

# Health care in the market sphere

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**Abstract:** Nations in sub-Saharan Africa have become increasingly unable to finance the provision of health care by public funds due to problems of increasing demand for these services in the face of diminishing budget allocation in real terms, decline in international assistance, and problems of managing health services in general. The wave of market oriented economic reform that is occurring in these countries is also further complicating this phenomenon. This article is a glance at the particular situation in Ethiopia with regard to the problem. Furthermore, using models of Organization theory, it is attempted to analyze the trend of health care provision in the country and come up with some suggestions that may be useful for policy related discourse. [*Ethiop. J. Health Dev.* 1997;11(2):169-176]

## I. Directions of health care reform in sub-Saharan Africa and the particular situation in Ethiopia

Changes associated with the new market oriented economic policy seem to have affected all economic as well as social sectors in Ethiopia, including the health care sector. Hitherto, this sector has been dominated with public provision of almost all services. Such was the trend in all of the sub-Saharan African countries. However, the government model is increasingly facing insurmountable problems in managing all the social sectors due to various reasons.

One of the major symptoms of these problems is reflected in resource allocation in the health sector. Most of the few available health institutions are under-equipped, and there is generally an insufficient spending on cost-effective health care. This is mainly due to the decline in the public sector budget (both in real and nominal terms) as well as in donor assistance.

In addition, there is an internal inefficiency of public programs reflected in situations like problems of management and lack of moral

and material incentives among health workers. Decline in real income of civil servants may result in diminished relative force of official incentives and increase the power of those that neglect formal duties. Due to the above facts, it is repeatedly mentioned that the transaction costs (e.g. resource wastage due to inefficiency) of government activities have increased and the incentives supporting formal organization purposes have diminished in most African countries (1, 2).

There is also an inequality in the distribution of benefits from health services. Undue emphasis is given to relatively high technology hospital care while the major problems are of preventable nature. Maldistribution of facilities and other resources with respect to urban versus rural and the rich versus the poor is also a significant problem.

Thus, due to the above problems, government financing of health care seems to have become unbearable in these countries. In addition, regardless of government initiatives, health practitioners are seen to engage themselves in private practice in urban areas. Most of these private practices are,

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majority in these countries) as well as the urban poor. Due to lack of drugs, reagents, and other medical equipments in these countries, there is concern that some of these private practitioners might shift some resources from the public sector illegitimately. The possibility that these workers may not perform their public duties actively and may even spend their public time in their private practices is also not an insignificant issue. On the other hand, there is a claim that these private services may help in relieving the public facilities from patient overload by attracting those who can

however, inaccessible to the rural populations (who are usually the

afford to pay (3). In any case, even if one claims privatization of health services as one of the solutions to the mentioned problems, there should be ways of assessing how this can be operationalized without compromising the public good aspect of health care.

The above mentioned problems also prevail in Ethiopia. Most of the public institutions are without the necessary drugs and equipment most of the year, the motivation level of the health workers is usually low, most of the health institutions are located in the capital and the few urban centers, where health workers tend to concentrate. The consequence is that we see a lot of workers underemployed and with minimal activities to perform in the urban centers, while the rural centers are badly understaffed (even for their inadequate facilities). This again has resulted in a dense concentration of private practices in the urban centers. The private practices are usually not well controlled and do not work in a uniformly regulated fashion. Drugs, reagents, and equipments do not seem easy to come by even in these facilities. Uniform guidelines for the type of activity to be performed by types of workers are only recently formulated. There is also complaint about the exorbitant prices charged by some of the private practices.

The government's new health policy includes, among others, such strategies as: encouraging the involvement of the private sector in health services delivery and financing and, regulating private health care and professional deployment by appropriate licensing (4, 5). Very recently, the government has also come up with a guideline for standardized private practice of medical care (6). Besides the need for some time for effectively applying this guideline, the management capability of some of the peripheral institutions to enforce the guideline is not very encouraging. In addition, the present political situation in most of the areas of the country does not seem to favor such an undertaking as a priority problem.

Nevertheless, the direction of the reform seems to be towards privatization of medical care practices. Thus, for policy makers, it is time to formulate strategies of implementing the reform in a way that can be fruitful and result in positive developments. For this purpose, one should explore some theoretical frameworks that can lead to useful suggestions for the process.

Therefore, the objective of this paper is to analyze the trend in health care provision in Ethiopia by applying the various tools of the New Institutional Economics. This new area deals with the economics of organizations, and is basically concerned with ways of creating incentives for better performance (7). However, before using such tools for suggesting solutions, the paper will attempt to predict the direction of the reform and the types of forces that shape its direction. In addition, it will also discuss the unfortunate consequences of market failure that would arise if the provision of medical care is exclusively left to free competition. After assessing the resultant direction that would arise from the interaction of the various forces, the paper will attempt to come up with some recommendations that may be of interest for discussions at policy levels.

