



THE COMPLEMENTARY ROLE OF PRIVATE HEALTHCARE PROVIDERS: PERSPECTIVES OF THE REGULATOR, PROVIDER AND CARE SEEKERS IN THE UPPER WEST REGION OF GHANA

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Abstract

This study explored the perspectives of regulators, private healthcare providers and healthcare seekers on the complementary role of private sector providers in the Upper West Region of Ghana. A mixed method approach was adopted. Key informant interviews were conducted with regional and district directors of health services as regulators, and managers of private healthcare facilities as providers, while a semi-structured questionnaire was administered to healthcare seekers. The World Health Organisation's framework on the three overall goals of a health system: improving health, responding to client expectation and financial fairness of care formed the basis for the collection and analysis of data. The data was collected in April, 2014. Overall, all three stakeholders acknowledged that private providers complement the services of public healthcare providers. Faith-based providers use their links with foreign partners to provide specialist expatriate services, a great relief to care seekers. Private healthcare is perceived to be responsive, both ethically and in relation to expectations of care seekers. Professionalism and quality in private facilities present them as preferred alternatives to public provision. Private care is also tailored to reflect the different social preferences of care seekers. Private provision in the Region is also perceived to be fair in terms of compliance with financial standards, costs and value for money. For instance, 96% of care seekers noted that private care gave them better value for money than public provision. The study also reveals that private healthcare provision is evolving, taking on traditional public provider roles such as vaccinations, immunisations and family planning, in order to remain a relevant partner as well as a preferred choice of care seekers. Policy makers and researchers need to employ robust approaches through which a broad range of stakeholders are engaged in evaluating the emerging complementary role of private providers in order to harness same.

Keywords: Healthcare providers, Complementary healthcare, Public-private partnership, Health services management

Introduction

Generally, in both policy fora and research circles, there have been longstanding debates on the role of private providers in healthcare delivery (Chahine, Bitar, & Idnani, 2012; Deloitte, 2014; Mitchell, 2008; Reich, 2000). Arguments for increased private sector role in healthcare delivery have pointed towards reducing government health budgets and improving access and quality (Deloitte, 2014; Stuckler & Basu, 2009). In low and middle-income countries (LMICs), the private provider's contribution to total healthcare delivery is poorly documented (Mackintosh et al.,

2016). It has been suggested that an enormous and largely untapped private health sector potential has been a major cause of healthcare delivery constraints in LMICs (Deloitte, 2014; Pricewaterhouse Coopers, 2011; World Bank, 2004). In this paper, we refer to private healthcare providers as any non-governmental health facility, including self-financed private, not-for-profit, and faith-based facilities, which are involved in the direct delivery of healthcare (Bitran, 2011; Mitchell, 2008).

Globally, there is evidence that the private provider sector is increasingly expanding while sole public provision is giving way to public-private partnership (PPP) delivery (Propper & Green, 1999). In sub-Saharan Africa (SSA), the private sector constitutes over 60% of healthcare delivery (International Finance Corporation, 2008). In LMICs, care seekers at private healthcare facilities are more satisfied than those who visited public facilities (Abihiro, Mbera, & De Allegri, 2014; Boller, Wyss, Mtasiwa, & Tanner, 2003; Walker, Muyinda, Foster, Kengeya-Kayondo, & Whitworth, 2001).

Studies at the global level largely present the private healthcare sector as being more effective and efficient in performance than its public counterpart (Aljunid, 1995; Chahine et. al., 2012; Deloitte, 2014; Mitchell, 2008). However, most of the conclusions at the macro level have been drawn based on expert opinions in relation to specific disease areas. Studies have also concentrated on comparing public and private care. Thus, the exact role of the private sector as a compliment to public provision is not clearly documented. In Ghana, particularly the Upper West Region, there is limited evidence on the role of the private health sector (Dugle, Akanbang & Fielmua, 2015). While the public sector dominates in the Region's healthcare delivery (Ghana Ministry of Health, 2013a), there is limited evidence of the role of private providers. As global calls for PPPs in improving universal health coverage intensify, more and better evidence is needed on:

- What value the private providers offer the health system; and
- What disagreements among stakeholder perspectives on this potential value are likely to be obstacles to sustainable PPPs in care delivery.

