

Role of Private Healthcare Facilities in Public Health Programs: A Study in Greater Accra Region

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Abstract

Background: Public health is a collective responsibility of everybody. Private sector plays a key role in the functioning of many sectors in both developed and developing countries which includes provision of public health services. However, there is dearth of studies on the role of private health delivery institution in public health programs in Ghana. Therefore, the purpose of this study was to examine the role of private health care delivery institutions in public health programs in Ghana.

Methods: Resource dependency theory was used as the theoretical framework.

The study used mixed method to derive the advantages of both quantitative and qualitative research methods. The sample size was fifteen private healthcare facilities in Greater Accra region. It of ten private for-profit healthcare facilities and five mission facilities. Records of public health activities of the private health care institutions from 2015 to 2019 were collected from the selected health facilities for the quantitative analysis. In-depth interview was used to gather the qualitative data. Descriptive statistics and Welch two sample t-test simple to analyse the quantitative data. Thematic analysis was used to analyse the qualitative data.

Results: The results of the study indicate that, private for-profit healthcare facilities were not taking part in designing public health programs in Ghana. However, the mission facilities were consulted in the policy making process due to their organised nature.

Conclusion: There is also a significant difference in the number of public health cases undertaken by mission and private for-profit health care facilities. The study indicates that private health care facilities undertake a lot of public health programs. However, mission facilities accommodate more public health cases due to the support they received from the state and other organisations in terms of resources.

1. Background

Public health is a collective responsibility of everybody. Through organised effort of society, public health aims at preventing diseases, promoting health and prolonging life among humans (Winslow, 1920: cited in Wells et al, 2017). Private sector plays a key role in the functioning of many sectors in both developed and developing countries. The role of private sector in healthcare provision has been regarded supplementary to that of the public sector (Chapman, 2014 and Hanson *et al*,2008). The inability of the state to prevent higher number of infant and child mortality in developing countries can be changed by involvement of private sector who have the potential to expand coverage of health services with expanded infrastructure, making healthcare accessible, available and affordable (Bayray, 2015; Waters, Hatt & Peters, 2003; Levin &Kaddar, 2011; Soeung *et al*, 2008 and Agha & Do, 2009).

Due to the profit motive of the private sector (profit - oriented healthcare facilities), private healthcare markets do not do well in provision of preventive services (Hanson *et al*, 2008). However, in another study (Powell-Jackson *et al*, 2015) private not-for-profit was regarded as best in terms of antenatal care (ANC)

quality and the public and for-profit facilities were regarded equal. With regards to the use of modern method of contraceptives, there was higher sourcing from the private sector in Latin America than the public sector. Countries with minimal use of the private sector for family planning purpose were those from the poorest regions like sub-Sahara Africa (Berman & Rose,1996 and Zellner et al., 2005).

In a study of vaccination service in India, Sharma et al (2016) noted that, more people in high income states used the private sector contrary to the low-income states. This suggests the possibility of inequity if health services are left within the domain of the private sector. However, Hotchkiss et al (2011) argued that, pervasion of private commercial sector supply of contraceptives in four countries they conducted their studies did not increase inequity. Inequity rather decreased in two of those countries. Reich (2002) indicates that, the traditional public health provision groups are hampered by scarce financial resources, multifaceted socio-psychological factors, rapid globalization of disease transmission, and reduced state capabilities. Studies on the contribution of religious organisations to health systems in many developing countries revealed that, religious organisations contributed 30 to 44 percent to their countries' health systems (WHO, 2006; Bandy, et al, 2008; Kagawa, Anglemeyer & Montagu, 2012 and Olivier, et al, 2015).

Generally, there has been a lot of studies on the role of private sector in health financing and healthcare delivery in sub-Sahara Africa. Also, there has been some studies on the role private sector has played on vaccination (Sharma et al, 2016; Soeung *et al*, 2008 and Levin & Kaddar, 2011), family planning (Hotchkiss et al, 2011; Berman & Rose,1996 and Zellner et al., 2005) and ANC services (Powell-Jackson *et al*, 2015 and Waters, Hatt & Peters, 2003) but there is a dearth of studies in wider scope on the role of private healthcare facilities in public health programs in Ghana. That is the gap this study is designed to fill. The study will also inform policy makers the approach that can be used to deepen ties in order to expand public health programs across all categories of healthcare facilities.

The main purpose of this study was to examine the role of private healthcare facilities in public health programs in Ghana. The remaining sections are as follows: section two reviews the theoretical underpinnings and the existing studies, section three explains the method used in gathering and analysing data for this study, section four analyses and discusses the findings of this study and section five concludes and gives relevant recommendations for enhancing the role of private sector in delivering public health services.

