# A COMPARISON OF THE PRIVATE SECTOR IN ASIA AND AFRICA

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Western pharmaceuticals have the dubious distinction of being as popular and available around the world as coca cola! In the smallest villages in many countries one can purchase an antibiotic capsule as easily as a bottle of Coke (Bledsoe and Goubaud, 1985). How does this come about?

## GENERALLY THROUGH PRIVATE HEALTH SECTOR OUTLETS

What is the Private Health Sector? It includes not only health workers in private practice but also non-governmental organizations, mission organizations, voluntary associations and other groups (Muschell, 1996) and a largely ignored group - the Informal Private Sector. Private practitioners have been defined as "individuals who were perceived by the community to provide resources and assistance in illness but were not employed by the government health service" [Claquin (1981) in Aljunid (1995)] (Table 1).

Table 1

The private health sector.

| The Private Health Sector | |
|---|---|
| Formal | Informal |
| Private hospital | Drug sellers |
| Private clinic | Injectionists |
| Pharmacy | Pharmacy assistants |
| | Quacks |
| | Traditional: |
| TBAs (trained) ..... | TBAs |
| | Herbalists |
| | "Witch doctors" |
| (Qualified) | (Unqualified) |

Very little information on the Informal Private Sector is available, which is understandable because of the difficulty in accessing data. Since the Informal Private Sector comprises illegal (or at least not legitimate) health providers it is not always easy to count them, let alone elicit information from them. Frequently, too, this sector tends to be more common in rural areas where access for the research worker is not always easy.

Since governments cannot afford to carry the burden of total health care the private health sector is here to stay. How is this being addressed by Ministries of Health? It is recognized in many countries that staff in other public services (*eg* education and agriculture) are more numerous 'in the field' than are health staff. Is it feasible to enlist these other services to assist in health care delivery? It would seem particularly apt to encourage rural school teachers to monitor illness in school children and provide them with simple analgesics and possibly a first course in anti-malarials before referring them to health care providers.

Analyses of the effect on attendance at Public Sector facilities following the introduction of cost recovery systems, which have been increasingly introduced following the Bamako Initiative, appear to be the focus of research on African health systems, and very little is said about the Private Sector.

Do governments accept the fact that their figures for numbers infected/year is a gross underestimate, and that already under-funded health budgets should be increased, or should the *status quo* continue? *ie* since we cannot afford to look after all our ill, the Private Sector must continue to carry its share. However, governments must bear on them to improve the quality of care they provide through training and monitoring - which in themselves will be a drain on current resources.

Perhaps the above has already been accepted, and the only approach is to accept (formalize) the Informal Private Sector by training them to do "the right thing" without putting them through an even more expensive qualifying examination system - here I ignore the Formal Private Sector, since they are (technically) already qualified.

Before looking at examples of how the Private Sector is used by the public, and seen by governments, perhaps we could consider some possible

Table 2
Malaria in public and private sectors.

| MALARIA | |
|---|---|
| Public Sector | Private Sector |
| Reported no. of cases | Unknown no. of cases |
| Overdiagnosis | No diagnosis (many) |
| Overtreatment | Undertreatment |
| Drug wastage (too much) | Drug wastage (too little) |
| Inappropriate $T_x$ (non-malaria) | Inappropriate $T_x$ (malaria) |
| Rising cost of antimalarials - wasted financial resources | Drug resistance |
| | Injectionists - Hep, AIDS, etc |

differences between the Public and Private Health Sectors, using malaria as an indicator (Table 2).

Vision 2020 (Ghana and Vietnam); 8th 5-year plan in Thailand, and presumably similar edicts in other countries plan to introduce policy changes to bring in the Private Sector. How is it being done?

In Ghana the Private Sector, including NGOs, plays an important role in the provision of health services, and many mission hospitals are the *de facto* District Hospitals; they make monthly returns, but other private facilities are not required to do so. Eighty percent of the population has easy access to traditional healers and almost half the total visits to health facilities occur in the Private Sector. However, the Private Sector has not been involved in national health policy formation, and their contribution to health has not been fully recognized. There has been little government support or linkage to the Private Sector. These issues are being addressed by fostering links to the Private Sector, promoting partnerships between the public and private provision of health services and providing support to the private sector, and facilitating private provision where the private sector has a comparative advantage, *eg* by

- the development of a link between government and the private sector; contracting out of services;
- provision of training, equipment and grants; and
- incentives such as training, subsidies and technical assistance, and promotion of the development of allopathic and alternative medicine.