This study explored key stakeholders' perspectives on the complementary role of private providers in improving health system outcomes, responsiveness and fairness in financial contribution, within the public-provider-dominated health system of the Upper West Region of Ghana.

Methods

Study context

The World Health Organization (2000) proposed a landmark framework to accelerate the development of evidence based outcomes of health systems. The framework proposed three overall goals of a health system: improved health, responsive healthcare delivery and fairness in financial contribution (Murray & Frenk, 2001). The framework provides clear understanding of how the nature of a given healthcare provision impacts core healthcare goals (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012). Although the framework has attracted some criticisms (Helms, 2000; Navarro, 2000), we believe it represents an extensive effort towards empirical assessment of health systems in general and care providers in particular.

Guided by the content of the WHO framework, we constructed our conceptual framework as illustrated in Table 1 to guide this study. In our conceptual framework, we assessed how the private sector complements the public sector in relation to three key health system themes (goals): improving health, responsiveness of the care to the expectations of the population, and contributing to health system financial fairness/equity.

While the degree of attainment of health improvement and responsiveness to expectations define the quality and efficiency of the health system (Murray & Frenk, 2000), fairness in healthcare financing relate more to equity. We believe that WHO's framework for health system performance assessment is an innovative tool for presenting empirical discourse on the roles of healthcare providers in particular. It is a useful tool through which scholars, practitioners and health managers can explore the extent to which healthcare provision (public and private) respond to overall health system goals of health improvement, responsiveness and fairness in financing.

Table 1: Conceptual framework for assessing the complementary role of private healthcare providers

<i>Theme</i>	<i>Content</i>	<i>Indicators used</i>
Health improvement	Public health functions	-Range of care provision
	Availability of care	-Access to facility and care -Provision of specialised services
	Care seeker retention	-Rate of care seeker return
Responsiveness of care	Ethical responsiveness	-Respect for the dignity of the care seeker -Professionalism of health personnel
	Care seeker expectations	-Care seekers' contributions to decisions about their health -Waiting time for the care -Basic amenities in the facility -Choice of care provider
Fairness in care financing	Financial standards	-Conformity to financial reporting rules
	Financial barriers to care	-Affordability of care -Extent to which care delivery commensurate payments

Adapted from WHO (2000). The world health report 2000. Health systems: improving performance

We acknowledge that the WHO's three overall health system goals may look too broad for this study. However, we have critically developed contents and indicators for assessing them. This is intended to help operationalise what is being assessed, present objective evidence on private provider contributions and report results on stakeholder perception, mapping areas of agreement and disagreement. While the content specifications in Table 1 are conceived from the framework, indicators used were compiled from conceptions of the three broad goals in the literature.

Study setting

The study was conducted in the Upper West Region of Ghana. The researchers chose the Region mainly

because it is a typical example of a growing society whose case could be likened to other developing regions in the country. Secondly, the researchers currently reside and work in the Region and therefore have better access to data for the study in the Region than other parts of the country (Creswell & Clark, 2007; Passi & Mishra, 2004). In Ghana, the Ministry of Health (MoH) is responsible for policy, governance and oversight of the health sector, while the Ghana Health Service (GHS) is in-charge of delivery of public sector health services and the oversight of private sector services (Bitran, 2011). The GHS has decentralised significant planning and implementation authority for health services to the ten Regional Health Directorates that are responsible

for both preventive and curative care. At the district level, District Health Management Teams (DHMTs) are commissioned by the MoH to provide services, and provide planning, coordination, and oversight of the sector at that level (Ministry of Health, 2007).

In the Upper West Region, there are eleven DHMTs, representing the eleven administrative districts of the Region. The 11 main districts are further divided into 65 health sub-districts (Ghana Ministry of Health, 2013a). The study was conducted in four districts: Jirapa, Nandom, Nadowli-Kaleo districts and Wa Municipality.

