

Public and private practice: a balancing act for health staff

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Attempts to reform the health care sector in Africa have frequently failed to respond to the aspirations of staff concerning remuneration and working conditions. Salaries are often inadequate and may be paid late, and health workers try to solve their financial problems in a variety of ways.

In some instances, support is provided by churches or families. Incomes may be supplemented through educational, agricultural and commercial activities. However, health personnel obtain additional income mainly by undertaking extra duties in their specialist fields. Doctors in the public sector are increasingly offering their services to private patients. In many African countries, doctors are no longer full-time public servants. Combining public and private practice is commonplace and the boundary between public and private health care is becoming blurred. Whereas the public sector still provides a large part of the income of doctors in rural areas, those working in urban environments turn to private practice for a considerable proportion of their remuneration.

This state of affairs has been substantially ignored by ministries of health. The public authorities in most African countries lack the wherewithal to raise salaries sufficiently to compete with the strategies adopted by individuals for coping with their requirement for higher incomes. The authorities may hope to stabilize the situation by simply allowing doctors to boost their incomes in the ways mentioned above. This approach is encouraged by development agencies, pharmaceutical companies, urban élites and health workers themselves, all of

which derive advantages from the prevailing circumstances.

There are clear consequences for the performance of the health care system as a whole. Coping strategies affect the public service through competition for providers' time. Scarce resources are diverted and the mix of activities becomes distorted when only certain programmes, notably those favoured by donors, can provide living expenses for personnel or otherwise make life easier for them. When providers in the public sector begin seeing private patients, an element of competition between public and private work is introduced. Technical quality declines, the provision of care becomes less patient-friendly, access to it becomes more restricted, and efficiency, effectiveness and equity suffer. Diminished prestige and unsatisfactory working conditions are among the factors leading doctors to pursue activities not normally within the ambit of public servants. The combination of public and private practice creates a conflict of values and the traditional professional culture tends to break down. Health care becomes a commodity and the public health sector is seen as a place where private clients can be recruited.

The disruptive effects of structural adjustment programmes are exacerbated by this situation, and the ability of the state to provide, organize and regulate the health sector is rapidly undermined. In limited areas these roles may be fulfilled in some measure by nongovernmental organizations or donor-assisted projects. However, in countries where health care was, until very recently, provided exclusively as a public service, no organization of professionals, populations or patients has emerged with the capacity to replace the state in ensuring accessibility, equity and quality.

There is no prospect of public authorities being able to raise doctors' remuneration as a quid pro quo for the prevention or banning of coping strategies. Ministries of health should no longer act as employment agencies and should cease to guarantee the jobs of all health workers. Instead they

should concentrate on ensuring the health of populations and on regulating and controlling the health sector as a whole, including its private elements.

Achieving this requires the public sector to be substantially reduced in size, leaving a nucleus of dedicated, well-paid officials who can effectively concern themselves with policy-making and regulation. The combination of public and private practice should be allowed while ways are sought for minimizing the erosion of the public sector. In Algeria and Poland, for example, doctors are allowed to undertake private practice at specified distances from the locations where they perform their duties in the public sector.

Furthermore, the private sector should be enabled to create bodies meeting the needs of doctors and other health personnel, while ensuring a commitment to equity, efficiency and quality. A cooperative approach to health care, such as exists widely in Latin America, would be one possible solution.

Such policy initiatives, together with ethical principles and notions of social acceptability, are essential if the development of a commodity market in health care is to be avoided. Measures aimed at strengthening the public interest role model of doctors should be explored so that coping strategies can be shaped which do not conflict with public service goals and the delivery of care of high quality. Further progress along these lines can be expected as democracy gains ground, community organizations flourish, voluntary bodies proliferate, public demand for high-quality care increases, and the health care sector becomes more accountable. ■

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