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Viewpoint: Public versus private health care delivery: beyond the slogans

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In most settings, a 'public' health service refers to a service which belongs to the state. The term 'private' is used when health care is delivered by individuals and/or institutions not administered by the state. In this paper it is argued that such a distinction, which is based on the institutional or administrative identity of the health care provider, is not adequate because it takes for granted that the nature of this identity automatically determines the nature of the service delivered to the population. A different frame of classification between public and private health services is proposed: one which is based on the purpose the health service pursues and on the outputs it yields. A set of five operational criteria to distinguish between health services guided by a public or private purpose is presented. This alternative classification is discussed in relation to a variety of existing situations in sub-Saharan Africa (Mali, Uganda, Zimbabwe). It is hoped that it can be used as a tool in the hands of the health planner in order to bring more rationality in the current altercation between the public and the private health care sector.

Introduction

There is a growing interest in increasing and improving co-operation between the public and private sectors in the field of health care delivery, particularly in the developing world. A range of different explanations for this boost in interest can readily be identified. For a start, the already scarce resources for health care are dwindling yet further and linkages with the private sector may raise additional resources. There also is the gradual acknowledgement of the need to develop a *systemic* approach to health care delivery. The private sector is an important actor in this system, and can, under certain circumstances, substantially contribute to a consistent development of health systems.

Our field experience in sub-Saharan Africa confronted us with the rigidity, and even the strong emotions, that often tend to colour this debate on co-operation between the public and private sectors. The relative lack of rationality and objectivity in these discussions has contributed to a state of affairs where the concerned interlocutors clutch at their respective positions. It is common, and even natural, to notice a certain diffidence among civil servants and public health managers towards matters outside their control. The private health sector has often grown independently from the public health sector and is rarely taken into account in health planning scenarios. This has been the case in Uganda where the non-governmental sector, which generally has been in the forefront of the development of primary health care initiatives and which accounts for about 65% of the current primary health care delivery in the country, is rarely taken into account by the District Health Teams in their planning exercises. On the other hand, there is often in the private sector an excessive jealousy for its own independence, with a disregard of policy guidelines, aversion to evaluation, and hostility towards regulative measures.

It is increasingly evident that co-operation between the public and private sectors is a must in a systemic view of health service provision and in order to avoid expensive and useless duplications. In this perspective, it becomes important to move towards an ever progressive integration into the health system of all elements accepting a 'public' rationale of operation. But the definition of 'public' is, at present, somewhat hazy and needs focusing. The purpose of this paper

is to contribute to a proper definition and understanding of the terminology. We acknowledge the limitation of this paper to the specific context of sub-Saharan Africa. We intended it to be this way, since we believe the misconception to be stronger in that part of the world than elsewhere.

The confusion: what is the meaning of *public* and *private*?

In our view, one of the major stumbling-blocks in the process of understanding is the lack of consistent use and interpretation of the terminology public and private, be it conscious or not. We think attempts merely to answer the questions 'what is a public health service?' or 'what is a private health service?' would reveal the heterogeneity of views on the matter. The purpose of this paper is precisely to present some thoughts on *how* these very words 'public' and 'private' are used and to attempt to clarify *what* content they should refer to. We think that the development of a more coherent vocabulary is a necessary step in the broader process of co-operation between public and private sectors in the field of health care, or in any other social field for that matter.

In the majority of situations, the definition – both implicit and explicit – of a *public* health service refers to health care institutions *belonging* to the state. In sub-Saharan Africa, health care delivery is often supplied by private individuals and/or institutions whose ownership and/or administrative guardianship is *not* the state. In that case, the term *private* is used. It is generally understood that the public health sector should be supported by public money and protected by a series of privileges regulated by law, while the private health sector should operate on private funding, obtained through fees, donations or other means in the arena of a market oriented provision of service and of competition. This understanding is based on the assumption that the private sector is homogeneous and financially self-sustaining whereas, in reality, a remarkable heterogeneity exists in the private/non-government sector (DeJong 1991; Green 1992; Zwarenstein and Price 1990; Smith 1989).

Generally, when the service is rendered without lucrative purposes the specification 'not-for-profit' is added. The term 'non-governmental' is used to indicate organizations offering services without profit-making purposes, and whose ownership and/or administrative guardianship is not the state. We think that a distinction between public and private based on the institutional or administrative identity is not always adequate in dealing properly with the variety of existing situations.

The limits of this classification can be exemplified by the mushrooming number of non-governmental organizations operating for outright or hidden lucrative purposes. At the same time, there are public services which operate, to varying extent, on a lucrative basis, even if the intensity and the sometimes radical character of this shift in rationale within public facilities has not necessarily been the result of the planned choice of policy-makers. Examples of such shifts are the situations of some government hospitals in Zimbabwe and Uganda. In both countries, medical officers are allowed to develop private practice in tandem with their responsibilities and tasks in the hospitals. In the case of Zimbabwe, this measure is part of a broader effort aiming to attract national medical officers into the public sector in a context of massive brain-drain to neighbouring countries or to the private sector. In the case of Uganda, it grew out of a legitimate concern to increase the revenue of national doctors beyond the extremely low level of government salaries. In both countries, government officers are allowed to use the hospital infrastructure and hospital resources for treatment of private patients who pay them a fee, but without recompense to the hospital.