Study design

The study adopted a mixed method design to ensure a holistic understanding of the perspectives of the three actors in the delivery chain: regulator, provider and care seekers (Creswell & Clark, 2007). For the regulators and private providers, data collected was qualitative, whilst a mix of qualitative and quantitative data was collected from the care seekers. Integration of the findings to identify commonalities and divergence in opinions from the three stakeholders was done during data analysis and discussion of the results.

Population and sampling

Directors of health services, medical directors of private healthcare facilities and care seekers constituted the population of the study. The four districts were purposively sampled for the study because they have relatively better experiences in private healthcare delivery. For instance, the St. Joseph's hospital in Jirapa and St. Theresa's hospital in Nandom have provided healthcare in the Region since 1953 and 1966 respectively. The Wa Municipality and Nadowli-Kaleo district also have good experiences in private healthcare delivery, especially with Islamic Mission providers. In all, five private providers were studied: two Christian Health Association of Ghana (CHAG) facilities; two Islamic mission; and one self-financed private (SFP). The locational distribution included one CHAG facility in Jirapa District, one CHAG and one SFP facility in

Nandom District, one Islamic Mission facility in Nadowli-Kaleo district, and one Islamic Mission facility in the Wa Municipality. While private as legal entities, CHAG facilities in Ghana are often considered to be a quasi-public extension of the GHS, and they receive substantial public funding from GHS, MoH, and National Health Insurance Scheme (NHIS).

Seven key informants from the side of healthcare regulation were purposively sampled. They comprised the Regional Director of Health Services, Deputy Regional Director of Health in-charge of clinical care, Regional Health Information Officer, and the four Directors of the District Health Management Teams (DHMTs) of the selected districts. Regional manager of CHAG and medical directors (managers) of the sampled private healthcare facilities were also purposively sampled. The inclusion of the Regional Health Information Officer and Regional manager of CHAG in the study was to enable us establish the profile of private care providers in the Region.

The number of care seekers sampled per provider was proportional to each facility's average daily outpatient-department (OPD) attendance for the year 2013. The strategy for selecting the sample for each provider was a convenient 50% of the average daily OPD attendance for 2013. In view of resource constraints, where 50% of the average daily OPD attendance was more than 24 care seekers, a convenient sample of 25 respondents was chosen. Where the total average daily attendance was less than ten, the total OPD attendance was studied. Finally, where the provider had no OPD data, a convenient sample of nine respondents was studied. The eventual sample was 78 care seekers (see Table 2). The researchers invited care seekers (on admission or those who had completed treatment and were exiting the facility) or their care-taker relatives to participate in the study until the sample per facility was attained. For patients on admission, the researchers moved from one ward to another to avoid interviewing too many respondents from the same ward.

Table 2: Sample of care seekers studied per facility

<i>(1)</i> <i>Districts</i>	<i>(2)</i> <i>Private facilities</i>	<i>(3)</i> <i>Annual OPD attendance for 2013</i>	<i>(4)</i> <i>Average Daily OPD Attendance</i> <i>= (3) ÷ 365</i>	<i>(5)</i> <i>50% of Average Daily OPD Attendance</i>	<i>(6)</i> <i>Number of patients interviewed</i>
Jirapa District	St. Joseph's Hospital	47,981	131	67	25
Nandom District	St. Theresa's Hospital	41,335	113	57	25
	Good Shepherd Maternity Home	2,272	6	3	6
Nadowli-Kaleo District	Ahamaddiya Hospital	9,457	26	13	13
Wa Municipal	Islamic Hospital	-	-	-	9
TOTAL					78

Data collection

Key informant interviews were used to collect data from the regulators and private healthcare providers. To ensure a systematic interview process, semi-structured interview guides were developed and used to collect the data from key informants. The interview guide was structured into sections reflecting the three broad goals. Under each section, respondents were asked questions specifically relating to the contents of each goal (presented in table 1). Interviewers probed for responses to elicit information on the indicators (see table 1) required to analyse each goal. All interviews with key informants were conducted in the English Language, tape-recorded and later transcribed. The interviews lasted between 50 – 60 minutes.

