Public health care under pressure in sub-Saharan Africa

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Taking as point of departure the need for a strong public health care sector in developing countries the article firstly outlines how in sub-Saharan Africa enhanced scarcity has characterized the content and quality of health care in the public sector. This has eroded the trust among the public in the government as provider of health care and guardian of public health. Secondly, it describes how workers in the public health domain have dealt with the implications of scarcity by etching out a 'puvate' zone in health care provision and how these informal activities need to be interpreted as "muddling through". It also points out what are reactions of clients to a decline in public health care provision. Thirdly, it discusses the changing relation between the state as provider of health care and private sector health care provision at a time of emerging public–private partnerships. The article emphasizes the need for strong health services at basic health centre level. It is at that level that the state has to address problems of scarcity and regain public trust. It also is at that level where major long-term health policies like the imminent large-scale delivery of antiretrovirals (3by5) have to be accomplished.

[Sub-Saharan Africa, public health care, public–private mix, scarcity, quality of care; 3by5]

1 Introduction

The Report of the Commission on Macroeconomics and Health (CMH, Chair Jeffrey Sachs, commissioned by the World Health Organization) concludes that investing in health is an effective strategy for poverty reduction in developing countries [1]. One road towards health improvement is by way of better health care, and as a variable but considerable part of health care provision is situated in the public sector it appears crucial that this remains strong and viable. The CMH points out that public health

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systems of poor countries face a host of problems, including procurement systems that work inadequately, public service delivery that is not accountable, and supervision that is not effective.

Recently, in a series of articles in The Lancet on child survival in developing countries, a group of public health experts concludes that strong public health systems are important in order to address the problem that while efficacious interventions are available still many children are dying: “Although private initiatives can and should contribute, the longer-term goal must be systems of public health that are capable of defining needs, generating resources, managing programmes and people, delivering cost-effective services, and gathering and using data to improve the effect of their efforts” [2].

One important way to better understand prevailing problems in the public health sector in developing countries is by lowering the level of analysis in order to investigate how such issues take shape at the level of district health centres, small rural hospitals and the daily practice of health workers. It is there that public health service delivery and its clients interact most often and intensely, and where the stress on implementation of the new broad long term delivery policies of antiretroviral drugs against AIDS will be experienced continuously [3]. This paper focuses on conditions and changes at that level of public health care in sub-Saharan Africa.

The paper outlines, firstly, the general setting of scarcity in which health care in the public sector in sub-Saharan Africa operates. Secondly, it describes and discusses how workers in public health care at health centre level deal with the implications of scarcity, how their activities need to be interpreted when their behaviour deviates from the formal duties of a public role [4], and how their clients perceive problems in health care delivery. Thirdly, it describes some changes in the position of the state as provider of health care and maker of health policy that may affect availability of resources and operational culture in the public sector. Arguments are illustrated by referring to developments in Uganda, which have been well studied and documented. The Uganda case is relevant because processes that have been observed in Uganda, both before and during the introduction of the Health Reforms of the 1990s, also occur or have occurred in other countries in the region, although their specific shape and effects may differ. Moreover, more recently the Ugandan public health sector has shown signs of vibrancy, which imply that there are ways out of the serious problems discussed below.

2 Scarcity in public health care

In most countries in sub-Saharan Africa independence marked the beginning of a period of extension of curative public health care to the rural areas. Health centres were built and health care staff was trained. For a long time after independence the utilization of public health care was free of charge. Apart from vaccination campaigns when epidemics occurred and other efforts to control infectious diseases, public health care provision was largely a static phenomenon: people with health complaints needed to

attend fixed health centres. Still, this period of the 1960s and a large part of the 1970s meant for many that what they may have seen as Western or modern health care, as compared to that provided by their local folk healers, became a lasting presence in their lives. What had been available to some of them, particularly through the health care activities of the Christian missions, became a public provision for all [5]. Particularly for those living in peripheral areas the new provisions remained scarce, however, because material and personnel resources did not reach them. Moreover, provision of pharmaceuticals in the public sector was grossly inadequate in many places, eroding the trust in the government as a provider of health care [6].

