care System' has to be a coherent and comprehensive delivery system capable of answering the needs of a well defined population in the context of Primary Health Care. To achieve this all health care providers/facilities in the district have to be part of the system.
- Governments have a constitutional obligation to ensure equal access and use of health services. Past ways of operating and financing health care favoured the urban well-to-do. To ensure equity Governments need to improve access and use of health services of the rural and peri-urban household. Most health facilities of private voluntary organizations can be found in rural and peri-urban settings.

The main strategies that the World Bank propagates to reduce governments' direct engagement in health care provision are privatization and decentralization. Private for profit providers can ensure clinical services for the wealthy and contribute to cost-effectiveness and quality of services through competition. Public Health tasks and access for the poor will only be taken on by private providers, if special subsidy measures are taken by the government. However, in many areas the population has no choice of providers as no other health facility is available. Privatization can thus not contribute to comprehensive and equitable PHC. The district health system, as a form of decentralization, aims at ensuring equal access while delegating the responsibility for execution of essential clinical services and public health tasks to local authorities and parties.

In the document the role of the NG0s seems to be in both. no clear choice is made. As private providers and competitors, the contribution of NG0s to alleviating the government's
burdens can only be limited. As part of the district system a solution has to be sought to ensure that the NGOs can take up the appropriate district tasks and responsibilities. The solution lies either in integration into the health system or in delegation of specific tasks and responsibilities to them. Here again the World Bank does not indicate a clear choice. It seems towards delegation when it mentions contracting of NGOs.

**The case of Tanguiesta In Benin**

Better Health in Africa takes up the District Health Care System as promoted by WHO. The need for close cooperation between governmental and NGO providers and integration of NGO facilities, in the context of the district health care system, has already been well argumented in all documents on the issue. However, experiences show that achieving cooperation needed to establish a coherent district system, is far from easy to realize. Experiences and policy guidelines are lacking all around. To find solutions I propose to look at the obstacles as they are perceived by a NGO requested to take on responsibilities in a health district. The example chosen is exceptional in that little or no cooperation existed between the hospital and the public sector before.

**Country situation:**

The hospital under consideration is situated in the northwest of Benin.

Benin is a French speaking Sub-Saharan African country, The problems that the health care providers are facing are largely identical to those of most developing countries.

The former government was communist inspired. This meant a high degree of centralization and no recognition for other social service providers. Since 1989 a Structural Adjustment Program is being implemented. This was followed in 1990 by political changes favouring democratization. The new policy for health care aims to improve health care for the rural population through strengthening Primary Health Care, decentralization and allowing private providers to practise. Cost sharing is being introduced under the implementation of the Bamako Initiative. Relations between the government and NGOs are coloured by the past. NGOs covered their own running and investment costs by asking fees and raising donations from their European counterparts. The degree of organization among NGOs is limited.

In 1994, at the instigation of the Government's International Donors, a Round Table Conference was held between Governmental parties, representatives of the donors and representatives of Non Governmental health care providers to determine the strategies for decentralization in health care. One of the main decisions of the round table conference was that NGO hospitals that are well placed to take up the role of district hospital, should be given this role. The details regarding how this should be achieved still need to be elaborated.

Atacora Region is the northwestern region. In comparison to others, it is the least developed region. Living conditions are harsh and communications difficult. This means that well trained staff does not want to work there. There are three hospitals in the region, two NGO and one governmental. Apart from the NGO hospitals the various institutes function far below their capacity. The Regional Health Department is assisted by the 'Dutch Support to Primary Health Care Project'. The fourth phase of their program is directed at reorganizing and improving the performance of the health care services. The approach chosen is to develop a district health care system. As a pilot experience the
Atacora Health Department and its Dutch partner wanted a NGO hospital in the Tanguieta district to take the role of district hospital.

