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ABSTRACT

Health remains a sector that requires sustained efforts on the part of the public authorities, given its public service nature and its economic and social importance. The role of the state in this sector is paramount. It is in line with the powers assigned by the public authorities to the risks of diseases and other threats to the community. The presence of the State is appreciated in this specific area, since it provides assistance and assistance to the most needy whose health needs are considerable. Rethinking the role of the state in the health sector is a necessity that is self-evident since the social sectors are closely linked to the global economic sector which is experiencing, in turn, upheavals since the reorientation of the health sector. Algerian economy of the centralized management mode, where the State is omnipresent, in the mode guided by the logic of the market. In this paper, it will be a question of highlighting the new role of the State in the field of health in Algeria in the light of the changes made on the economic scene and the removal of all obstacles to growth and development of the private care sector by analyzing all the resulting repercussions.

Keywords: public health care system, private care system, combined effects of globalization, institutional reorganization, rethinking the role of the state in the health sector.

Introduction

There are several segments of care in Algeria (public care segment, parapublic care segment, private care segment and care abroad) before it is decided to narrow it by becoming essentially bipolar: coexistence public segment of care and the private segment of care while maintaining care abroad but for serious diseases excluding sending abroad for care for minor diseases.

The parapublic segment of care was constituted in the agricultural mutuals (regroups the health centers of the agricultural mutuality under the supervision of the Ministry of agriculture and the agrarian reform), the social security funds (the health structures of the safety social) and public enterprises (the "CMS" health centers of national companies) where a multitude of medical and health infrastructures (laboratories, medical centers, clinics, etc.) have been developed.

Most of the structures belonging to the parapublic care segment are located in Algiers, Oran, and Constantine, and the latter have only one health activity: curative medicine. All these infrastructures belonging to the parapublic sector of care are annexed to the public sector of care after the resolution of 1980. Indeed, it is recommended in this resolution in point "No. 32" that the health units run by national enterprises and social security organizations be integrated into the national health system and that their activities be integrated with those of the national health system public sector.

The objective pursued through this unification of guardianship is to unify the regulation of wages and certain advantages granted by the parapublic segment to the detriment of the public segment, which will in turn be characterized by an unequal importance between these structures hospitals and these structures of light care, accompanied by the marginalization of the latter and their impoverishment.

The unification of the health care system is considered as the prerequisite for the granting of autonomy to the health sectors (regrouping the hospital and out-of-hospital health structures) because depending on several guardianships implies interference from one or more parties and their interference in the internal management of the health sectors, something that will necessarily create dysfunctions within its health sectors in the organizational and decision-making aspects.

As for this unification, it has not been achieved smoothly because there are many differences between the benefits offered by the parapublic care segment compared to the public segment of care, so it is quite normal that resistance to any change is noticeable at the level of the personnel of the parapublic segment and of those who pilot it to not achieve this unification which does not benefit them. Indeed, the benefits offered by the parapublic care segment are of several kinds and as an indication we can cite: a significant remuneration and a less demanding workload.

The Health Sector, or more precisely the Architecture of the Healthcare System recommended in Algeria

The health sector, or more precisely the architecture of the health care system advocated in Algeria, is that of a unified, integrated and finally decentralized system. These are the three principles that constitute the bedrock of the national health system and its corollary the health care system, with a fourth which is none other than an arsenal of legal and legal texts refined to operate these different refittings. These principles, in fact, have had different fortunes, since some of them can not be realized in the field have remained for a long time pending their effective implementation: this is the case of the principle of the decentralization of the health care system. Which remains a hot topic on which we have not completely decided.

Unification of the health care system means, as previously mentioned, the annexation of all the structures belonging to the parapublic healthcare segment in the public care sector. The total annexation of these structures took place in 1984. On the other hand, by integration, one understands that the public system of care in Algeria consists of a multitude of structures each having a mission to fill in the geographical area where it is located. The care system in Algeria is structured in a hierarchical way according to the degree of complexity and specialization of care provided to the population.

In fact, hierarchical structures are judiciously distributed throughout the national territory so that the entire population, be it urban or rural, has access to all levels of care, starting with basic care distributed in treatment rooms located in different areas of the country. Villages and urban neighborhoods by moving up the hierarchy of planned levels of care to appropriate facilities to the highly specialized care of hospitals in health regions.