The gloomy prospect is one of governments ending up subsidizing – with tax-payer money – a private lucrative sector where basic measures of quality control are lacking and with a poor accessibility for lower income population groups. A 'two speed' health care system becomes a real threat – the same government would instead deny subsidies to private institutions striving, but finding it increasingly difficult, to offer financially accessible services, often at lower costs than those observed in public institutions.

The core of the matter really is that the adjectives private and public refer to the institutional or administrative identity of a given health service, taking for granted that the nature of this *administrative identity* automatically determines the nature of the *service* that is actually offered to people. In a time of reform of many health systems, with decentralization as a key element, this assumption can no longer be justified. If a distinction between public and private needs to be made, we think it cannot be based exclusively on the institutional set-up of a given service, but rather on the objectives and the output of that service.

Maintaining a distinction between public and private on the grounds of the administrative identity will only perpetuate confusion, prejudices and discrimination (positive or negative but, in either case, inadequate to the changing context). In Uganda for instance, the non-government sector (mainly Church-related not-for-profit organizations) has been able to achieve acceptable levels of health care delivery in some very remote and insecure areas of the country and in environments characterized by important social and political unrest with a *de facto* absence of the state. Nevertheless, the posting of national doctors to these institutions has become very difficult because of uncertain career and training perspectives for those who choose to work in them; nurses trained in NGO schools, which are formally recognized by the national Nursing Council and the final examinations of which are supervised by government officials, can make their way to the government service only with great difficulty; no or very little government subsidies are being allocated to NGO facilities which are considered by District Health Teams as falling outside their scope of responsibility, even when their importance for the system is openly recognized. The (private) status of these NGO not-for-profit hospitals, and the consequent refusal of support for them from government sources, clearly has hindered long-term development efforts, both for the NGO and for the state.

Such a distinction will hinder the dialogue between the different components of the health system at a time when each one's contribution and co-operation is necessary. Indeed, in the light of decentralization policies implemented in many developing countries, the institutional set-up of many decentralized 'public' health services is far less clear-cut. In the past all public health services, with few exceptions, belonged to and were financed by the state, represented by the Ministry of Health. Today, there is a trend towards decentralized ownership and management by local communities, co-operatives, administrative districts etc.

Such a trend can be exemplified by the case of the network of community health centres ('centres de santé communautaires') gradually put in place in Bamako (Mali) from 1989 on. Former rural community-based experiences in the public sector served as an inspirational basis for young medical doctors who could not be hired by the government and who remained, jobless, in the capital of the country. With some initial external help, three or four health centres were organized so as to offer basic curative, preventive and promotional services. The owners of the facilities were members of community associations created for the purpose and the aim of these health centres was to provide health care to the subscribing members through a system of cost-recovery. Later, a 'second' generation of centres was put in place with virtually no external help other than small in-kind loans by existing centres. These new centres built up their revolving drug fund through the initial voluntary work of their employees. Several of them acquired grants from different donors, but only at a later stage.

The government played a promotional and regulatory role by considering these centres as active partners in its health development efforts. The existing centres constituted the starting point for geographical health coverage maps drawn up by the urban district teams. They also received small subsidies in kind from the government, especially for immunizations and family planning services. Their revenue was tax exempted and they were granted a special license to sell generic essential drugs. This support was provided in the understanding that the health centres themselves would not generate profits.

The debate on the status of these institutions is still ongoing. Legal texts have defined both the government's and the health centres' responsibilities, but the way the centres were put in place and the pressure from unemployed health workers in Bamako indicate that some of the attention has been diverted from the equitable provision of health care to the raising of revenue, mainly to hire additional staff.

An alternative classification?

What really matters to the health planner *and* to the public, are the contents, the quality and the costs of the package of services offered. For planning and evaluation purposes, and for the allocation of the meagre resources available, it is important that a clear and explicit *declaration of intent,* or mission statement, of the health care institution exists, so that the output and accessibility of these services can be evaluated. In an era of rapid change, it is also necessary to evaluate over time how, and to what extent, the performance of each health care institution fits the mission statement. Hence, we propose a different frame for the classification of health services based on their declared objectives and on their outputs. From thereon, a dichotomous classification in health services with respectively a public or private *purpose* can be proposed. More specifically, we propose a set of

		administrative guardianship and/or institutional identity of the health service	
		public	private
purpose the health service pursues	public	a	b
	private	c	d

Figure 1. Classification of health services according to their purpose and their administrative status

criteria for the classification of a health institution in the category of 'public':

- A social perspective: a concern to enhance people's well-being and autonomy in a perspective of human promotion. In the case of health services this more specifically means contributing to people's realization of a socially productive life, in a climate of dialogue between all implicated partners and in harmony with the prevailing overall socioeconomic development.