It is estimated that the allocations to recurrent and development budgets could approximate to $9.00 *per capita, cf* 1996 estimate of $6.4 (Anon, 1996).

It has been reported (Güldner, 1995) that very little is known about the performance of the Vietnamese health system prior to 1990 because of the unreliability of the data. After 1986, the health sector was incorporated into the extensive program of socioeconomic reform known as *doi moi,* or renovation. Despite positive macro-economic results, *doi moi* reforms such as deregulation and the sanctioning of private practice are threatening the government's wish to preserve equitable access to health care. Because private health initiatives mushroomed within three years, the Private Sector has developed at a faster rate than the Public Sector. Thus, while 100% of hospital inpatient care is provided by the Public Sector, two thirds of outpatient consultations are provided by the Private Sector, and less than 20% of all medical treatment involves a Public Sector physician or health professional. In Cu Chi province in 1991 approximately 10% of patients sought services from a commune clinic, while 40% attended private clinics and 15-20% accessed services directly from hospitals. The poor are more likely to use a commune health clinic when ill, with a 10% chance of being treated by a physician, in contrast to the more affluent, who obtained treatment in hospitals and were seen by a physician 90% of the time. A negative outcome of the free market in health care has been the reduction in equity. Thus, Vietnam has successfully established an infrastructure through which primary health care could be delivered, but it is not currently

operating as it might (Gellert, 1995).

The *per capita* health expenditure in Vietnam is less than $1.00 - one of the lowest in Asia (World Bank, 1992), and with more attractive opportunities in the Private Sector, staff with higher qualifications are already abandoning Public Service jobs.

Officially accepting the Private Sector raises another problem: that of requiring both the Formal and Informal Private Sector to report their case findings to the Public Sector. How can this be achieved when a large proportion of the Public Sector are illegal practitioners?

Access to health care is deteriorating in Africa: this has been documented in Mali and Senegal. Between 1978 and 1985, the number of patients seeking consultations in Senegal dropped by 36%, the number of hospitalizations by 67% and the hospital utilization rate by 22% Similarly, health service resources are shrinking. In Burkina Fasu, the Ministry of Health's purchasing power fell by 38.7% between 1983 and 1990 (Unger and Yada, 1993). Having said that, the government remains the largest single provider of health care throughout the developing world (Bitrán, 1995). Owing to a variety of circumstances, health services in many sub-Saharan countries are delivered inefficiently, are not readily accessible, and are of poor quality.

Following a comprehensive comparison of public and private health facilities in Senegal, Bitrán (1995) showed that private providers are highly heterogeneous, and tend to offer better quality services. A specific and important group of providers - Catholic health posts - were shown to be significantly more efficient than public and other private facilities in the provision of curative and preventive ambulatory services at high levels of output.

In several francophone African countries, rural people expressed dissatisfaction with the public health service. In Benin, for example, 59% of serious cases were initially treated at home, and for illnesses considered to be benign home/traditional remedies were the first resort in 72% of cases (Bichmann *et al,* 1991). Only 10% of interviewees who needed further treatment for serious illness remained with modern medicine, and 30-40% used traditional remedies exclusively.

A study of public, private and voluntary dispensaries in basic health service provision in the coastal region of Tanzania (Ahmed *et al,* 1996) showed that when the health activities in *each facility* were taken into account it was clear that the private dispensaries had a higher capacity in infrastructure than did *the other two types* of dispensaries, but the highest capability for providing curative and preventive services in accordance with national guidelines was seen in the public dispensaries.

In Kenya, during the period 1989-1991, cost-sharing at public health facilities (excluding dispensaries) was introduced; suspended for 20 months, and then re-introduced. Attendance patterns reflected these changes in cost for services. Following the introduction of cost-sharing, attendance at government health centers dropped by 52%, and increased by 41% after the suspension of fees. Demand at private and missionary health facilities dropped by 32% after suspension of cost-sharing, and attendance at government dispensaries rose by about 4%. It appears that the introduction of cost-sharing drove some 20-26% of patients out of the health system (Mwabu *et al,* 1995).