That said, for this system of care to be functional, it must be integrated because it is like the links in a chain that would suffice for its malfunction or blockage that one of these links is weakened. Unfortunately, our health care system is never integrated because of the marginalization of light structures, which has been reflected in the "dispensarization" of hospitals in the health sector or those belonging to university hospital centers.

The marginalization of light structures is the consequence of their pure and simple abandonment by a qualified medical staff in this case doctors. In addition, this marginalization came because of the small proportion of the budget allocated to the basic health structures that hospitals of dairas, headquarters of the health sectors, largely monopolize. For the rehabilitation of these basic structures, it is proceeded to the creation of health sub-sectors consisting of several basic units grouped around a polyclinic or failing that, a health center which constitutes the technical-administrative headquarters.

Decentralization consists of leaving as much power as possible to the health and other health sub-sector to assume their organization and internal management without the intervention of the central administration. However, this management and organization must be effective because health structures have long functioned as administrative and bureaucratic structures and their management is usually

limited to cash management no more. The center was to focus on the design, adjudication and evaluation of health policy and programs.

Reasons for the Predominance of the Public Care Segment to the Detriment of the Private Segment

In its article 5, the law n ° 85-05 of February 16th, 1985, relative to the protection and the promotion of the health, sets the foundations of the foundations of the national system of health in Algeria. Indeed, the latter is based on the following points:

- The uniqueness of the health system (in other words the existence of the public health care sector and the private health care sector) in its organization and development. However, Article 5 of the said law provides for the predominance and development of the public sector;
- Health planning that fits into the overall process of national economic and social development. It ensures a harmonious and rational distribution of resources, both human and material, in the context of the health map. Indeed, it is to health planning that the burden or the mission is to define the objectives and to determine the means to be implemented in terms of: infrastructures; equipment; human resources; training programs; health programs.
- Intersectorality in the development and implementation of national health programs;
- Development of human, material and financial resources in line with national health objectives;
- Complementarity of prevention, care and rehabilitation activities;
- Decentralized, sectored and prioritized health services, with a view to fully covering the health needs of the population;
- The organization of the active and effective participation of the population in the determination and execution of health education programs;
- The integration of health activities regardless of the exercise regime.
- This being the case, the reasons for the predominance of the public care segment in the private care segment include:

The Establishment of Free Healthcare in Public Health Structures in Algeria

Indeed, it is a decision taken by the Algerian public authorities that is part of the Algerian doctrinal texts that needed to be implemented in the field. It is the free treatment implemented by the order N 73.65 of December 28, 1973. Created health sectors are in charge of the distribution of care to the whole population whether city or rural. It is true that the decision to apply free medical care coincided with the second most ambitious quadrennial plan (1974-1977) for the construction of our economy and social infrastructure. The

free treatment is supported by the state wanting to establish like the socialist countries the same health system (free medicine).

The Absence of Financial Constraints

The absence of financial constraints is undoubtedly the most plausible hypothesis of the introduction of free medicine. The financial constraint is lifted even in the public enterprises and other social organizations that have equipped themselves with a multitude of health infrastructures called parapublic segment of care which reinforces the public offer of care and which is part of the "public policy". Social enterprise "which has been conducted until then by public enterprises and other social organizations such as social security.

The Presence of a "Welfare State"

The presence of the state in the field of health is appreciated, even more, by the most disadvantaged social strata. They seek social protection against the risk of illness and any other risk that may affect it. For a long time confined in its role of a "welfare state" called to achieve a social and economic policy of the most ambitious, the Algerian state in its quest for social progress uses the system of social security. Indeed, social security is used as one of the instruments of the realization of the economic and social policy of the State. The role of social security continues to grow as it is involved in the financing of social transfers. That said, this trend began to develop from the 1980s when social security was involved in taking over some of the public social spending.

The Fascination of the Algerian Legislator for everything that Concerns the Non-profit Sector

The public health care sector in Algeria is often considered, rightly or wrongly, to be fairer than the private health care sector. Indeed, the preponderance of the state sector and its hegemony in the provision of care are rooted in the fascination of the Algerian legislator to all that pertain to the non-market sector considered egalitarian and more egalitarian than those of the private commercial sector. More turned to the maximization of income and the limited satisfaction of special interests in complete contradiction with the interests of the whole community.