Toward the end of the 1970s the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) initiated the global health strategy of Primary Health Care (PHC) to improve access to public health care, to extend the package of services provided and to raise the quality of their delivery. PHC aimed to achieve these aims by mobilizing both public resources, including those of national governments and of multilateral and bilateral donors, and the resources of the rural population itself. It endeavoured to extend preventive and simple curative care to communities by emphasizing the principle of self-reliance and by involving village health workers. Emphasis was on extending coverage of first level care to a rapidly increasing population, while improvement of dismal conditions in curative facilities got little attention [7].

In the course of the 1980s any progress that was being made in health development and in public health care provision in post-colonial sub-Saharan Africa faltered in a setting of economic recession, financial indebtedness, structural adjustment measures and political instability. On the one hand the economic problems and the by International Monetary Fund (IMF) and World Bank imposed austerity measures negatively affected household livelihoods, including possibilities to seek treatment in case of health problems, while on the other hand less funds became available for the daily running of government health care [8, 9 and 10]. Two mitigatory responses to such developments by UNICEF need to be mentioned: (1) a set of measures and programs called "adjustment with a human face"; (2) the Bamako initiative (BI), that aimed at sustenance of public health care by way of cost recovery through payment for drugs. The BI, which focused on Western African countries in particular, resulted in better availability of essential drugs, particularly in areas with scarcity problems.

Under the increasing influence of the World Bank the international discourse and organizational focus on public health care provision in developing countries changed at the end of the 1980s. Public policies of *Health Reforms* inspired by these new views characterized the 1990s. Firstly, more emphasis was put on efficiency and technical quality of care in health service delivery. Secondly, the interest in community participation and village health worker schemes waned. In its place came an organization focus on strengthening district level health care management. Thirdly, at the same time decision making in the public health care sector was de-centralized to the district level. Fourthly, in future people would have to pay for services received.

What did these developments imply for government health care provision in peripheral areas? It meant that the investment, extension and optimism of the early post-

colonial period stagnated or disappeared. What remained was marked by deterioration and increasing scarcity. Streefland et al. [11] have called this a process of contraction, including a shrinking coverage of basic health services, whose accessibility decreased due to the introduction of user fees. Quality of care diminished, as drugs became less available and the motivation of personnel waned as their salaries were reduced or paid with great delay. Village-based health care collapsed as external support to village health workers and trained birth attendants evaporated. Chabot [12] has documented this process of contraction for Cameroun, Agyepong [13] for Ghana, Inoussa et al. [14] for Benin and Dubbeldam [15] for Mali.

At the same time that government health care provision deteriorated, the health problems that the public health services encountered were changing significantly. Emerging epidemics of HIV/AIDS, malaria and tuberculosis led to a sharp increase in demands on the services, particularly of in-patient curative care and medicines [16]. Moreover, in quite a number of countries in the region – Angola, Congo, Eritrea, Ethiopia, Sudan, Uganda, Liberia, Sierra Leone – health service delivery was thwarted by (civil) war and refugee problems.

In summary, since the early 1980s in sub-Saharan Africa government health care provision is characterized by increasing scarcity of resources that in many places has led to a process of contraction. At the same time the international donor driven discourse on health care emphasizes the importance of a good standard of quality of care. High levels of incidence of major infectious diseases, notably AIDS, malaria and tuberculosis, burden the basic health services and those who run them and stretch their possibilities and motivation sometimes to the extreme. Personnel in health centres and small hospitals working under such conditions find themselves in a double, maybe a triple, bind: they are short of everything while facing extraordinary health problems, working in dilapidated buildings, while the rhetoric of training courses they attend emphasizes the maintenance of high qualitative standards. And this is, of course, only part of the strains of everyday life. For some, particularly the women among them, there are the additional demands of raising children, running a household and caring for the ill at home. Using the Uganda case we now shall look at how health workers deal with some of these stresses.