2. Literature Review

Theoretical Framework

One of the theories that have been applied to understand a situation where resources are carefully distributed to enhance the functions of organisations is resource dependency theory. According to Pfeffer & Salancik (1978), the survival of organisations depend on the resources in their environment which are used in their operations. Due to scarcity of resources and uncertainties, managers of organisations are motivated to act in order to avail their organisations with resources and also reduce uncertainty. This aspect of resource dependency theory considers three environmental concepts in relation to resources.

Aldrich (1979) named those concepts as environmental dimensions. They are munificence, dynamism and complexity. This study focus is on the role of private health care facilities in public health programs. Resources are required to perform those functions. Therefore, the dimension relevant to this study is munificence.

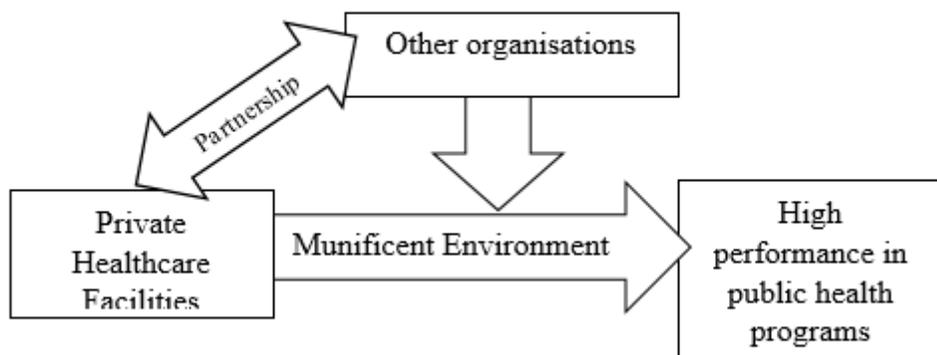
The ability of an environment to meet the needs of an organisation to be able to sustain its growth is what is called munificence (Aldrich, 1979). In order to explain munificence further, Castrogiovanni (1991) points out three categories of munificence: they are capacity, growth, and opportunity. Capacity is the extent to which resources are available to firm, growth is the change in capacity. The change can be negative or positive. Opportunity is how far a firm has been positioned to make good use of capacity. There is high munificence in organisational environment if the said organisation has been able to garner resources to perform its functions otherwise there is low or non-munificence.

Aldrich & Pfeffer (1976) emphasises that, organisations are not able to come up with all the resources and functions needed to maintain themselves. Base on that organisations have to enter into transactions and relations with others in their external environment that can supply the resources and services they need. Benson (1975) argues that liaising with others helps organisations to increase their resource-base and thereby helping them to decrease competition for the limited resources among the partnering organisations.

Two critical things that guide inter-organisational relationships and serve as central pillars of resource dependency theories are perceived need and organisational willingness (Bazzoli *et al.*, 1997). Alter & Hage (1993) made discussions on a range of dependencies – the need for human and financial resources by a partner organisation, the need for working capital, the need to manage risks associated with businesses and the need to maintain flexibility to allow adaptation in volatile competitive market economies. These needs emphasise what may drive any organisation to link up with others and they largely influence the willingness of an organisation to collaborate (Bazzoli *et al.*, 1997).

A study by Okeyo (2004) in Kenya on the influence of environmental dynamism, complexity and munificent on the performance of small and medium scale enterprises confirm the relevance of environmental munificence in the high performance of organisations. Eisenhardt and Schoonhoven (1990) also found that a high munificent environment may have a positive impact on the performance of organisations. Also, Goll and Rasheed (2004) conducted a study to find out the effects of environmental munificence among others on discretionary social responsibility and firm performance. The results of the study suggest that, where the environment is munificent, there is a possibility that firms will perform better and will engage in more social responsibility. Otherwise they will prefer to conserve their resources.

Conceptual Model



Source: *Developed by the authors from the theoretical frame work*

Examining public health programs in Ghana, it is undeniable that the state has a principal responsibility to ensure their execution. However, the state directs a lot of resources to ensure delivery of curative services. Private healthcare facilities are established for various reasons. Whilst some are established as not-for-profit entities, others are established to maximise profit. If partnerships are formed between other organisations (Ministry of Health (MoH), development partners and other governmental and non-governmental organisations) and private healthcare facilities, there will be a lot of resources (munificent environment) for the private healthcare facilities. This will lead to their higher of public health services.