The Factors that guided the Emergence of the Private Care Sector

The removal of all the obstacles to the participation of the private sector of care came following the failure of the policies followed which favored the

whole State in disregard of the logic which calls upon all the actors intervening on the economic scene to play their role without to worry or to attach, more importantly, more importance to the sterilizing ideologies which push to sclerose all the living potentialities of the country.

That said, the factors that guided the emergence of the private care sector can be summarized as follows:

Malfunctions of the Care System

The multiple dysfunctions that characterize our system of care have led to its poor performance. These malfunctions are related to several aspects including:

- The hospital-centrism of our care system favoring the curative on the preventive so an organization of the distribution of care having pivotal center the hospital which makes difficult any coordination between the different levels of hierarchical care;
- Lack of motivation of medical staff due to poor general conditions of practice of their profession, resulting in a massive departure of practitioners especially specialists to the private sector. Added to this is the instability of the staff in charge of prevention and primary health care;
- Frequency of drug and consumable shortages combined with a high rate of immobilization of biomedical equipment (18% in 1992, 21% in 1993)
- heaviness in the management and operation of health facilities;
- Faulty management of certain chronic renal, cardiac, cancerous pathologies ...;
- Regional disparities in human and material resources

Reversal of Attitude towards Free Medicine

Free admission is questioned several times. In 1984, with the restoration of user fees in other words a number of acts and medical care on an outpatient basis, as well as laboratory and biology tests became profitable. In 1995, there was the introduction of a lump sum contribution of access to care in public health structures in Algeria.

Slippage of Algerian health policy

In addition, this shift in attitude towards free healthcare is due to a certain shift in Algerian health policy that has moved from a logic of meeting the health needs of the population. To that of containment of health expenditure (the logic of costs).

The Combined Effects of Globalization: State Disengagement or the Decline of the "Welfare State"

The change of attitude towards free healthcare is finally a reflection of the withdrawal of the state or the decline of the welfare state. This decline is explained by the involvement of social security in the financing of social sectors including health. Indeed, social security becomes for a period of time the first financier of health expenditure in Algeria.

Indeed, Algeria has moved from a development policy based on development plans (three-year plan, four-year plans, five-year plans) to a structural adjustment policy, developed and implemented in agreement with the International Monetary Fund (IMF) and the World Bank. Such a rent economy is the prime characteristic of the Algerian economy. The energy and gas resources of the country are, rightly or wrongly, considered as guarantors of the country's development. The sustained effort that Algeria has made for its development is immense. An ambitious program of industrialization of the economy is launched the day after the valorisation of hydrocarbons. In addition, Algeria has developed a remarkable social infrastructure. Very substantial resources are allocated to health and education. Indeed, the oil rent has allowed Algeria to conduct a social policy of the most ambitious, and even to allow all the abuses in economic matters (plethora of staff in companies, distribution of individual and collective bonuses of performance on products mostly subsidized etc. ...). As a result, the oil rent has on the one hand allowed everyone to work, access to care and education, on the other hand, this rent is seen as a way to compensate for internal and external imbalances. It was enough to call into question all this scaffolding that a drastic drop in oil prices was observed on the world market. Algerian decision makers have based all their economic policies on energy and gas resources whose prices are set independently of their wishes.

The economic and social transition that the country is going through has undeniably influenced the health sector because, like the other sectors of economic and social life, it suffers from the poor performances recorded by the Algerian economy since 1986. days. These poor performances are mainly due to the socio-economic upheavals that have characterized Algeria following the fall in its revenues from the sale of hydrocarbons, the overwhelming weight of the external debt negating all development efforts, in addition to the transition to the market economy that has seen the country turn into a vast project of economic reforms resulting in a decrease in the allocation of resources for the health sector. In fact, the share of health expenditure which was in the order of 5.1% in 1987 fell to 3.8% in 1989 and 1991, rising to 4.7% in 1993 and 1995.

Nevertheless, the major effect of this economic and social transition remains the opening up of the health sector to private actors. In fact, since 1988, the Algerian legislator has authorized the opening of health activities to private clinics. It has also authorized the opening of diagnostic and exploration activities, thus initiating a process of creating analysis laboratories, medical imaging centers and endoscopy for private individuals. In addition, pharmaceutical production and import activities have been open to the private sector since 1992.