## II. Peculiar features of health care as a commodity

Before attempting to predict the direction of change in the health sector, it will be helpful to outline some of the peculiar features of health care that distinguish it from other commodities which are amenable to market forces (8, 9). Table 1 illustrates some of these distinctive characteristics of health as a commodity.

Table 1: **Distinctive characteristics of health care as a commodity**

Attribute	Standard market commodity	Health care	Possible solution
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1. Uncertainty	Need can be forecasted and expenditures can be budgeted	Problems are unpredictable and expenditures can't be planned	Pooling in the form of pre or post payment eg. Insurance schemes
2. Externality	Benefits or harm accrue only to the individual consumer	Some others benefit(positive externality eg. Herd immunity)	Public provision of health services
		or get harmed (negative externality eg. Spread of a contagion)	
3. Needs	Will be reflected by individual demand	Health needs may be present regardless of individual awareness	Public provision needs assessment
4. Information	Consumer has a reasonable degree of knowledge about the nature of the item	Lack of knowledge about disease processes on the part of the patient compared to the physician	The Hippocratic Oath Licensure requirements Regulation practices
5.Amenability to competitive Forces	Generally amenable (private goods)	Less amenable(Public goods)	Public provision
6. Consumption or investment	Not all items have both attributes	Health care has both (Raising the social Value of individual health)	Public subsidy

The other fact is that market failure in health care in developing countries has some special features that distinguish it from the same phenomenon in the more developed countries. One of the most important among these is the failure in insurance and other markets (the absence and the difficulty of establishing formal insurance markets in developing countries) which makes it very difficult to charge full cost of hospital or other catastrophic care. Therefore, approaching the problem in these countries needs a slightly different strategy.

### III. Applying institutional analysis of organizational change: The role of institutional (coercive, mimetic, and professional or normative) forces in privatization.

Now, let us try to look at the recent trend in health care provision in Ethiopia from the point of view of organizational analysis. This might help us in trying to predict some of the changes that will arise in the reform process.

There are several theories about organizations which have been developed in the Western context (10). These are classified into the closed and the open systems models. The closed systems models generally assume organizations as entities which do not have any interaction with their external environment. On the other hand, the open systems model assumes organizations as interacting with their environment and emphasizes the fact that this interaction is crucial in fulfilling organizational goals.

Within the open systems model again, there are various perspectives. The most important one among them is the institutional perspective which can be best applied to analyze and predict the changes that are occurring in the health sector in Ethiopia. This perspective emphasizes the role played by the institutional environment in determining organizational structure and behaviour.

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Institutional environments are the rules, regulations, and requirements that arise in the broader societal context to which organizations must conform in order to get legitimacy and support. The major hypothesis of institutional theory is that organizations which incorporate institutionalized myths are more legitimate, successful, and are likely to survive. The central concept in this theory is isomorphism, which signifies that organizational change results in organizations becoming more similar, not necessarily more efficient. According to DiMaggio and Powell, there are three mechanisms for attaining institutional isomorphism: coercive, mimetic, and normative. Coercive isomorphism results due to pressures from the state or regulatory bodies to which the organization is accountable in order to get necessary resources. Mimetic isomorphism is the act of mimicking an organization which is perceived to be apparently successful in a particular field where the technology and the goals are uncertain. Normative isomorphism is associated with professional pressures. In addition to institutional isomorphism, one also finds competitive isomorphism, which is governed by the standard market forces (11).

The institutional perspective is relatively new, and not much applications of it seem to have been made in the analysis of health care in the developing countries. However, one can mention a few works which are related to the perspective, even though they are not applications of the standard theory. The most important one in this regard is Arturo Israel's analysis of the performance of human services in the third world countries (12).

Arturo Israel has attempted to explain the institutional performance of human services in these countries. According to him, the most important elements to performance in these countries are the level of specificity and competition in the particular services. Specificity, as defined by him, is equivalent to technical efficiency; and competitiveness, is equivalent to institutional values and pressures in the institutional perspective. In activities with high specificity, there is agreement and certainty on both technology and goals for performance. Competition embraces, according to Israel, in addition to standard market competition with the other sectors, pressures from clients, beneficiaries, suppliers, the political and regulatory agencies (the institutional environment).

Applying Israel's analysis, human services, including health care, operate in technically undetermined and competitively weak environments in developing countries. The institutional environments are even much weaker than is happening in the developed world. The implications from such analysis for the management of health services in developing countries is that more emphasis should be given to strengthening the institutional environment in addition to strengthening the technical environment. The main strategies prescribed for these by Israel include: strengthening professional values of work, use of nonpecuniary incentives, and simplification of methods and goals as much as possible. Since modern health care is a relatively recent development in these countries, it may take some time for the development of technologies (technical environment) and necessary pressures from public and appropriate regulatory bodies (coercive institutional environment). Therefore, the role to be played by professionalization (normative institutional environment) is very high in this period.