3. Methods

Quantitative and qualitative research method were used in addressing the research questions of this study. The target population for this study was private healthcare facilities (hospitals/clinics/health centres) in Greater Accra region. The sample size was fifteen. Private for-profit healthcare facilities were ten and mission healthcare facilities were five. These categories of health facilities were chosen base on the classification of private sector in the structure of Ghana's health sector as presented by Abor (2011). Greater Accra region was chosen for the study because 68.8 percent of the people in Accra sought health care from the private healthcare facilities in 2018 (Ghana Statistical Service, 2018). The qualitative data were generated from the in-depth interviews conducted at the selected health facilities. The quantitative data were records of each public health service rendered daily to individuals by the selected healthcare facilities.

3.1 Data Collection and Processing

The public health programs of the private healthcare facilities considered in this study included antenatal care (ANC), postnatal care (PNC), family planning, immunization/vaccination and HIV counselling and testing. The units of analysis for this study were the record of daily attendance by individuals for any of these public health services at the private healthcare facilities from 2015 to 2019 and the periodic participation by the private healthcare facilities in public health policy formulation from 2015 to 2019.

The records were collected at the selected health facilities for quantitative analysis. The data was processed in Excel and transferred to R for analysis. All those interviewed were senior members of the health facilities management teams using an interview guide.

Thematic analyses was conducted for the qualitative data descriptive statistics was used to obtain averages of daily public health services carried out by private healthcare facilities in the years under review. Also, Welch two sample *t*-test was used to examine the difference between private for-profit and mission health facilities in terms of the number of individual episodes of public health services they rendered within the period under review.

4. Results

The in-depth interview revealed that, private for-profit healthcare facilities were virtually not taking part in public health policy design. According to the respondents, there was a body that represented private health facilities at the Ministry of Health, so if a consultation was going to be made to have the input of private healthcare facilities on policy formulation, that body was consulted. The body was Private Health Sector Advisory Group. However, members of the body were appointed by minister of health. The respondents believed that members of the body represent the minister not private healthcare facilities. They said these:

Every government tries to implement its own policies. So, Private Health Sector Advisory Group only concentrate on non-policy making aspect of its mandate prescribed for it by the Minister of Health. Besides, the minister does not consult private health facilities before appointing members of the Group.

However, the mission healthcare facilities believed they were making impact in designing public health policy in Ghana. The responses indicate that, the Christian Health Association of Ghana (CHAG) served as a stake holder in the health sector which was sometimes consulted when policies were going to be designed in the health sector. These are some of the responses:

CHAG is a proactive group, the leadership always thinks ahead of time. So, it does not relax when a public health issue needs attention at the national level. Sometime the association is consulted by the government on health issues and its inputs are included when a policy is going to be designed.

The total number of daily attendance by individuals for public services private healthcare facilities attended to within the period under study (2015 – 2019) was 347456. These services included antenatal care (ANC), postnatal care (PNC), family planning activities (FAMPLAN), immunization/vaccination (IMM) and HIV counselling and testing (HIVCT). Table 1 below shows the number of attendance for public health services at the private health care facilities within the period under review.

Table1: Number of Daily Public Health Services from 2015 to 2019

Year	Number of Daily Services
2015	37399
2016	38700
2017	37432
2018	40447
2019	39500
Total	347456

Source: Authors' compilation from the field

In terms of public health services undertaken by the two categories of private healthcare facilities, the study indicates that total averages of 25935 (SD 2544) and 12760 (1514) public health services were rendered to individuals by mission and private for-profit healthcare facilities respectively within the five-year period. Statistics on daily public health services base on types of private healthcare facilities from 2015 to 2019 are shown in table 2 below.

Table 2: Statistics on Public Health Services Base on Type of Private Healthcare Facilities.

Public Health program	Mission		Private For-Profit	
	Mean/SD	Min/Max	Mean/SD	Min/Max
ANC	6034.2/602.98	5332/6952	1719.6/314.30	1352/2115
PNC	6015.8/606.55	5332/6952	1782.4/285.16	1494/2160
FAMPLAN	1646.8/273.69	1418/1946	5711.6/226.26	5332/5885
IMM	6204.2/457.87	5728/6952	1858.4/321.82	1403/2160
HIVCT	6034.2/602.98	5332/6952	1688.4/365.86	1350/2219
TOTAL	25935.2/2544.07	28708/31146	12760.4/1514.40	8338/9518

Data are expressed as mean+/-SD and the Minimum and Maximum values.

Source: Authors' computation from the field data.

