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In the Perspective of Human Rights

A new place for church related NGOs in the health services?

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Before the church related NGOs could enter into a dialogue with the government on contracting, they need to strengthen themselves and define their vision, goals and objectives for church health services. They need to revisit their mutual working relations and strengthen their national organisations as negotiating partner for governments.

During the last fifteen years, in many countries in the world public service reforms have been initiated, with the aim to create a "lean and mean" public service. There are two reasons for these reforms. In the first place a kind of ideological reason: the belief in the effectiveness of free market mechanisms. In the second place a purely financial reason: cost reduction.

The ideological motivation is interesting to explore. After World War II in most European countries a state-controlled rehabilitation programme guided the building of a new economy. But after thirty years, it was felt to be inefficient. The fall of the Berlin wall and the fall of most Communist regimes in East-Europe added to the idea that state-controlled economies could not work. According to the new ideology, the state had to withdraw its control and had to stop providing services. It had to leave the market to find its most efficient ways of operation.

In most third word countries, the state-controlled economies were inherited from the Colonial governments and were hardly changed after independence. Bankrupt countries in East and Southern Africa had to accept the consequences of the free market economy under the structural adjustment programmes imposed by the International Monetary Fund in the 1980s and 1990s. Often the African governments were not very willing to embrace the new ideology, but simply had to accept a free market economy in order to get support from the IMF and the World Bank. Everywhere in the world we have seen and still see privatisation of former government services and parastatal companies, like post and telecom services, or in the transport and mining sector.

Health reforms

Though in some countries people in the health sector see the health reforms as a unique and autonomous process, they are just part of the public service reforms. However, in countries like Zambia and Tanzania the health reforms have a bigger momentum than the public service reforms.

Health reforms are taking place world wide, though sometimes not as openly discussed as in Eastern and Southern Africa. Examples of health reforms can be found in the United Kingdom, the United States, the Netherlands, but also in Latin America, in countries like Peru and Bolivia. Countries in Eastern Europe go through a very extensive reform process. The elements of the health reforms are more or less the same as those of the public service reforms: introduction of market mechanisms, reduction of the role of the central government in service provision and not to forget cost-reduction or at least cost-control.

A unique element in the health reforms in comparison to the general public service reforms, is the discussion on the contents of the services - often called health care package. This element of the health reforms was strongly promoted by the Word Bank, with publications like "Investing in Health" and "Better Health in Africa". Though there was much criticism on the way it was presented, it was an important discussion. It acknowledged that the government is responsible for guaranteeing a minimum package of health care for its people. In fact it acknowledges the limitations of the free market mechanisms in social services.

In many countries – at least in theory – the National Ministry of Health is "withdrawing" from service provision and is redefining its role as "regulator of markets". The government decentralises and leaves management to lower levels (district or provincial levels). In Eastern and Southern Africa, there are two approaches to separating market regulation from service provision. The Zambian approach is the introduction of autonomous Health Management Boards while in Malawi and Tanzania the approach is the handing over of health institutions to local government.

At the same time private health service provision is allowed, which is leading to the booming of private dispensaries, especially in urban areas.

As part of the structural adjustment programmes in most countries "cost sharing" has been introduced for government health services (in general in the form of patient fees). In general, church health institutions were already applying systems of patient contributions and did not suffer a lot from this ideological breakpoint.

History of the NGOs in the health sector

Before discussing the consequences of the health reforms for service providers, it is good to look back at the history of NGO health services in Eastern and Southern Africa. This history is in general very closely related to that of Roman Catholic and Protestant missions in Africa. The

services were not evenly spread over countries, but concentrated on areas where most missions were found. Most mission health services were purely curative and often in relatively big hospitals.

The relations between the government health services and church health services could in general be characterised by "mutual tolerance". Churches were allowed to go their own way in developing health services, while government planned its own programme. Where collaboration between the two was opportune, it was accepted. But sometimes government and church health services operated completely parallel to each other.

In most countries the Ministry of Health contributed something to the running of church health institutions through bed grants or secondment of staff. But the bulk of the costs was to be met by the church health organisations mostly supported by oversees donors. On the one hand the church health organisations were seen as private, autonomous institutions. On the other hand they were seen as belonging to the public health system. Their voluntary agency status did set them apart from private-for-profit providers.

During the last 15 years most church health facilities have been handed over to local church organisations. We have to acknowledge here that for most local church organisations, these health institutions constitute a heavy burden, both in financial and in managerial terms.

Consequences of the health reforms

The liberalisation of the markets is part of the health sector reforms. The entrepreneurial risks of running health services are pushed from the government to the health care providers. Instead of a guaranteed payment of costs, contracts and competition are being offered to health institutions. For example: health institutions become employers instead of having government staff on secondment. Because of cash budget systems imposed by the IMF the central government often does not comply with the budget allocations, but leave the problems of health workers' strikes, power cuts and telephone disconnections to the local health service providers.