The study also used interviewer-administered questionnaires to explore the experiences of care

seekers with seeking care from private providers. Although the questionnaire was largely open-ended, it also contained structured questions which were included to enable researchers quantify care seekers' background characteristics and some of their experiences with the private provider. Care seekers were also asked their views on the characteristics of the accommodation and procedures performed by staff of the facilities who attended to them. Questions related to payment and satisfaction and their general impressions of the facilities were also asked. Copies of the questionnaire were administered within 25 – 30 minutes. The interview guides and questionnaire were based on the private sector's role in improving healthcare, responding to the expectations of healthcare seekers and providing financial leveraging to healthcare delivery in the Region.

Data analysis

Analysis of the qualitative data was guided by the WHO framework. We then inductively identified specific sub-themes under each broad deductive code. The first author initially coded all the qualitative data. His coding was later reviewed by the second and last authors for the purpose of analytical triangulations. Direct quotations from the qualitative data that vividly illustrated the identified themes were selected and included in the results section. The quantitative data was analysed using the SPSS version 20 software. Only descriptive statistics on the key variables were generated from the quantitative analysis. In line with the study design, the qualitative and quantitative data were integrated in the results and discussion sections.

Ethical issues

Institutional access approval was obtained from the Regional Director of Health Services, District Directors of Health Services and the Medical Directors of the sampled health facilities. Informed consent was obtained from all respondents before data collection and tape-recording. Overall, this study followed the principles of the Declaration of Helsinki.

Results

Background characteristics of respondents

Of the six directors of health services interviewed, only the regional director and deputy director in charge of clinical care were males. Thus, all directors of health services in the four study districts were females. In terms of experience, all six directors had over ten years of professional experience and were also familiar with private healthcare delivery in the Region. Also, all directors had a Master of Public Health degree as required by the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525). Three of the five medical directors of the private healthcare providers were males. Three of them had over ten years of professional experience, while two had four to ten years of experience. In terms of educational qualification, three were Medical doctors, one had Master of Public Health degree and one had Bachelor's degree in Nursing. Across all

three categories of private providers, medical directors were responsible for ensuring that care delivered was in line with national and local health policies; and the execution of the decisions of their respective Boards of Directors.

Of the 78 care seekers interviewed, almost one-third (73.1%) were females. While respondents under 18 years were less than 6% of the total number of care seekers, those from 18-30 years formed half of the total number. In terms of educational level, 51.3% of these respondents had not been to school. A significant number of these respondents (79.4%) were engaged in peasant farming and other self-employed activities.

Role of private healthcare providers in improving health outcomes

The key informant interviews with directors of health services revealed that beyond the regular clinical care, private providers also assist the public provider in routine immunisation and vaccination, education on health related Millennium Development Goals (MDGs) and family planning. Directors of health services indicated that private providers were very instrumental in the implementation of Project 5 Alive (PPP project aimed at changing ideas that would enhance service delivery with regard to ante-natal care, post-natal care and skilled deliveries).

“They [private facilities] contribute significantly to improving key health indicators such as maternal and infant mortality” (District director of health services).

Some of the private facilities also serve as referral centres for some public facilities. Their operations have also contributed to reducing pressures on public health facilities and filling access gaps within the health system. Health services directors also acknowledged that private healthcare delivery had enhanced the health status of the overall population.

“The private facilities have been very complementary in promoting care delivery in the Region. The CHAG facilities for instance serve as major referral centres. Sometimes, even the regional hospital refers cases to the

two CHAG hospitals in the Region” (Director of Health Services)”. Frankly speaking, they [private facilities] have contributed to reducing pressures on public facilities, and access gaps” (District Director of Health Services).

Interviews with medical directors revealed that CHAG and Islamic mission providers also offered routine specialists expatriate consultancies in radiology, orthopedics, dermatology and neurosurgery, among others. Care seekers noted that such routine services were not common in the public facilities.

Of the 78 care seekers interviewed, 62.8% travelled from locations in the Region that were more than 1000metres to seek care at the study facilities. Researchers also encountered some care seekers from outside the Region (specifically from Northern, Volta and Greater Accra regions) in all three categories of private care facilities.