At this stage, one may question the applicability of Western organization theory in the analysis of third world management problem. Such a skepticism is especially justified since there are very few success stories in transferring management methods from one context to another. However, the most important element in the failure of transfer efforts seems to be the fact that most attempts were made using the closed systems models which do not usually give attention to the external environment and to socio-cultural settings of organizations. As a result, such transfers could not control for any contingencies that may arise in the other setting where the transfer is being attempted. On the other hand, the relatively new open systems models give important emphasis to the cultural and social settings in which the management is going to take place, and therefore, their principles can be better applied in cross-cultural settings to analyze and predict trends in organizational change instead of looking at a fresh start for other theories (13).

Presently in Ethiopia, as in most of the sub-Saharan African states, there is considerable change in health care organizations from the dominantly public form to private practices. Thus, applying the institutional perspective may give some insight as to the direction of this change and why it is following the particular direction now being observed. The main questions to be asked in this regard are: why do we see changes mainly to private practice forms and not other forms such as publicprivate contracting arrangements? what is the driving force behind these changes?

At this moment we see changes dominantly from competitive and mimetic isomorphism. We see changes due to competitive isomorphism because competitive isomorphism usually dominates the earlier stages of adoption of innovation or change (11). The fact that mimetic forces are working shows the uncertainty within the environment, and the fact that there are fewer alternative structures to be adopted since there is very little exposure to other forms of health care provision in the past.

Even though its effect is very small at present, we also observe changes due to coercive isomorphism in terms of following uniform standards in the types of buildings and technical equipment needed for establishing private medical practice. There are also some changes emerging as a result of normative isomorphism. These latter are seen to manifest in most of the organizations having similar patterns in their acquisition of laboratory and radiologic facilities, and in almost all of them hiring pharmacists and other professionals. Normative forces may become stronger in the near future because the coercive forces of the institution are relatively weak and there is a high degree of professionalization in the particular field.

We also can analyze the organization level predictors for the three types of isomorphic forces advanced by DiMaggio and Powell as follows:

1. Coercive - There is greater dependence on the centralized and local governments for licenses, continuing education (the training institutions are also owned by the government), drugs and equipments (these are also bought from government stores or the import license is to be approved by the government). There is also the need by professionals to remain employed in government facilities mainly due to a sense of national feeling and commitment to the public aspect of their profession. Economically this is also necessary in order to attract more patients, since revenue from private practice alone is not adequate at this stage in most of the areas.
2. Mimetic - Uncertainty in the future arrangements of institutions and the market in the face of a newly constituted regime.
3. Normative - The great reliance on having a specialist on the practice for attracting more customers, the symbolic effect of having laboratory, ultrasound and radiologic facilities and being affiliated to professional associations.

Thus, in the final analysis and in line with Israel's prescription for improving the performance of human services, it seems that normative forces will play the dominant role in shaping the structure and behavior of the health services and the direction of privatization.

#### IV. Possible ways of approaching the problem

If the trend of the reform is as predicated above, how can we combine the various forces to counteract the disasters that could arise from leaving health care provision exclusively in the market sphere or to undue coercive regulatory forces? Let us further analyze the appeals of each of the forces and try to come up with a combination of beneficial aspects.

##### 1. Competitive forces (privatization)

It is the contemporary paradigm that privatization and market competition outperform government provision of services in most circumstances. The fact that markets can decentralize decisions to the point where the relevant information about demand exists is claimed as giving those who make the decisions a strong personal incentive to make them efficiently. In addition, they are believed to be vastly simpler to administer and thus generally more effective than hierarchies (14).

It is further argued that government provision of goods and services at subsidized rates will not be effective in Africa since it neither provides a sufficient volume to satisfy the demands of all the people, nor effectively directs its subsidized programs to those who genuinely cannot afford the service otherwise so that the needs of the more wealthy are met by private suppliers. On the other hand, because of the tendency towards bounded rationality on the part of the lay community and due to the possible neglect of the collective good aspect of care by self-interested practitioners, a completely privatized, fee-for-service system would be susceptible to the consequences of market failure (15). Therefore, government regulation of private practices still remains to be one of the solutions to control these problems.

## **2. Coercive forces (government regulation)**

The public provision of health services is necessary for equity and to protect its public good aspects. The argument here is that the private sector cannot be relied upon to provide adequate levels of public goods without extremely close monitoring. However, the literature is not very optimistic about the feasibility and effectiveness of public sector regulation to provide this close level of monitoring in most countries. It notes that there is usually a considerable imbalance between the quite intense interest of the regulated group in favourable terms of regulation, and the diffuse interest of consumers in better prices or quality. Conditions favorable to regulatory effectiveness are especially rare in Africa where people are barely organized and where the state itself has already been seen to have a weak capacity for implementation (3, 9, 14).