- Non-discrimination: a concern to offer people accessible and quality health care without discrimination whatsoever with regard to race, sex, religion, political affiliation, social status, income level etc. This is not in contradiction with a positive discrimination of specified population groups, deemed to be in particular need of health care (e.g. women, children, disabled people etc), or with a focus on specific health problems in the frame of vertically organized health programmes (e.g. trypanosomiasias control programme, family planning services etc).

- Population-based: a concern to take responsibility for, and to be accountable to, a well-defined population for its health care delivery. This accountability could be based on a contract with the population, specifying the mission statement of the service or institution.

- Government policy guided: a concern to comply with government health policies for the level of care provided and to fit in a broader masterplan. Should any different views arise with regard to official policy, then it is necessary that they be argued, discussed and, when possible, formalized in official agreements between the health institution and the national health authorities.

- Non-lucrative goals: a concern not to reduce the purpose of the service to profit making. This does not, of course, mean that good working and living conditions would not be a right for staff, nor that the service must be run at a loss. On the contrary, it is desirable that any service be self-sustained (this is not always possible; it is even virtually impossible in the case of district hospitals) and that its staff can work in acceptable conditions. In any event, in order to preserve the public purpose of the service, profits made should be reinvested in the same service or in other activities of social interest in agreement with the concerned population.

These criteria, which are currently being tested in the context of district health care delivery in Uganda, do not exhaust the variety of possible criteria identifiable in other contexts. Nonetheless, they provide an instrumental framework which could be used to assess the purpose of health services rather than the administrative/institutional set-up only. Both perspectives can be represented in a simple two by two table (Figure 1).

The four cells of this table can be exemplified as follows: **a** corresponds to National Health Service (NHS) hospitals in the United Kingdom (although the current reforms of the NHS represent a gradual shift from **a** to **b**); **b** corresponds to most church-related

hospitals in Uganda; a shift from **a** to **c** is taking place in many government hospitals in Uganda and in some government hospitals in Zimbabwe; and **d** corresponds to the situation of many hospitals in the USA. The relative strengths of the actors involved in the environment of the health centre of Bamako will determine whether these centres end up in categories **b** or **d**, or remain somewhere in between.

It is clear that the variable 'purpose' does not completely fit the nature of a dichotomous variable: indeed it covers a range of intermediate situations in the wide spectrum from public to private. The same comment holds for the administrative guardianship as well. Figure 1 is thus an oversimplification of reality. We nevertheless think that it is useful to illustrate our point. If governments agree and accept the rationale of this classification according to the very purpose of the service, then it would allow them to achieve more accuracy in targeting their support to health care institutions and organizations – both government and non-government – who serve a public purpose. The case of designated district hospitals in Tanzania or Ghana illustrates that it is possible to define consistent policies. In the case of Uganda, it appears that many (but by no means all) of the non-governmental and church-related organizations would sufficiently fit the criteria defining a 'public' service. This classification could also be helpful to distinguish organizations in the present mushrooming of private practices throughout the developing world: it may help to separate the corn from the wheat. A consistent policy would then be to support those organizations and individuals that pursue a public mission, and not only those that fit a given administrative status.

Conclusion

We have argued that a distinction between private and public based on the institutional set-up of a given service is not always adequate in defining the very nature of the service offered, the latter being of paramount importance to the health planner at any level of the health system. For example, many private hospitals and health centres in developing countries operate according to a rationale which could be defined as public; at the same time, lucrative goals are being introduced into public health services which, eventually, endanger their adequacy, relevancy and accessibility. An operational definition of what could be considered to be a public health service is still lacking. This is not without consequence at a time when, on the one hand, most governments are (or have become) unable to respond in a satisfactory way to the health needs of people, and where, on the other hand, the contribution of the private sector is called upon more and more.

This paper attempts to identify some operational criteria which would enable services to be distinguished according to their public or private rationale. These criteria do not necessarily fit each situation, but they can open up debate among health planners aiming to bring more rationality into the current altercation between public and private. They may also bring the various actors beyond the slogans and to a constructive dialogue.

What could this classification be used for? In operational settings public administrations could use these criteria to identify elements in the health system which need to fit the rationale of public-oriented health service provision. It should not be impossible to develop from these criteria some simple indicators, both quantitative and qualitative. In Uganda, for example, the criteria 'population based' and 'non-lucrative goals' are progressively being used to identify those elements of the health system eligible for integration and, sometimes, for partial financial support. But there is definitely a need for further research: the set of criteria need to be tested in a variety of different situations and precise indicators need to be designed so as to render the whole process less of a theoretical exercise.

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Biographies

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