Shapiro – Wilk normality test was conducted at 0.05 level of significance to verify if public health services rendered by private healthcare facilities under study were normally distributed. The test shows the following results: $W = 0.70827$, $P\text{-value} = 0.001$. The results show that the data was normally distributed. This paved the way for Welch two sample t -test to find out if the difference between the averages of public health services undertaken by the private for-profit and mission health care facilities was significant. Table 3 below shows the test results.

Table 3: Welch two sample t -test

t	DF	P-value	Mean (M)	Mean (PFP)
-38.194	5.3717	0.000	25935.2	12760.4

Source: *Computation by the authors*

The P-value (0.000) for the *t*-test results indicate that there is a significant difference between the number of public health services rendered by mission and private for-profit healthcare facilities. The results further indicates that mission healthcare facilities rendered more daily public health services than the private for-profit healthcare facilities within the period under study.

The in-depth interview revealed that, private for-profit healthcare facilities did not undertake many public health services compared to mission healthcare facilities within the period under study due to the reasons for their establishments and delay in reimbursement of funds for the facilities by the National Health Insurance Authority (NHIA). The following is what was said by some respondents from the private for-profit healthcare facilities:

Our primary motive is to make profit. So, we concentrate on the curative services. However, when people come with public health issues, we attend to them. Besides, there are certain public health services like immunization which we are mandated to carry out. Also, some of the curative services we undertake also go with public health services. Our major problem is the delay in reimbursement of our money by NHIA. This is because a lot of the public health programs are covered by the National Health Insurance Scheme.

As a result of the challenges faced by private for-profit health facilities in taking up public health programs, they try to cope by infusing revenue generation in the public health programs. A respondent said this:

We used to render antenatal care services absolutely free but this time we take GH₵10 [US\$2] on every visit by the pregnant women to sustain our health facility.

The study revealed that the pharmacy departments of some of the profit-oriented health care facilities sold nutritional supplements to pregnant woman as if it was part of the basic required medicines for pregnant women. According to some of the respondents, their facilities set up ultra-scan facilities to render those services to pregnant women as a way of raising revenue. In addition, some health facilities sold 'weighing sacks' to mothers who attended healthcare facilities for examination of their children. It was also observed that, some of the private for-profit healthcare facilities charged fees for the services rendered to the National Health Insurance Scheme (NHIS) subscribers after taking their health insurance records.

4.1 Discussion

It is clear that profit-oriented health facilities do not take part in designing public health policies. This could be due to the fact that their focus is on how they can meet the objectives for which they are established, that is to maximise profit. So, they remain competing with each other instead of collaborating to have a solid front to represent them. Even though there is Private Health Facilities Association of Ghana, the members only complain when their facilities are not reimbursed within the expected time by the National Health Insurance Authority (NHIA). The association is mostly silent on public health issues which do not directly affect their revenue generation effort. According to Ministry of Health [MOH] (2013), a unit has been established to co-ordinate the private healthcare providers, but that unit is ineffective because it is far down the top echelon of the ministry's administrative structure. The unit is also under-resourced and under-staffed. World Bank (2011) noted that, there is no overall representation of the private healthcare providers in Ghana. In effect MOH admitted that the private healthcare facilities are not sufficiently represented in policy formulation at any level.

In contrary, since mission facilities are not profit oriented, they do not compete with each other, they rather collaborate to make sure that their objectives are met. This makes CHAG strong enough to present one voice. Besides, CHAG has an indirect voice through which its grievances can be channeled to policy makers. There are churches CHAG members are affiliated to, the stakeholders that represent those churches at the national level, like Christian Council of Ghana and Catholic Bishops Conference among others may be speaking the voice of their health appendage (CHAG) on public health issues in Ghana. As a result, they are recognised in the policy making process. That is Ministry of Health can easily earmark them for consultation as stakeholders during policy making. Even though their participation is described as being insufficient by MOH.

Immunisation services happens to have the highest average in this study. This confirms a study by Levin &Kaddar (2011) that private healthcare institutions undertake immunisation in their facilities which provide access to health services to the people. It also confirms a study in Cambodia by Soeung *et al* (2008) that private health care facilities are playing vital role in combating the transmission of vaccine preventable disease. The high number of immunisation cases is understandable, this is because there are a lot of people who go in for different kinds of immunisation for various reasons.