“I went to many facilities in Ho and Accra with this fractured leg, but nothing happened. A northerner friend of mine referred me to this hospital, and true to his words, I will be leaving here soon with my leg strong as before the accident” (Male care seeker, CHAG facility).

Across all three categories of private providers, there were more returning care seekers (52% for CHAG, 63.6% for Islamic mission and 66.7% for SFP) than first-time visitors. Also, 98.8% of care seekers said they were willing to return to the same facility, rather than go elsewhere with their current condition.

“All my family members use this hospital. We have never used any other health facility around because we get the kind of care that we seek from this hospital” (Female care seeker, CHAG facility).

Responsiveness of private healthcare to consumer expectations

All directors of health services conceded that care seekers were satisfied with the kind of care provided by private care providers. They acknowledged that

generally, society perceives private facilities as better than public facilities in providing quality healthcare. However, they argued that this was largely due to “uninformed opinions” on what constitutes quality healthcare as care seekers often directly associated quality with the quantum of medicines that are given them at the facility.

“What do they (care seekers) know about quality healthcare? When they go there and get a good quantity of drugs, they are happy. Is that quality healthcare? In the public facility, no one will just fetch drugs for you”. (District Director of Health Services)

From the perspective of directors of health services, care seekers visit private facilities purely due to a desperate search for quick healing, proximity of some private facilities and religious beliefs.

“You do not expect a patient who is in serious pain to by-pass a private facility, which is closer and to go looking for a distant public facility” (Director of Health Services).

“A typical Muslim woman will prefer that a colleague Muslim woman attends to her during delivery of a baby. Such a woman will only visit a public facility if there is no Islamic facility close by” (Director of Health Services).

Medical directors of the private facilities however indicated that the major reason why care seekers visited their facilities was the responsiveness of their care to the expectations of patients. According to them, care seekers visit private facilities due to good quality, short waiting times, and the professionalism with which private healthcare is delivered.

“We are providing quality healthcare, otherwise, we will not attract care seekers to our facility” (Medical Director).

Interviews with care seekers revealed that 46.2% of all respondents spent less than half an hour before getting treatment. Only 2.6% spent more than three hours before getting their treatment. Across all three categories of providers, medical personnel were largely rated excellent and good in listening to

patients, taking time with patients (attending to patients' needs), explaining what patients needed to know about their health problems and in giving good advice to patients regarding their conditions. Care seekers indicated that vital statistics (temperature, weight, blood pressure) were taken across all categories before they went to meet medical officers for consultation. Of the 61.5% of care seekers who had been to public facilities for same or similar treatment, 70.2% stated that 'to a very great extent' care seekers' questions were better answered in an appropriate and timely manner in the private healthcare facilities than public facilities.

"The doctor did not just write down drugs for me, but told me my condition and what I should do or not do" (Female care seeker, Islamic Mission facility).

As to the extent to which care seekers were involved in decisions made about their care and treatment, 96.2% of the respondents stated that they were involved in the decisions made about their health problem. Similarly, 94.9% and 89.7% of respondents said patients were to some extent told what they needed to know about their health problem and medicine respectively. Responses on all these variables were similar across all facility categories.

"After listening to me, the doctor referred me to the laboratory for tests. I suggested the need for the test and he referred me to the lab. When I went to the government hospital, for three conservative times, I was given malaria treatment without any tests. At the third visit, I pleaded with the consultant to let me do some tests, but he asked me why I came to the hospital since I knew what was wrong with me" (Male care seeker, CHAG facility).

"At the government facility that I visited last before coming here, a young lady at the dispensary gave me some medicine and when I asked how I should take it, she said everything was written on the pack. But here, they told me how many to take, what time to take them and how my eating should go with the medicine" (Female care seeker, SFP facility).

All facilities surveyed had places of convenience (toilets, bathrooms and urinary). The researchers observed that all the facilities surveyed had decent places of convenience and spacious waiting places. For instance, 73.1% of care seekers observed that the general environments of the facilities were clean.

"Every morning and evening, cleaners come around to mop the floor with detergents. They wash the washrooms too (Female care seeker, CHAG facility).

