Public versus Private Health Sector

Useful Partnership or Unfair Competition?

by Dr. M Zakir Husain

It does not make sense to let public hospitals remain poorly managed, stretched beyond capacity, kept underfunded, restricted from generating own resources and retaining these, left largely without public accountability with no public participation in governance. It makes ample sense to bring all healthcare providers under the umbrella of quality assurance and enforce minimum standards for all. . .

PUBLIC sector health services, by definition, are services delivered by the State, while private sector healthcare is provided by individuals and institutions that are outside the State (public) sector, usually making profit. Following the introduction of market economy, the private sector is growing as the dominant sector. There is growing interest in how the private and public subsectors work and the relationship between the two in the health sector as a whole.

As market economy takes hold, private healthcare market thrives and consumes a significant portion of the national health resources. It is today accounting for, even in poor countries, health expenditures exceeding by far those by the government. Side by side with under-funding and decline of the public health sector, private sector health care is now occupying a dominant position. Yet, it is rarely coming under serious scrutiny.

Governments in many countries continue to prepare ambitious health plans; numerous individual projects are launched but rarely completed within the stated timeframe. Though plan documents make some reference to the private sector, the plans remain effectively confined to the creation of public sector facilities and allocation of public funds. There is no real integration with the private sector in the planning exercise nor is there explicit definition of preferred areas or co-ordination of activities between the sectors.

Curiously again, policy makers usually give blanket endorsement of the private sector healthcare; various forms of incentives and indirect subsidies are also provided. In the absence of close scrutiny and analysis of the private health market, doubts remain about quality, cost, ethical conduct, and equity — all of which are particularly important in the case of healthcare. These doubts frequently prove real. It has to be admitted that health care is not really a free market; consumer public has little knowledge and control; providers enjoy near monopoly and can fuel demand and supply.

Due to lack of consumer awareness and lack of enforcement of regulations even where these exist, the health care market is virtually *laissez faire* — free for all. This could well be a prescription for disorder, distortion, non-accountability, and even ethical lapses and reflected in frequent public grievances.

The Distortions

The private sector is growing independently of, and often in competition with, the public sector. The private sector views with suspicion any form of regulation or evaluation from the outside. Aversion to any form of interference or criticism prevails. Nonetheless, health is not merely yet another market commodity; it is a social merit good of high value; quality and standards are extremely important; so are concerns for public safety and equity. Some form of regulation is highly desirable to control runaway costs, wasteful and inefficient duplication, and ensure acceptable standards and quality. In fact, it is essential. The present state of free for all market, in the end, cannot but harm the public interest.

The distortions take many forms. For example, when public hospitals are used to conduct private practice, when subsidies are obtained to enhance private income by using premises, equipment and supplies, when paid employment is used as a springboard to attract private patients, when concessions are demanded or extracted for procurement of supplies — these are distortions.

In order to bring some order into the present situation of disorder, to restore credibility and image to the public sector institutions, several steps may have to be taken.

Some Early Steps

Public and private sector in health should be redefined and re-classified according to the purpose the institutions serve and not just on ownership or administrative label. The mission of public and private sector should be clearly stated and widely known; and these should be compatible with the overall goals of the national health policy.

The efficiency of the public sector should be improved by providing the resources and managerial inputs needed to achieve its stated objective. You will not have good public sector hospitals by burdening these with open ended commitments but starving these of funds, equipment, supplies, and accountable management. You cannot permit plunder of public sector resources to support private income and then condemn these institutions as providers of poor public service.

It should be clearly established that the entire health system operate on a public or social rationale for public good even after allowing reasonable profits on investment to the private sector. You cannot run the private sector on what the market will bear in prices and profit just as you cannot run the public sector under chronic handicaps of poor funding and weak management.

A system of checks and balances supported by formal accreditation of health institutions — both in public and private sectors — should be in place and requirements of minimum acceptable provisions and procedures should be in force.

Key to Partnership

Times have changed. Public sector is no more an exclusive preserve for service free of cost to the client at the point of delivery. All public facilities are no more totally free; many of these charge fees for services provided to those who can or will pay. Then there are non-government facilities who give service free of cost or at minimal cost. Of course there are fully private profit making facilities. Whatever the type or nature of the healthcare establishment, these must run efficiently and within the parameters of an overall social mission.

When all facilities become efficient and operate to optimum capacity, there will be conditions for true complementary co-operation and not competition; there will be sharing of resources based on comparative strengths; many public facilities will cost effectively use privately provided services and vice versa. Clear mission statements and good management are the twin preconditions of partnership between the public and the private sectors of health.

Neither benign neglect of the public sector nor total freedom to the private sector will bring about a meaningful partnership. The worst case scenario is when the public sector is left to subsidise the private practice and income bingeing disrepute and loss of image to the public sector facilities and giving undue and unfair advantage to the private sector. That unfortunately is often the case at the present time. No wonder, there is so much dissatisfaction and discontent with the running of public hospitals and health centres which perform poorly either due to lack of essential supplies or lack of motivated and accountable health workers. To compound the problem, when the private sector is allowed to have a free run of the market, things can only get worse for consumers many of whom may not get their money's worth.