The Welch *t*-test indicates a significant difference between the private for-profit and mission healthcare facilities in terms of the number of public health services rendered by those facilities. The averages indicate that mission healthcare facilities render more public health services than the private for-profit healthcare facilities except family planning. This confirms studies by Hanson *et al* (2008) that preventive and public health services will be under – provided by private for-profit market as they are not valued in the market transactions. The relatively low number of family planning services rendered by mission healthcare services may be due to religious-base objections to certain family planning services. Especially those which are under Catholic Church (Barden-O'Fallon, 2017). This study supports other studies (Murray, et al, 2005; Campbell, et al, 2015 and Peters, Mirchandani & Hansen, 2004) which indicate that, many young people prefer the private (for-profit) sector for their family planning services due to their accessibility, availability on time, less waiting time and privacy. Due to the profit motive

nature of the private for-profit healthcare facilities, they try to raise revenue from all the public health programs some of which are rendered free of charge at the mission healthcare facilities. This will certainly compel a lot of people to attend mission healthcare facilities for certain public health programs which brings about congestion in those facilities.

The study indicates that, CHAG facilities are in a high munificent environment due to the reasons behind their operations. The critical resources that determine the performance of a healthcare facility are human resource and equipment. CHAG healthcare facilities receive funds from government to support payment of their personnel and for personnel training. They also receive equipment and subventions from the government (MOH, 2013). This makes the environment very conducive enough to ensure higher performance by CHAG facilities.

The study illuminates the fact that, both mission and profit-oriented facilities are in a form of collaboration with the state. The collaborations that are common between the state and the private healthcare facilities are attending to the National Health Insurance subscribers and supply of vaccines that are supposed to be administered free of charge. However, the collaboration between the state and CHAG facilities goes further to include financial support, subventions and provision of equipment by the government. The kind of collaboration between CHAG facilities and the state makes it possible for the CHAG facilities to undertake more public health services. Besides CHAG facilities receive support from external development partners (MOH, 2013). This increases the resource bases of those facilities. This study confirms studies by Okeyo (2004), Eisenhardt and Schoonhoven (1990) and Goll and Rasheed (2004) which indicate that if there are high-quality resources (munificence) in an environment, the organisation is likely to perform better.

In a contrary, the collaboration private for-profit facilities have with the state does not help much in boosting their resources. The National Health Insurance Scheme (NHIS) removes the barrier that prevented a lot of people from attending private for-profit healthcare facilities. Ideally, the more NHIS patients they attend to, the more revenue they should be able to generate through the reimbursement of their funds. This is not the case; the reimbursement is always delayed which affect the resource base of those health facilities. As a result, private for-profit facilities find themselves in low munificent environment. This compels some of them to engage in certain coping strategies. This study again supports a claim by Staw and Swajkowski (1975) that organisations that are in low munificent environment will try to conserve their resources and sometimes engage in certain unconventional acts in order to continue functioning. This study supports the conceptual model that if private health care facilities form partnership with significant others, it will create a munificent environment which will lead to increase in performance in public health programs.

5. Conclusion

The study indicates that private healthcare facilities undertake a lot of public health programs. However, mission facilities accommodate more public health cases. This could be due to the fact that they have

different form of collaboration with the state and other NGOs. As a result, they have more resources to take up public health programs. Besides, the private for-profit health care institutions have profit making as the basic objective of their operation. So, if public health programs do not give them the profit they need, they may have good reasons to concentrate their resources on services that will let them meet the objectives of their establishment. Therefore, the basic reason for accommodation of more public health cases by private health care facilities is availability of resources.

5.1 Recommendations

The state needs to have a strong and reliable collaboration with the private for-profit health care institutions as it collaborates with the mission healthcare facilities. This collaboration can be a form of financial support to enable those facilities deliver public health programs. The state can support those facilities with tax reliefs so that such money will be used to acquire the resources needed to make public health programs available to the people.

Apart from that, some community or public health nurses can be posted to the private for-profit health facilities to be taking care of public health programs. Those nurses should be under the pay role of the state. If the private for-profit health facilities can derive some benefits from those nurses in the form of services, they may increase the number of public health cases they undertake. If the government establishes such collaboration, there should equally be a way of monitoring and evaluating the public health programs of those healthcare facilities to keep them on the right path.

Declarations

Ethics approval and consent to participate :

Ethical clearance was given by Ethical Committee for Humanities (ECH), University of Ghana with protocol number ECH 088/19-20. Verbal consent was sought from the respondents before data collection. Also, some of the facilities wanted to remain anonymous, therefore all the healthcare facilities involved in the study were granted the anonymity.

Consent for publication :

Not applicable

Availability of data and materials:

All data generated or analysed during this study are included in this published article.

Competing interests:

The authors declare that they have no competing interests.

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Authors' contributions :

ARS analyzed collected and interpreted the data regarding the role of Private healthcare facilities in Public Health Programs, and also did the write up of the manuscript. PAA guided and supervised the writing of the manuscript. All authors have read and approved the manuscript.

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