"When I was admitted at a government facility at the early part of this pregnancy, I vomited severally because of the stench in the ward. I almost lost my pregnancy" (Female care seeker, Islamic facility).

Fairness in the structure of private healthcare financing

All five studied providers were accredited under the NHIS. Of all 78 care seekers, 96.2% had active insurance policies with the NHIS. All of them said the insurance paid for the largest portion of their health expenses. Household members and respondents themselves also paid for expenses. We found that 17.9% of care seekers paid out-of-pocket (ranging from a lowest 50Gp to a maximum GH¢20.00) for registration/cards/folders, medicine and treatment.

According to Directors of Health Services, private facilities sent periodic reports to the regulators on financial operations, service and drug utilisation statistics, and adverse events. Financial reporting includes service charges and income and expenditure statements. Some of the Directors of health services indicated that private healthcare in the Region is affordable and also reflects value for money. Others however stated that due to regulatory gaps, it was difficult to effectively assess the affordability of private healthcare.

All five medical directors of private providers stated that their services were relatively affordable to care seekers. On financial regulation, medical directors indicated that regulators were more interested in enforcing standards that related to monitoring the safety and quality of care to the neglect of regulatory

requirements that related to fostering the private sector to meet general healthcare goals.

“The regulator is quick to follow us on issues of standards in care delivery, but when it comes to providing a good investment environment for us, they want to pull back”
(Medical Director of private facility).

Out of the 61.5% of care seekers who had been to public facilities for same or similar treatment, 96% indicated that the private care gave them better value for money.

“You see these drugs, if it were a government facility, they would have given me the cheapest one from their dispensary and asked me to go and buy the rest from a drug store”
(Female care seeker, CHAG facility).

In terms of affordability of private care, care seekers stated that illegal charges and absence of drugs in the dispensaries of public facilities make them relatively expensive than their private counterparts.

In my village clinic, they take your money and give you receipts that do not tally with the

amount paid (Male care seeker, CHAG facility).

As to the worth of payments made for care received, 39.7% of both insured and non-insured care seekers were very sure that care received was worth the payments they made while 52.6% of respondents were not sure since they were yet to start their medications. However, 6.4% identified that care was worth more than payments made.

“If you have work to do, then never visit a public hospital. There, it can take you a whole day to be attended to. The most painful thing is that, after waiting for so long, what they give you is paracetamol and the rest of the drugs have to be bought from a drug store”
(Female care seeker, Islamic facility).

Putting WHO framework in context, we summarized the multiple perspectives of the complementary role of private providers in table 3.

Table 3: Summary of the multiple perspectives on complementary role of private providers based on the WHO framework

<i>Category of stakeholder</i>	<i>Health improvement</i>	<i>Responsiveness to the expectations of care seekers</i>	<i>Fairness in financial equity</i>
Regulator	<ul style="list-style-type: none"> • Private providers assist in traditional public provider functions such as routine immunization, vaccination, education on health related MDGs and family planning. • Private providers contribute significantly to improving key health indicators like maternal and infant mortality. • They help in reducing pressures on public health facilities and filling access gaps within the health system. 	<ul style="list-style-type: none"> • Society perceives private providers to be better than public facilities in providing quality healthcare. • Care seekers are satisfied with private care. • Care seekers are not technically capacitated to assess responsiveness of private care. • Care seekers prefer private care due to desperate and religious reasons. 	<ul style="list-style-type: none"> • Private facilities are responsive to periodic financial reporting standards. • Private healthcare is largely affordable and reflects value for money. • Regulatory gaps make it difficult to effectively assess the financial fairness of private care.
Private provider	<ul style="list-style-type: none"> • Private providers offer routine specialists expatriate consultancies in radiology, orthopedics, dermatology and neurosurgery. • Private providers offer a wide range of care. • Private providers provide what public providers are unable to provide and serve areas where the public provider does not serve. 	<ul style="list-style-type: none"> • Care seekers visit private facilities due to good quality, short waiting times, and the professionalism with which care is delivered. • Provide what care seekers want, otherwise, we will not attract care seekers to our facility. 	<ul style="list-style-type: none"> • Comply with financial regulations. • Our services are relatively affordable to care seekers. • Regulatory gaps are due to selective enforcements of standards relating to monitoring quality of care. • Regulator is not committed to fostering the private sector to meet general healthcare goals.
	<ul style="list-style-type: none"> • Private providers give locational and time utilities. 	<ul style="list-style-type: none"> • Medical personnel are good in attending to patients' needs, 	<ul style="list-style-type: none"> • Illegal charges and absence of drugs in public facilities make them relatively