What Makes Good Sense?

It does not make sense to let public hospitals remain poorly managed, stretched beyond capacity, kept underfunded, restricted from generating own resources and retaining these, left largely without public accountability with no public participation in governance. It makes ample sense to bring all healthcare providers under the umbrella of quality assurance and enforce minimum standards for all, to introduce efficient and transparent management, and maintain good accounting and evaluate cost and output ratio.

National accreditation council make very good sense. These should lay down acceptable minimum requirements and enforce that these are met equally by all public and private health establishments. The consequences of not doing so are all too clear to see and fearful to contemplate.

If the present disorder is allowed to take a firm hold it will be much harder to restore order in future. Let health sector be an example of how things can work better in public interest, how true partnerships can flourish. True partnerships best grow between equals and not between the pampered and the punished.

One must resist the current fashion of unilaterally blaming the public sector for all that is wrong with the system. That is like throwing the baby with the bath-tun. What should rather be done is putting right what is wrong and not condemn the whole system outright. A flourishing private health market is not necessarily a responsible institution; it is no cure of all that ails; there is proof enough of that already.

The private healthcare sector in Bangladesh is still in the growing phase, the time to set it in the right course is now. The public health sector in Bangladesh has an extensive infrastructure but very rudimentary management and the running of public facilities on a profit motive much of which goes to private pockets will not do any good. A public facility can be efficient and well run without surrendering to private profit-making or sacrificing its public service mission. There are many good NGO-run hospitals and clinics that show the way, though all of those may not be without fault. The time to reorder and restore a good balance between responsible and well managed public and private sector facilities is passing by. Good management with accountability and efficiency cannot be compromised. With a solid base of partnership, it is conceivable that both the public and the private health sector in Bangladesh can and will flourish, one complementing the other and not eliminating each other.

New Planning Parameters

Incremental creation of health facilities in the public sector by government planners will not make the desired difference in public health; open ended public commitments will only stretch limited public funds too thin; existing facilities will be deprived of much needed funds even more; public sector will likely lose credibility even further.

Instead, what will improve effective use of resources is investing in better management and functional improvement of existing facilities such that they become viable and self-reliant. What the planners need to do is determine the type, quality and cost of the healthcare in public and private ownership, and a measure of who benefits from what. What the planners must resist is creating facilities that carry little possibility of being sustainable. The planners must incorporate the private sector in their plan, define its role clearly, establish incentives and disincentives, and create a level (market) playing field for competition within the private and co-existence with a public sector.

Let us all agree that efficiency has little to do with ownership but everything to do with overall policy regime, appropriate investments, management and other inputs. Planners must respond to change and manage change and create environment that rewards performance, quality, and consumer satisfaction. A *laissez faire* environment often creates chaos and cut throat competition with attendant distortions — none of which can bring public good in the long run.

A healthy partnership between the public and private health sector is not only desirable but indeed essential in a free market regime. But it has to be built on true complementarity conceding to each its particular role and mission, and not on unfair competition and contesting claims.

When efficiently run, many public services may be accessed and used by private providers and many public hospitals may use private providers for services when indicated to improve quality, efficiency, and cost-effectiveness. The ultimate beneficiary will be the consumer public and social control will establish social and public good rationale.

Sandhani — the Way it Started

by Dr M Idris Ali

1977: We were studying in the new 2nd year MBBS class of the Dhaka Medical College — all in the "E" batch. Incidentally I came to know that on many a day for financial constraints a classmate of ours attended classes starving up to 2 o'clock in the afternoon. It shocked me severely. We, all the six friends who started *Sandhani* later on, came of middle class families. We had a special respect in our families as medical students. Each month we received from our homes allowances sufficient to live quite lavishly. On knowing that the classmate attended classes without having even breakfast I was thinking of telling my other five friends about this and of finding out a way to assist the incumbent.

February 5, 1977: At the interval of classes after having snacks with the five friends in the Hospital Employees' Canteen, I told them that I would like to discuss something important and wanted them to select the venue. Accordingly, later we sat under the big tree at the courtyard of the Science Annex Building of the Dhaka University just in front of our hospital gate. I narrated the hapless position of that classmate. At that very sitting we decided to arrange for his regular breakfast. We fixed the rate of monthly subscription for the purpose : five friends to pay Tk 5.00 each while the sixth Tk 7.00 every month. We collected Tk 32.00 in the first month. In those days one could have breakfast for Tk 30.00 a month as we got two *porota* (bread fried in oil) and *bhaji* (fried vegetables) for one Taka at our College Canteen.

We then thought how to give the money to him as he might refuse to accept the offer if it was made public. It was, therefore, decided that all would hand over their subscriptions to me and I would alone contact, convince and then give the money to him. Thus commenced our journey on 5th February 1977 with an initial fund of only Tk 32.00.