Tanguieta is one of these districts. This district counts about 150,000 people. It comprises 54 village health posts together with 54 village health committees; 13 first line centres and one NGO hospital in Tanguieta town: St. John of God Hospital. The Saint John of God hospital at Tanguieta is geographically and functionally well placed to take the role of district hospital. It is owned by the catholic diocese of Parakou and managed by the congregation of the Brothers of Saint John of God (Fatebenef rate 1 li) of Milan, Italy.

The diocese and the congregation have the basic capability to take responsibilities in the management of the district.

Started in 1970, St. John of God hospital grew out to a be a 190 bed hospital. At present it considers the population of at least five surrounding sub-districts as its target population (approximately 200,000). The hospital provides first line, first and second level referral care. It has taken on all these functions in answer to the team's views on care for the poor and in response to deficiencies in the surrounding region. Patients have a large confidence in the hospital. They come from all over the region and the surrounding countries. Bed occupancy rate is 70%.

The financing of the running costs is covered for 33% by patients fees. The remaining part is contributed by the congregation's headquarters in Milan. This is a high rate of outside dependency (in most other countries the level of outside support is approximately 20%, mainly for investments). The congregation wants to retain accessibility for the poor in this way. At present it feels that the outside support cannot be increased any more. At the same time the devaluation of the CFA is driving up costs. The hospital is therefore forced to increase fees.

The hospital is well staffed with personnel (92) from the region and for the larger part trained on site. The management is still totally in the hands of expatriate members (6) of the congregation. The population is not involved in the hospital board. In the past the hospital had started two peripheral centres and outreach preventive activities. These were handed over to the regional health authorities around 1987.

St. John of God hospital as district hospital offers the opportunity to take charge of all the health related problems of a well determined population. First of all, this will increase the possibilities to reach the poor. Secondly, it will be able to plan the activities in a comprehensive way, so that it can improve delegation of tasks among staff, optimize the use of resources and improve efficiency. Furthermore, a responsibility towards first line centres together with a key role in installing and maintaining a two-way referral system, give the team much more scope to ensure continuity in care and services. Due to the hospital's financial restrictions and in view of equity it hopes that taking on responsibilities in the district will give it access to government subsidy. The leadership role and the subsidy will enable to install more rational fee systems.

To be able to progressively achieve this aim, the Atacora Health Department and their Dutch partner commissioned a study by an independent consultant to determine the issues to be addressed. The obstacles can be regrouped in four categories:
• Political and legal constraints

There is no legal context yet for the installation and functioning of a health district. The mandates of the district and its governing bodies, to determine local policy and resource allocation, have not yet been set.
There are no legal documents which recognize and determine the role of private non-profit health facilities. The absence of legal regulation of the district health system means that the execution of public duties by NGOs will have no legal basis.
There are serious inconsistencies between the ministry's policy statements and actions. The interpretations of the role of a district hospital differ between local level (referral care and strengthening of first line units) and the ministry (only referral care).
Determining the actual responsibilities is thus hampered.

• Organizational and structural constraints

The health system elements are not well interlinked. The district medical officer is not part of the hospital management and the hospital management is not part of the DHMT.
Vertical programs, separate projects and parallel authorities cause serious disturbances to local working relations, responsibilities and plans.
For the hospital, taking on new PHC tasks, causes a conflict of interests between financial self-sufficiency and equity/high quality standards and affordability.
The present services of the hospital need to be reoriented, but this can only be done if the surrounding facilities become fully operational: first line tasks for the population of the town have to be taken over by a first line unit in the vicinity; second line referral care has to be ensured by Atacora regional hospital.

• Resource constraints

The amount of finances, allocated by the government to health services, is very limited in comparison to the needs of the population and the problems the health system faces.
There are also inefficiencies in the allocation of resources.
Bilateral funding of running costs and motivational allowances endanger the sustainability and may prevent the mobilization of local resources, The same counts for the high degree of dependency on outside support of the hospital.
The hospital's high fees already raise fears regarding the actual accessibility for the poor. If these have to increase, to fund new activities, the access for the poor to referral care may become nil.
The region has a great lack of competent and motivated staff.
Staff management problems result in under-utilization of first line units. It is not yet clear where, under who's responsibility, staff management will be placed in the district system.
The hospital lacks staff that is capable of initiating and guiding operational integration and structural cooperation (e.g. a public health officer).