It seems clear that in Africa, given the overall government budget constraints, achieving a more appropriate balance between personnel and medical supplies is likely to require significant shifting of funding from personnel salaries to medicine and other supply expenditures, and that drug policies are likely to be among the most important policy actions that could simultaneously improve efficiency, quality and effectiveness of health care (Table 3).

All the above reflect the interest in the Formal Private Sector, but what of the Informal group? As said earlier, this is a more difficult group to quantify, let alone analyse, and will be even more difficult to incorporate into a revised government health sector.

Unrestricted access to medication is the norm in Africa, and self-medication with powerful drugs is common (Einterz, 1996), and private practitioners are significant health care providers in Asia (Aljunid, 1995). For example, Donnelly *et al* (in press) found that although 32% of self-referred malaria patients sought treatment at more than one facility, only 2% exclusively used Public Sector facilities and 87% used the Private Sector (59% exclusively).

As mentioned previously, information on the Informal Private Sector is scarce. However, Plasai and Spielman (1996) working on the Thai/Cambodia border recorded that local non-regulated healers

Table 3
Health care utilization in Asian countries.

| | |
|---|---|
| Selangor (18 yr adults)<br>32.5% public services<br>22.2% private clinics<br>33.6% self-medication<br>11.7% traditional healers | Philippines (adults - rural poor)<br>31% to private practitioners<br>18% to govt clinics<br>51% to traditional or none |
| Maharastra (1989)<br>77% illness episodes to private practitioners<br>13% to govt facilities | Papua New Guinea<br>15% of private practitioners patients were nationals in 1974<br>50% of private practitioners patients were nationals in 1984 |
| Western Java (1998)<br>12.8% private providers<br>16.8% public providers rest with traditional or self-medication | |

Source: Aljunid (1995).

prescribed orally administered concoctions containing chloroquine, quinine, tetracycline or primaquine for mild illness and administered parenteral chloroquine for the severely ill, and quinine for life-threatening malaria. Both "folk healers" and "injectionists" prescribed and administered Western medicine.

Also in Thailand, Okanurak *et al,* (1995) noted that the main source of antimalarial drugs (quinine and Fansidar) acquired by patients who practised self-medication was the drug store, and Fungladda and Butraporn (1992) noted that in Kanchanaburi province 78% of malaria cases who visited malaria clinics preferred to use self-treatment as the first stage of treatment, giving the reason that the cost of buying antimalarials from local drug dispensers was allegedly lower than the cost of travelling to malaria clinics.

Why do people use the Private Sector? To generalize, it seems that cost is the most important factor, and convenience, credit facilities and provider attitudes played important parts in the decision-making process.

Private health care expenditure in Thailand increased from 66.7% of the total health expenditure in 1978 to 73.2% in 1987 (Wilbulpolpraset, 1991).

In Thailand the Private Sector is not permitted to use some drugs, *eg* Artemisinin. An unconfirmed report from NW Thailand noted that government clinics were being asked to sell drugs to Private Sector, and Formal Private Sector practitioners were taking appropriately prescribed drugs from patients and replacing them with inappropriate drugs.

Finally, aspects of the Private Sector to be considered for future work (Tables 4, 5).

Table 4
What we need to know?

NEED TO KNOW

| | | |
|---|---|---|
| Type of service provided | | Quality of service provided |
| Perception of service | | Which service is best? |
| Who goes where? | Why? | What do they get? |
| Gender; age; acute/chronic status | attendance rates | Quality of diagnosis |

Table 5
What should governments do?

CAN GOVERNMENTS

- 'Accept' the informal private sector?
- Train informal private sector practitioners?
- Monitor formal and informal private sector practitioners?
- Expect reliable (accurate and regular) reporting from the private sector?
- DO GOVERNMENTS HAVE TO CONSIDER PROVIDING AN INDUCEMENT TO THE PRIVATE SECTOR TO ENSURE COOPERATION?

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