## **3. Normative forces (professionalization)**

The main issue here is proposing institutional arrangements that can combine the appropriate prices of the market sector with appropriate incentives in the public sector (7). As mentioned above, in Africa the state alone cannot be relied upon to protect the public good aspect of health care. Therefore, one should resort to other approaches. Normative forces in the form of professional associations would play vital role in this respect. Associations for health care professionals have been observed to exist in most countries in Africa. Furthermore, they will increase quantitatively and get more differentiated and the resultant market position warrants their commitment to service quality. Most important, however, professionals are expected to adhere to 'institutional altruism', a set of professional norms which involve a collectivity of service orientation. This attribute contributes to their not neglecting equity and other public good aspects of the service (9).

Professional associations also serve as media for advancing knowledge and expertise and for updating members on what is happening elsewhere in the particular field. This also has a considerable impact on overall service quality. In addition, the peer group pressure and constructive criticism that may arise from constant interaction will help sustain the professional integrity of the members in the face of any contrary environmental pressure. It is also possible, even if usually rare, that the association may suspend or revoke the license of those who violate professional standards.

## **4. Combination (subcontracting or quasi-private)**

One important caveat for the above arrangement is that most of the better learned professionals tend to concentrate in urban areas. On the other hand, the majority of the population and the major health problems are to be found in the rural areas, especially in countries like Ethiopia. Besides the lack of reasonable living conditions, the private fee-for-service market in such areas is not inviting for full professionals. One possible solution suggested is to allow government employed practitioners in these areas to practice privately in their spare times. In this suggested quasi-private scheme, the state can also contract the delivery of selected services to these employed practitioners or alternatively contract with the private practitioners in such areas to provide certain public functions (14).

In this regard, it is to be noted that public health officials in Ethiopia are concerned about the fact that most of the private practices are concentrated in urban areas and private practitioners are not usually willing to operate in rural areas. The quasi-private option, if properly implemented, may be one of the solutions to such a problem. However, one of the concerns about such schemes is that without close monitoring the public good aspect of the care may be jeopardized in the face of strong private incentives for the practitioners. Nevertheless, the integrity of professionals should be counted on in counteracting such situations. In addition, this is where the professional associations become important in encouraging and regulating adherence to ethics and professional values. The other problem in this context would be whether such quasi-private schemes could operate in a competitive manner and how to administer the licensing and the operation of such contracts which will have very high monitoring costs. Given the conditions prevailing in many parts of Africa, agents of the state may be bribed or influenced to give or renew a contract for a practice to someone with bad performance or greedy enough to exploit a monopoly position in an area. Some of the strategies to avoid this problem include involving the client in the provider selection and contract renewal processes and encouraging the private sector effort to focus only on certain health services where the public goods argument is weak, or where monitoring is relatively easy (3). In addition, a strong professional body can be a factor in fulfilling the above function than a government ministry. These associations are usually dominated by the better trained ones unless they are politically manipulated otherwise. Therefore, it is to their best advantage if consumers are able to differentiate services of better quality from those of lower ones. The result is that these professional associations tend to regulate themselves and improve their market position (16). Such a behaviour would be even more facilitated if the state involves or delegates these associations in the processes of licensing and performance monitoring (14).

In conclusion, the real issue is whether we are better off leaving health care provision exclusively to market forces. According to the present analysis the answer seems to be a 'NO'. Of course, the market should play a crucial role. However, due to difficulties of enforcing the public good aspect, and due to the peculiar features mentioned above, other forces should play the dominant role. These are the coercive forces of the government and the normative forces of the profession. In this regard, strengthening the available professional associations in the country should be a formidable task of concerned public health officials. The need for the central role of the coercive (regulatory) forces of the government arises not only due to the fact that the professional associations in the country are not strong enough to take full control of the situation, but also due to the fact that these associations have increasingly become self-enhancing interest groups that usually give attention to elites and those who can afford to pay more than average prices (17).

Therefore, it is very important, at this particular moment, to make every effort to strengthen the professional associations in the country with particular emphasis in controlling the expansion of quality and cost effective private practices in urban as well as rural areas. The government sector also should be strengthened in its capacity to effectively regulate and give the necessary support for the development of efficient private practices along with creating the necessary incentives for deploying health professionals at all levels of government health institutions.

Particular emphasis should be given to further research on some topics of relevance to the present issue. Most important among these include: assessing the effect of user charges on quality of service and willingness to pay, identifying mechanisms of maintaining equity with reforms, investigating the applicability of the mission health service model to health care provision and to public-private subcontracting arrangements, and identifying services that are most appropriate for the private sector provision.

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