• Constraints related to attitudes, orientations and training

The communities are not yet well informed on the charges in policy and lack of understanding of its objectives. Health authorities and staff have little experience with participatory management (e.g. the communities have not been consulted regarding the role of St. John of God hospital).
The hospital and NGO fear losing their autonomy when becoming part of the district system. The health authorities are unsure of the allegiances of the NGO: to the people or to the mother organizations in Europe.
The fact that the dialogue between the two parties has and is instigated by donors instead of the Ministry of Health, does not facilitate the establishment of an equal working relationship.

At regional and district level there is a significant lack of management and planning capabilities. Together with the ingrained habits, this strengthens dependency on central level and outside support for determining the Public Health Policy.

In conclusion

In order to enable St. John of God hospital to take the role of district hospital, at least the following issues need to be addressed: the inconsistencies in policies; the legal embedding; clarification of tasks and responsibilities; operational relations with the DHMT and the regional health department; the health information and referral system; and, the funding of new tasks.

One and a half year after the round table conference the government still has to start work on elaborating the operational details. This also means that the Atacora Health Department and St. John of God’s hospital have not been able to constitute a workable relation for Tangueta District. Could it be that all are floundering because a leading principle, the ultimate goal for the collaboration is missing?

Autonomy versus integration

From the reasons for seeking closer cooperation between Public and Private non profit Providers and from the many obstacles facing regional health authorities and the NGO hospital to sharing responsibilities within a district, one can suspect a multitude of hidden agendas for all parties involved. How can we get these above board and/or can we make these manageable? A first step has to be to know and agree on where all involved parties want to go. Close scrutiny of the various obstacles also shows that a clear ultimate aim needs to be set in order to find solutions. The options seem to be integration or delegation. As stated before, the World Bank did not clarify its choice in this.

The non-governmental organizations of religious and social non profit origin, thought of here, are autonomous local organizations. Their involvement in health care stems form a broader religious or social mission to support the poor. The democratization and decentralization developments at national level provide new challenges to contribute in other ways to the improvement of services. They also open up possibilities to support popular movements in search of a more just society. They want to play an active role in the broadened society the World Bank advocates,

In health care NG0s present isolation from the system limits their possibilities to provide comprehensive PHC. Their financial constraints limit their possibilities to realize their commitment to the poor. They feel the need and have the capabilities and experience to assist in strengthening the existing health care system. NGO assets are: an important network of facilities, experience in community involvement and experience in providing health care under economical constraints. Most NGO facilities are either first line centres or first line referral hospitals. Geographical coverage can be largely improved when they are included, On the other hand, the tasks that they have taken on through the years, are often wider or more restricted than described in the OHS. Also, as they have had to ensure their own running costs, their fees may differ largely from the surrounding governmental facilities. The district health system offers, to their perception, great advantages for improvement of the health care provision and to solve the inadequacies and duplications
that exist at present between the two parties. Full integration of NGO facilities into the
district health. system is often seen as the most suitable approach. However, many NG0s
feel that, by definition, this would mean that they become one with the government system
and thus lose their identity. This is in contradiction with their wish for autonomy and
independence. To their opinion these guarantee their freedom to act in line with their
original aim. Their hesitations are often strengthened by past experiences with government
nationalization policies. The fact that most NG0s have not yet developed specific policies
in face of the new challenges, complicates matters still further.