The evolution of the socio-economic data of the country characterized essentially by an economic recession which was accompanied by very strong tensions in the social field and the implementation of the economic reforms resulting in the fall of the part of the expenses of health in Gross domestic product (5.1% of GDP in 1987, 4.7% in 1993 and 1995) means that the state has gradually disengaged to make room for the gradual participation of certain categories of citizens in financing their basic needs. health. Also, a contribution of the patients to the expenses of their consultation and hospitalization is required since 1995. By rendering the services of paying care, the patients going to address the health structures will inevitably require, in their turn, more attention of their structures Home. Moreover, the social security system, which was the largest contributor to the health care system before it was replaced by the state as the primary financier of health expenditure, is considering changing its funding arrangements for the health care system by putting it wants to fund not health facilities, as is currently the case, but programs of activities that they will have to develop.

Institutional Recompositions Operated

In the face of the poor performance of its health system, Algeria has put in place reforms aimed essentially at correcting the errors or anomalies of the health policies already elaborated and at revitalizing an increasingly burdensome sector of resources. Social security and public finances, but the results are often mixed. All these reforms are aimed, as a last resort, at leading to institutional recompositions, operated, without a trace of doubt, by a set of measures available to the Algerian decision-maker such as:

- The removal of all the barriers to the development of a private sector able to relieve the State and the social security of the financing of healthcare services;
- The privatization of the medical exercise by removing all the constraints hitherto on the offer of care like the authorization to settle which is removed from 1986, when the counter shock oil is felt as a devastating phenomenon for the Algerian economy but also for the health care system, which is not long in coming to terms with reforms such as those which admit privatization by mere opposition to the public sector;
- The authorization to open private clinics decided from 1988;
- Authorization is granted to the highest medical personnel in the university-hospital hierarchy to practice in these private clinics;
- The lifting of the State monopoly on imports, production, and wholesale distribution of pharmaceutical products;
- Widening the financing options for public health care services by making them pay a lump sum contribution to public health structures from 1995 onwards;
- The administrative decentralization which made it possible to transfer to local authorities some responsibilities in the matter of health, for example

the construction of the treatment rooms or the assumption of responsibility for the surveillance of spring waters in order to guard against all the diseases with waterborne transmission (MTH) while taking care of environmental hygiene;

- Autonomy of the public care sector based on a legal status;
- Deconcentration to give more responsibilities to local officials of the Ministry of Health or to the health directorates (DSP) of the various wilayas of the country with regard to the realization of certain health investments such as polyclinics knowing that these directions are In addition, they are responsible for the application of regulations, the execution of national and local health programs, the coordination of the functioning of health structures at the local level, and so on. ;
- Initiation of a policy of controlling health expenditure which is reflected in a set of measures in the sense of giving social security organizations a few savings, for example, the soaring prices of medicines whose reimbursements are increasingly weighing on its social insurance branch (the reimbursement of medicines based on real prices is abolished from 2001 and replaced by a reimbursement on the basis of a reference tariff which is in fact a social security fund liability rate)
- Finally, the contracting policy, inspired by international organizations, was launched in 1993 with a view to the performance of the public care sector.

The New Role of the State in the Health Sector: The Search for Synergies

All these recompositions should logically result in a multiplication, a diversification and especially in a more sustained involvement of the actors of health in the future of their institution. Nevertheless, these actors continue to live in isolation and do not seek the favorable synergies that are offered to them while the mode of organization of the supply of care remains largely based on the hierarchical power, ie on a vertical command, which does not favor the participation of all.

The isolation that often characterizes traditional health actors is no longer possible today. Indeed, the state and the social security are now unable to support, on the one hand, the errors of a system of care whose financing needs tend to a continual increase because the frantic expenditure of health reduce the resources of the public authorities but can also lead to structural imbalances in the different branches of social security. On the other hand, these expenses are supposed to improve the health services for patients who become more demanding by asking for more and more care of better quality because the supply of health services, public or private, does not always give them satisfaction. . Thus, the health actors are led to reconsider the terms of their relations. These are increasingly based on contractual arrangements, which formalize agreements between actors who bind each other.

The reforms initiated have put more emphasis on the logic of institutional restructuring that is considered a prerequisite for any improvement in the

performance of health systems. Nevertheless, in order to break the continuous isolation in which the health actors find themselves, it is necessary at the same time to emphasize the logic of the interrelation between these actors that we will call for convenience contractualization.