3 Informal economic activities of health workers in Uganda

In Uganda downward changes in government health care already began with the onset of a period of dictatorial government and civil war in 1971 that would last well into the 1980s. Before it began to deteriorate public health care in Uganda was among the best in Africa, whence its breakdown showed sharply [17, 18, 19, 20 and 21]. Descriptions of the deterioration process mention shortage of drugs, highly qualified staff members (doctors, nurses) leaving the services and migrating to another country, delays in payments of salaries [19, 20 and 21]. How did the remaining health workers deal with these strains, and what were the effects of their reactions? Results of two studies provide some answers to this.

The first study, by Whyte [21], regards developments in Eastern Uganda. She observed that deterioration of services – no drugs available, too few staff members who are often absent and give inadequate care for which they sometimes demand payment – goes hand in hand with diminishing attendance. Government health workers played an important role in the privatisation of medical care in the late 1980s. They did this by appropriating time from their working schedule to use that for private practice, and at times by taking away medicines. Whyte describes how at the time the private health care sector mushroomed. She concludes [2]:

> A weak public system motivates development of private activities, which in turn help keep the public system weak. Underpaid health workers, who have developed private practices, are little motivated to strengthen the state system. Yet public health care does not collapse totally, because it is supported by private health care both in the sense that health workers can afford to keep their underpaid state jobs and in the sense that for patients the private sector supplements the public one.

Whyte also points out that the wide availability of drugs in the private sector in combination with self-treatment may jeopardize health.

The second study, by McPake et al. [19 and 20] of 10 health care facilities in two districts, one in the Southeast and one in the Southwest of Uganda, focuses on informal activities of health workers during the late 1990s, the period that the government engaged in an effort to strengthen the public health services. It was observed that the informal economic activities of health workers were extensive and included leakage of drugs from public stocks, the levying of informal charges, the appropriation of time, and the leakage of money from formal user charges. It was further noted that the informal activities of the health workers jeopardised the accessibility of the services to the poor, because of the level of informal charges, and the misapplication of exemption rules. Among the study's conclusions two stand out. Firstly, the authors emphasize the survival value of the informal activities for the government health units. Without this way out the health workers would not have been able to maintain the government services functioning, even at a dismal level. Secondly, they point out that the differentiation among health workers is important. Some of them have better access to drugs or fees than others do, some have more extensive private practices and interests than others. This differentiation may preclude them to engage in collective action to create the public good of a well operating and accessible health facility that raises formal charges and exempts the poor and will, in due course, gain back its dwindled patient population [22].

4 Reactions of health workers and their clients to scarcity

The sick person who attends a government clinic has expectations about the quality of care he or she feels entitled to. Munene et al. [23] have studied the possible effects of the new Health Reform policy of the Ugandan government and observed these percep-

tions and expectations of users of public health care. They mention that getting medicines, being examined and getting an explanation about diagnosis and treatment are important among these expectations, with getting curative medicines clearly coming first. Non-availability of drugs, high fees for examinations and lack of explanations form a betrayal of trust at this level, a denial of feelings of entitlement. However, the researchers also observe variations between health centres and between users: some centres get a positive mark from the users; some users get better treatment than others, for instance on the basis of primordial ties between them and a health worker.

Birungi [24] describes how in Uganda deterioration of public health care led to erosion of trust among the public and subsequently to people acquiring and keeping syringes privately. She emphasizes how in a context of messages about getting HIV infection by using contaminated needles, people perceive keeping and using syringes for getting injections at home safer than receiving an injection in a public health care setting.