Delegation: the feasible goal for collaboration

The principles of PHC and the definition of the OHS implies that the district has to be an
entity with a coherent system of participative management and an equitable financing
system (including user-charges). Each health facility/provider has to be part of the system
to ensure its cohesion and comprehensiveness. The definition does not imply that there
has to be unilateral ownership. The responsibilities and tasks for providers/facilities am
clearly defined/definable. This means they can be divided amongst the parties present, on
the basis of location and capabilities. The government has to remain responsible for
ensuring that the population has access to the health care it needs and that each person
benefits from an equal share of the national health care resources. Under the new policies
it can delegate responsibilities and grant access to such resources to other parties.

NG0s want to keep their autonomy while contributing to the improvement of health care
delivery to the same population. If NG0s want to remain faithful to their original aims and
play a positive role in society building, they need to know what is at stake at community
level as well as have influence at policy formulating and implementing level. Accepting
delegated responsibilities in the district health system, as partner of the communities and
the government, would give them both, while retaining an important degree of autonomy.
Integration would increase governmental responsibilities instead of diminishing these.
Delegation of tasks gives the government the possibility to diminish its executive
responsibilities, while retaining its constitutional obligation to ensure access to health care.
If its new role is to concentrate on policy formulation, regulation and control, it needs a
degree of independence from the actual providers. Also Governmental parties want a
degree of autonomy to be able to choose the best providers in a given area. The aims of
community participation and ownership in the health care district, also recognized by the
World Bank, are improving responsiveness to local needs and ensuring accountability.
Integration will limit the possibilities of free choice of the communities and households still
further. If the NGO is owned or strongly rooted in the community, it will also not want to
loose autonomy. Approaching Public-Private collaboration from the angle of delegation
ensures that the community’s free choice of providers is retained or broadened. The
participative management views imply that communities have a say in which providers are
part of the district system. The different autonomous partners also can ensure that the
composition of the district's policy and management structures can be more pluralistic.

Delegation implies an equal relationship between two or more parties: each party has
something to give and each party needs something from the other. This equal footing
allows each partner to determine what it can and wants to contribute towards the common
cause and what it expects from the other party in return. Negotiations can lead to
agreements. Execution of agreements can be monitored, controlled and changed.
From this angle the issues to be addressed, e.g. policy formulation, legislation,
organization and management, resource allocation, training and support structures, can be
approached more dearly and more easily.
Conclusion

It is an important step forward that an influential institute like the World Bank advocates larger roles for NGO health care providers in the health care reforms it wants Governments to realize. It is regrettable and to a certain degree dangerous that this policy document does not outline more clearly how these roles should be achieved. A pity because it would have greatly helped all parties concerned. Dangerous, because the general tone of the document seems to point towards Privatization. If Governments stick to this option, the potential of NG0s will be left untapped and the aims of the reforms will be harder to achieve.

All Government and NGO health care providers recognize the possibilities and challenges that the district health care approach represent towards improving the delivery of comprehensive Primary Health Care. The basic willingness to cooperate to achieve the essential aims is present. The case study shows that there are important obstacles for a NGO hospital to take up the responsibility of district hospital. Removing these constraints will not be easy and demands important efforts of all parties. Mainly it demands that all parties concerned determine what the ultimate goal should be. Integrating NGO health care providers into the governmental system is not a feasible strategy. It ignores the right to a basic form of autonomy of NG0s and adds to the burdens of the government instead of diminishing these. It also ignores the value of continuous dialogue between equal partners of different origin to shaping a democratic society.

Approaching the subject in the perspective of delegation of public duties and partnership between Government and NG0s respects, as much as possible, the autonomy of all partners. More importantly it facilitates determining the extent, the conditions and methods required to establish the necessary cohesion and comprehensiveness at district level. In order to respect the autonomy of NGO providers and use their technical capabilities optimally, delegation of the responsibility to manage a district or sub-district seems the most appropriate strategy.

In all situations of reform and reorganization Hidden Agendas occur. To enable public and private institutions to jointly build comprehensive district health systems, one should be able to get these hidden agendas on the table and try to deal with them. To achieve this, the goal to collaboration needs to be clearly identified. I hope to have shown that the best option is delegation.

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