Conclusion

To improve the performance of the health system, a strategy should be put in place, based initially on concerted action by the actors with a view to improving their effectiveness by better coordinating and combining the efforts of the health system. Each in the implementation of a health policy. Then, in a second step, translate this individual efficiency into the effectiveness of the system as a whole. This transformation can only take place if concrete modalities are envisaged for the construction of relations that go beyond the informal to raise the bar with more formal commitments and arrangements. The contractual arrangement is the tool that meets the expectations of each other in order to give more consistency to their relationship.

One of the ways taken to get the actors of the health system out of their isolation is to better coordinate the efforts of each one that can take several forms: the recognition of the other or the consultation. Neither one (in the case of recognition of the other who calls health actors to recognize each other because it is difficult in reality to get rid of his feelings of superiority and taking for example the administration which often finds it difficult to consider the person opposite as a valid interlocutor) nor the other approach (consultation) or the exchange of information and points of view between health actors on a common ground or fundamental values that unite them and the conduct of their respective activities. Consultative meetings can thus lead to the elaboration of common principles of intervention by making a joint statement or by drawing up a charter whose commitment is moral, without the relations that are created creating obligations in the legal sense of the term.

The two forms of coordination listed above, however, have limitations because the actors who interact with each other are aware that the relationships they maintain are not formal, which implies that they do not create reciprocal obligations. Hence their moral commitments but no more.

The contractual arrangement, meanwhile, "is a voluntary alliance, on a given object, independent or autonomous partners who engage with mutual duties and obligations and who expect each of the benefits of their relationship." This definition has some key elements that we think are important to mention:

- The alliance is voluntary, which means that it is not possible to compel an actor to enter into relations with other partners. Nevertheless, the fact that they all have a status or a legal personality, it allows them to go towards this alliance with an equality of right, but the reality reveals an irregularity between the actors of a contractual relation because even if everyone is

independent, there is an asymmetry or a power imbalance between them, for example, a tutelage exercising power over a public entity;
- any contractual relationship gives rise to reciprocal duties and obligations;
- a contract is a binding commitment in the sense that it must be rigorously respected by the contracting parties, nevertheless the manner in which the contract will be respected varies according to whether it is a contract, in the classical sense of the term, where the purpose of the contract is clear, its duration is quite limited and the contracting parties know exactly what they expect or what it is about, a relational contract based on the confidence that the actors have to act in the common interest. In this case, the actors agree on the objectives of the relationship, on the working methods to be followed and, lastly, on the means that will be mobilized to carry out common actions. This type of contract is more flexible than the traditional contract, which can also provide for sanctions in the event of non-compliance with the commitments made;
- The actors who engage in contractual relations are now expecting profits, otherwise why join forces except to take advantage. However, profits may not necessarily be appreciated in direct financial terms even if any contractual relationship entails costs.

Bibliographical References

Abid.L "Current Health System Organization and Perspectives", DGSSRH - MSPRH

Cheriet. F "Effects of Structural Adjustment on the Health Sector: Some Methodological Difficulties in Evaluation" in "From Reform to Reform: A Health System at the Crossroads", pofesseure Oufriha.FZ and collaborators, CREAD, 2006.

Kaddar.M "The relationship between social security and the health care system in Algeria" in review of CREAD n ° 19, 3rd quarter 1989.

Mebtoul.M "The challenges of the privatization of care in Algeria", journal of anthropologists, 2004.

Ministry of Health, Population and Hospital Reform "Projection of Health Sector Development: Ten Year Perspective", July, 2003.

Perrot Jean "the role of contracting in improving the performance of health systems" discussion paper, number 1- WHO Geneva EIP / FER / DR.F.04.1,2004.

Perrot Jean "the role of contracting in improving the performance of health systems" discussion paper, issue1- WHO Geneva EIP / FER / DR.F.04.1 2004.

Salmi Madjid "Essay of analysis and reflection on the organization and management of health sectors in Algeria: elements for a diagnosis. Case of the health sector of Larbaa Nath Irathen ", thesis of magister, Tizi-Ouzou, 1999.

Salmi Madjid "Health system in Algeria at the time of the plural transition: elements for an evaluation of the quality of care", doctoral thesis, Tizi-Ouzou, 2009.

Zehnati.A "Private clinics in Algeria: the emergence of a new player in the health landscape". Review the Cahiers du CREAD N ° 105/106, 2013.

Seminar on the Development of the National Health System, MSP, April 1983