Care seeker	<ul style="list-style-type: none"> • Private providers promote care seeker retention, reducing tendencies of self-medication. • Provides alternative delivery to public care, giving care seekers the freedom to choose their preferred provider. 	<p>explaining what patients needed to know about their health problems and in giving good advice to patients regarding their conditions.</p> <ul style="list-style-type: none"> • 46.2% of care seekers spent less than half an hour to get treatment; only 2.6% spent more than three hours before getting their treatment. • Care seekers are better treated in an appropriate and timely manner than in public facilities previously visited. 	<p>expensive than their private counterparts.</p> <ul style="list-style-type: none"> • Private providers give better value for money. • 39.7% of care seekers were very sure that care received was worth the payments made; 6.4% identified that care was worth more than payments made; 52.6% were yet to start their medications.
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Discussion

We have highlighted the perspectives of private healthcare regulators, providers and care seekers on the complementary role of private healthcare providers. From these multiple perspectives, the study revealed that the private provider is an instrumental complement of public sector healthcare delivery in line with the WHO's goals of improved health, responsiveness to the expectations of the care seekers, and financial fairness of the provider's care (World Health Organization, 2000).

The study established that private providers deliver beyond in-facility care. They also engage in routine immunisation and vaccination, health education and family planning, revealing their involvement in a wide range of public health services in the Region (Barnett, Connor, & Putney, 2001; Loevinsohn & Harding, 2004; Sood, Burger, Yoong, Kopf, & Spreng, 2011). One novelty in our study is that it highlights a critical health improvement function of the private provider, which is retention of care seekers. This role of the private provider can significantly reduce care seekers' search for treatment from quack informal providers and self-medication, which are very prevalent in LMICs (Sudhinaraset, Ingram, Lofthouse, & Montagu, 2013; Zaidi & Nishtar, 2011). Another novelty of our study is the discovery that faith-based providers use their links with foreign partners to provide specialist expatriate services. This role of private healthcare providers helps to bring such specialists services closer to care seekers, hence, reduce the cost of access.

By these roles, the private sector care providers help in scaling up the delivery of essential interventions to achieve regional healthcare goals. Our findings on the range of private healthcare are in line with evidence which suggests that the private sector engages

in a wide range of public health services, including such traditional public provider functions as immunization and family planning (Basu et al., 2012; Forsberg, Montagu, & Sundewall, 2011; Madhavan, Bishai, Stanton, & Harding, 2010). We believe that our study is probably one of the few to document the essential role of the private providers in retaining healthcare seekers in formally regulated and standardized facilities. This can contribute to limiting negative health outcomes that result from attendance at informal facilities and self-medication (Abasiubong et al., 2012; Hughes, 2008; Roth, Fredman, & Haley, 2015; Zafar et al., 2008), hence facilitate attainment of overall health goals. Routine specialists' expatriate services offered by faith-based private providers is rarely documented. In a developing region like the Upper West, this is a great relief to care seekers who cannot afford such services at tertiary public facilities outside the Region. Thus, improved health in the Region can be enhanced through effective engagement with the private sector care providers.