Introduction of competition and free markets leads to the increase of private for profit providers, who enter the most profitable segment of the market, i.e. outpatient care in urban areas, whereas governmental and non-for-profit private providers are left with the hospital functions and preventive health care. Especially in Tanzania this effect can be felt even in the rural areas.

The church health institutions are faced with a specific problem. They were very much used to the status of being autonomous and at the same time being part of the public health system. With the district health office, there was a collaboration in health programmes like TB or EPI when necessary, but mostly from a distance.

Now, with the health reforms the church health institutions are forced to choose: either be private or be part of the public health system. Being private guarantees further autonomy, but deprives the health institutions from financial contributions from local government or health board.

If the church health institutions want to become part of the public health system, they have to accept "interference" in for example the service provision, in the number of beds or in the service package (family planning!). They have to become part of the District Health Management Committee. They have to enter into negotiations and have to put their cards on the table (e.g. financial transparency).

The theory of health reforms is simpler than the reality. Where in theory the central government is stepping back from service provision and leaving it to local government or health board, in practice there is still a direct line of command between district health services and central government. This is called a problem of the transition period.

It is no surprise that the church health institutions feel tricked; they see the referee playing with the other team! The one, who pretends to be a "regulator" of the market, is a market player well. Leaving the health reforms too long in a transition period creates opportunities for misunderstanding and mistrust between the parties.

The churches, as owners of the health facilities, are faced with an even more complex situation. They have "inherited" the health facilities from expatriate missionaries and feel responsible for the continuation of the services. At the same time they see the external support dry up. They see the limited managerial capacity in the health institutions. They see the overwhelming changes as result of the health reforms, which they experience as threats. Sometimes in a kind of panic reaction, services are shut down, most unfortunately the primary level facilities and outreach activities.

In general, the national co-ordinating bodies of church health institutions, the boards or associations, face a dilemma. On the one hand they have a limited mandate by their member organisations. The owners of the facilities want to define their own policies. On the other hand in the health reforms process, the National Ministry of Health considers them as the negotiating partner on behalf of the church institutions.

The way forward

The present situation calls for not less than a strategic repositioning for the churches and the church health institutions.

Most owners of church health institutions (Dioceses, Parishes) have inherited the facilities from missionaries and have never formulated for themselves what is their mission in health care. In the past when the rural areas were neglected, the choice for starting health services was clear, but now governments have built a health service infrastructure, what is the comparative advantage of church health institutions?

What is the task of the church in the light of its Christian ministry of healing? Where is the linkage between pastoral work, social work and health services? The Catholic Secretariat in Zambia has rightfully put this question on the agenda. Isn't it time to go back to the roots of Christian work in the society and concentrate on home based care for AIDS patients, nutrition education for parents and children, etc.?

Churches are faced with huge managerial and financial problems in the health institutions. We can already see now that the health reforms will not solve these problems, certainly not in the short run. Oversees donors are no longer a reliable source for filling deficits. Why endure all this trouble and become a part of a public health system, where the only distinction between church institutions and other institutions is the name of the owner?

The "Contracting NGOs for Health" initiative by Medicus Mundi International has skipped that question until now. In my view that is a mistake. It is essential to answer the fundamental question first: "What is our mission in health service provision?" If churches come to a clear choice, they make an end to the present status of muddling through and can come to a more pro-active role in the health reforms at district and National level.

The second step church health institutions should make is the "right" seizing of institutions. This right seizing first of all depends on the demand by the population, especially the poor and the needy. The right seizing also depends on the "market", on what other health service providers offer. And finally, the right seizing also depends on the ability of the owner of the institution to sustain the services in a good way.

Thirdly, church health institutions should come out with a clearer profile, which underlines their distinct competence. What makes them different, even better, than other health service providers? Many people consider it not appropriate talk about this issue, but they forget that church health services are in competition, especially with private-for-profit providers. The church health institutions need good marketing to attract clients. At district and regional level, church health institutions have to improve their networking, use each other's specific capacity, even between institutions from different denominations.

Lastly, the national boards or associations of church institutions should get a clearer mandate, to operate as negotiating partner with the national government, not only in issues of finances, but also issues of contents of services.

In several countries, the Ministry of Health is dragging its feet with health reforms. At times, it comes with half-hearted measures, which do harm to the not-for-profit private providers.

More intensive contacts between the national organisation and its member institutions could bring common problems earlier in the open and allow for a quicker response at national level.

Potentially the national church health organisations can become the motor of health reforms and direct the process in a direction that does justice to the mission of the churches in health care. In my view, the church organisations have to put the health services in the perspective of

human rights. They should indicate clearly the limited regulatory capacity of free markets. Every person has the right to receive an essential package of health services and governments should pay more than lip service to this right.

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