The breakdown of trust in the state as a provider is a consequence, not the cause of the deterioration of the public health services, although in due course it may contribute to further worsening of services because the clients stay away. At the basis of the decline is scarcity of resources, particularly salaries, staff and drugs, that I discussed in a general sense earlier. This scarcity is, first, selective. Taking the health sector in Uganda as a whole there may not be sufficient drugs in relation to demand, it is true, but the quantity, diversity and quality of medicines available outside the public sector may be larger and even increasing, as was the case in the late 1980s [21]. Moreover, scarcity is partly created by health workers who used the health centre stock for private transactions with patients. From the perspective of the people who need health care, the result is a rather diffuse situation in which public officials run private clinics at home, and sometimes even in the public premises, during the hours that they are supposed to run the public facilities. Clients also meet with new rules about payments, that are not the result of government decisions or negotiations between health staff and communities, but that are put up arbitrarily by the health personnel. It is this diffuse mixture of private transactions by public servants using public time, stock or premises that is characteristic for what in general may be called corruption, if this is generically defined as "misuse of public position for private gain" [25]. But if we look at the process from the perspective of how under specific conditions of scarcity the relation between the public and private in health care at the health centre level are articulated, it also may be called the emergence of a mixed 'puvate' zone. This term is chosen to distinguish the informal combinations of public and private at the health centre level from the formal health policy strategy regarding the intertwining of government disease control programs with drug donation programs of pharmaceutical companies called the public–private mix [26]. From the perspective of the health workers and of health care delivery the informal activities may, finally, be seen as 'muddling through' difficult times, with the aim to survive while keeping public services at a minimal functional level and keeping one's public position in the process. The health workers' behaviour, particularly beneficial to that part of the public (kin, neighbours) they feel morally most obliged to, then becomes institutionalised and sustained by a discourse of survival need.

5 Trust in the state as the provider of health care

According to Garrett [27] the provision of health care by the state is based on trust between that state and its citizens. The state is entrusted to further and protect the public good of health; the citizens agree to follow the rules and give payment. Consequently, the deterioration of public health care in many sub-Saharan countries can be interpreted as "a betrayal of trust", the title of her book on the collapse of global public health. According to Garrett this breakdown can have dire consequences, because it is the public health services that have to guard society against the spreading of epidemics.

After independence the new nations in sub-Saharan Africa inherited fledgling public health programs with an urban bias. They began to extend mainly curative health services to the countryside. At the time the preventive side of public health was restricted to malaria control measures and food and sanitary inspection. Still, it is this preventive and infectious disease control face of public health care that from the perspective of the state taking on guardianship for the public good of population-wide health is of great importance. International pressure on strengthening that side of the public health sector has been increasing significantly from the 1960s onwards, including drives to improve rural water and sanitation, immunization, and control of the infectious diseases malaria, river-blindness, guinea-worm, bilharzia, HIV/AIDS and TB. But it is the curative side of public health care that the population is most interested in. They want to have good quality care and medicines in case they are ill. There is, in this sense, often a real mismatch between what people want from the public health services (medicines, treatment) and what they get (vaccinations, health education, pit latrines). This affects the bond of trust whose importance Garrett [27] emphasizes.

This situation of trust under pressure is not stable. Economic conditions in the country are important for the resources that are available to a spending ministry as the Ministry of Health. International organizations like IMF and World Bank can curtail the financial degrees of freedom of the government as during the years that Structural Adjustment Policies were in place. Health related international organizations like WHO, UNICEF and, again, the World Bank, but also bilateral donors, put pressure on governments to improve, redirect or add to their public health care package, and particularly to the preventive elements of it. Recently, programs of global initiatives and alliances, including the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to combat HIV/AIDS, malaria and tuberculosis, have been added. Some effects of these programs will be beneficial, since they provide training, increase resources and boost health worker motivation, at least for a while. But when funds are used to finance special 'vertical' programmes, organizationally separate from the mainstream health care delivery structure, they add to the strains on public health care by drawing on the important scarce resource of trained personnel.

In a thorough analysis of trust in public health care Gilson [28] emphasizes the pivotal position of trust in regard to the effective operation of health systems in developing countries, as elsewhere. But according to her [28] there is much more to it:

> At one level, therefore, trust is important to health systems because it underpins the co-operation throughout the system that is required for health production. But trust-based health systems also offer more to society. Rather than simply being shaped by the changing basis of societal values, a trusting and trusted health system can contribute to building wider social values and social order.