On the second theme of our study, responses from all three categories of respondents revealed that private providers' care is responsive, both ethically and in relation to expectations of care seekers. Our study presents the private healthcare provider as a preferred alternative to public provision in three ways. First, care seekers reluctantly seek care at public facilities because they have access to good private care. Second, some care seekers who are dissatisfied with public care see the private provider as a better alternative. This is reflected in the high care seeker retention rate in the studied facilities. Finally, private care is also tailored to reflect the different social preferences of care seekers. For instance, care seekers with strong religious attachments find specific private facilities that match their preferences. We see these as critical roles of the private health

providers that contribute significantly towards universal health coverage in the Region (Mishima, Campos, Matumoto, & Fortuna, 2016; Reis, 2016; Ughasoro, Okanya, Uzochukwu, & Onwujekwe, 2016). On the third theme of the study, our findings contradict suggestions that private providers are not responsive to financial reporting standards (Ghana Ministry of Health, 2013b; Sood et al., 2011). Largely, the power of regulation resides with the regulator. Interestingly, the regulator in the Region sees private provision as largely being compliant with financial reporting standards. Both regulators and care seekers see private care as affordable. This contradicts suggestion that private care is unaffordable (Das & Hammer, 2007; Reddy, 2015; Shabila, Ahmed, & Yasin, 2014). Care seekers also pointed to illegal charges in public facilities, which present private provision as the fairer care. We particularly believe that between the regulator and the private provider, care seekers are in a neutral position to rate the fairness of private care. Based on the perspectives of care seekers, private provision in the Region is fair in terms of compliance with financial standards, costs and value for money. However, directors of private health facilities' indication of the regulator's non-committment to creating a conducive environment for the private sector may pose obstacles to sustainable PPPs in care delivery and the attainment of general healthcare goals.

Responses from care seekers indicated that private healthcare delivery in the Region is characterised by relatively shorter waiting times, good professionalism of medical personnel, and a high degree of patients' involvement in the decisions on the treatment of their conditions. These findings support the suggestion that care seekers prefer private facilities because they generally provide better care than public facilities and are particularly efficient in staff attitude and

waiting time (World Bank, 2011). Previous studies from various countries have also revealed that care seekers got worse hospitality from public than private facilities (Basu et al., 2012; Bhatia & Cleland, 2004; Lim, Yang, Zhang, Feng, & Zhou, 2004; Lindelow & Serneels, 2006; Pongsupap & Lerberghe, 2006; Siddiqi et al., 2002).

Much of the literature on reasons for care seeker's choice of private facilities relate to specific disease areas (Auer, Lagahid, Tanner, & Weiss, 2006; Dato & Imaz, 2009; Lambert, Delgado, Michaux, Volz, & Van Der Stuyft, 2004; Vandan, Ali, Prasad, & Kuroiwa, 2009). This creates a limited view on patients' decision to choose or not to choose private and public facilities. In such a context, care seekers may be compelled to choose a private or public facility because that is the only available facility where treatment for the specific disease is provided. In this paper, the researchers present a wider context, in which care seekers with various conditions (including illnesses, injuries, follow-up for medicines or reviews, prenatal care, deliveries and postnatal care etc.) choose to visit private facilities.

Conclusion

In measuring the health improvement, responsiveness and financial fairness functions of health systems in general and providers in particular, researchers need to establish a mix of the perspectives of multiple stakeholders. All three stakeholders studied (regulators, providers and care seekers) strongly acknowledged the complementary role of private providers in improving health, responding to care seekers' expectations and ensuring fairness in care delivery. We find the role of private providers in improved, responsive and financially fair healthcare delivery to be emergent. The private healthcare provision is constantly evolving, taking on traditional public provider roles such as vaccinations, immunizations and

family planning, in order to remain a relevant partner as well as be a preferred choice of care seekers. We argue that private healthcare providers have untapped and undiscovered potentials in contributing to universal health coverage, but selective commitment by the regulator to regulatory enforcement is a hindrance. The study disputes the regulator's suggestion that care seekers are technically deficient in assessing the health improvement, responsiveness and financial fairness performance of private healthcare providers, especially quality of care, and concludes that the former's description of private sector care as being of better quality than public delivery is a matter of encounter of two worlds (public and private healthcare providers). In order to address non-commitment of the regulator to fostering the private sector, the study recommends a business-like, proactive and collective approach to regulatory enforcement, one in which all three stakeholders (regulators, private providers and care seekers) can contribute to and benefit from. We also propose robust research approaches and regular assessment of the emerging complementary role of private providers in order to harness same.

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