To regain trust, there is work to be done. Birungi [28] in her analysis points out how in Uganda trust may be restored by involving clients more personally in the operation of public health institutions, so that they can assess the safety of medical procedures. As Gilson [28] puts it, trust has to be actively produced and negotiated, by improving personal behaviours, particularly those between providers and their clients, that build inter-personal trust. Further, by strengthening managerial and organizational practices that provide opportunities for inter-personal interactions needed for the building of trust. Finally, by providing political support to the development of such practices.

6 In conclusion: public health care under pressure and beyond

Using the example of developments in Uganda, this paper argues that public health care in sub-Saharan Africa has gone through a long period of enhanced scarcity. At the level of the health centre scarcity of resources may result in an erosion of trust in the state as provider of health care. It also may lead to an intertwining of public and private activities and roles of health workers that create a hazy 'puvate' sphere where public servants provide private services. Moreover, a reaction by the clients may be to take a certain medical practice or instrument from the public domain of the clinic to the private domain of their home, as was the case with syringes in rural Uganda [24].

The scarcity in sub-Saharan public health care was partly related to the restrictive policies of World Bank and IMF in the 1980s and 1990s. These policies impinged on the possibilities of the state to provide adequate public care and as such be a good guardian of public health. Towards the end of the century two important changes took place in international health with repercussions for the state as public health guardian. A reorientation occurred in the public health discourse regarding the role of the private sector, e.g. of pharmaceutical companies, and the co-operation of international (e.g. WHO) and national (e.g. Ministry of Health) public health organizations with those in the private sector. New global alliances (e.g. GAVI and the Global Fund) and national forms of co-operation between public and private sector actors emerged [29 and 26]. All public–private partnerships are geared to infectious disease control. The international forms focus on prevention of a range of infections (GAVI) or are more disease specific (the Global Fund). The national forms of such public–private partnerships mainly addressed the provision of pharmaceuticals in relation to specific infectious diseases. In Uganda, such tropical disease oriented programmes cover, for instance, leprosy, lymphatic filariasis, river blindness and sleeping sickness [30]. An important point is that although such focused provision of drugs is extremely important, in itself it does not address the more general form of scarcity of resources discussed in this paper.

The change in the international public health landscape, supported by an acceptance of private sector companies as necessary and credible partners, are addressing scarcity in a specific not a general way. Within countries they put pressure on the state affecting its autonomy in a way that Reich [31] calls the reshaping of the state from above, from within, from below. He [28] warns: "… measures are needed to shore up the state, not wither away the state, while allowing growth in the private sector and non-government sector and encouraging innovative public–private partnerships." Interestingly, in Uganda the state pursues a policy of achieving a balance. The government emphasizes integration of the previously isolated private sector into the national health care system, but also enhances regulation and control of the private sector; it provides incentives to attract private health services into the most underserved areas of the country, and avoids unnecessary duplication of services and wastage of resources [32]. But this is not an easy road to travel, because the regulatory and control measures are met with severe opposition [33 and 32].

The introduction of this paper emphasized the need for sustained strong public health care in developing countries. In order to achieve that it is necessary that a situation of general scarcity is addressed, so that district health teams are able to improve quality of care because they have the means (staff posts and salaries, drugs, maintenance of facilities, transport) to supervise and manage. Subsequently, through improving the relations between staff and clients mutual trust and respect will be enhanced. Any intertwining of public and private activities by health workers will be discontinued, as there is no longer a need for it. At the national level the state engages health improvement activities by private national and international organizations and professionals. Although many of such activities will have beneficial effects for those who suffer from specific infectious diseases, by impinging on the state's autonomy they also may jeopardise any efforts of the state to enhance public health care at the health centre level. It is crucial that also in the world of private–public partnerships the rural health centre that forms the primary source of biomedical care for millions of people stays clearly in the picture. Only with strong basic health services can big issues like improvement of child health, or long term delivery of antiretrovirals to AIDS affected adult populations, be accomplished. Only then can public health care adequately face the pressure of the health problems that confront it.

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