Next month we thought of giving an organisational shape to this venture. We requested each to come to the Suhrawardy Uddyan at 6 o'clock in the evening on 19 March, '77 with a proposed name for the organisation. In those days, trees were just being planted at the Suhrawardy Uddyan. Everybody enjoyed having a stroll there in the evening. Our intention was, however, both to go for a walk as well as to attend the meeting. We got names including *Onirban, Amra ko jano, Sandhani,* etc. We selected *Sandhani*, proposed by Mosharraf Hussain Mukto as the name for our organisation of dream.

After a few days while sitting in my hostel room with a worker of *Sandhani*, a reading partner of mine, Selim (now Major Dr Mostafa Selimul Hasnain), we talked about the farming of a constitution for Sandhani. Soon I prepared a 4-page draft — *Sandhanir Niyomaboli* (Sandhani Rules). In the subsequent meeting my draft was approved with minor amendments as the *Constitution of Sandhani.*

Perceiving the present status of Sandhani at the national and international levels, I feel fancy to recall: *'Sandhani might some day turn into a national organisation'* — a wishful thinking that occurred to me while I was framing the draft constitution. At the same time I was rather a bit doubtful as I was also well aware that the venture was the brain-child, and an exercise of some six immature 2nd year medical students only. But now, after 22 years, with the sincere efforts of our most capable successors, both at national and international levels, the present status of Sandhani is a pride reflection of the good intentions as well as the ground work of the pioneers of that day. Seeing all these, we are thoroughly pleased, and the credit goes to all of our successor workers and leaders of Sandhani.

I now recall many incidents of that time but it is not possible to recapitulate them in this short article. I only reproduce below some data and some events.

Yesterday, February 5, was the founding anniversary of Sandhani

The six founder-office bearers of Sandhani are : President — Mostafiqur Rahman Swapan, private practitioner (Anaesthesiologist), Dhaka; General Secretary — Mosharraf Hussain Mukto, private practitioner, Bagerhat; Organising Secretary — M. Idris Ali (Monju), Asstt. Prof. of Neurosurgery, DMC&H; Finance Secretary — M. Abdul Quaiyum, senior operations researcher, ORP, ICDDRB; Secretary (Library) — Mostafa Selimul Hasnain, Major (eye specialist) in AMC, Ctg. Cantt; Secretary (Magazine & Publication) — Khurshid Ahmed Apu, Govt. job (Medical Officer).

• The aim and objective of Sandhani as mentioned in its first Constitution was to build up ourselves as ideal persons by freeing from all improper conducts and immoral practices.

• The first slogan of Sandhani was : The best way to serve God is to serve humanity.

• The first voluntary blood donation programme of Sandhani took place one 2nd Nov., 1978, at Blood Bank, DMCH. Total number of donors was 27 (26 Sandhani workers and 1 Professor). The first blood donor was M Idris Ali (Monju), the then Patient Welfare Secretary, Sandhani, now Asstt. Prof of Neurosurgery, DMC&H. The only outsider donor in that function was Prof. Dr M Yusuf Ali, the then Head of the Deptt. of Medicine, DMC&H. The only female blood donor was Hosne Ara Lucky, later married to Dr Mosharraf Hussain Mukto and now doing private practice at Bagerhat.

• The first voluntary blood donation programme outside Sandhani was held on 17 January 1979; where 28 students of the Social Welfare Institute of the Dhaka University donated blood.

• The first Sandhani unit outside DMC was the Mymensingh Medical College unit formed in Oct. 1979.

• Formation of the first Central Committee of Sandhani was in January, 1983.

• The first central President of Sandhani was M Abul Kalam Azad, now Associate Prof. of Nutrition & Biochemistry, NIPSOM, Dhaka.

The date of foundation of Sandhani is 5th of February (though the naming of the Sandhani took place on 19 March) as all its basic works commenced on that date.

Publicity-free Preliminary work : Many of our preliminary actions and activities were free from publicity. Let me cite an example. It was winter. A student of our next batch had no quilt. He suffered tremendously from cold. We decided to buy him a quilt. He was not aware of our decision. On purchasing a quilt, Swapan and I quietly entered his room, put it on his bed and whispered to him : "This is a present from Sandhani for you. Nobody other than you knows about it." We then instantly left without giving him any chance to speak. He is now a physician serving abroad. I believe that till today no worker other than the two of us knows his name. In those days we also purchased shirts and pants and gave them to many students — keeping that secret too.

Mild objections from leaders of student organisations : We were junior students. Senior students of all student organisations treated us with special affection. Some, however, raised question: "Why are you organising a new party?" This question was raised because a few years ago a similar organisation participated in student politics. With humble submission we succeeded in convincing them of the necessity, and non-partisanship, of our organisation: "The best students of the country, boys and girls, come to study in the Dhaka Medical College. Many of them do not like to be directly involved in student politics though they have extra-curricular abilities. The country will be benefited if such faculty is utilised. So we have a mind to organise a common platform where every body would be interested to participate and make contribution according to his ability. We swear that Sandhani will not be involved in student politics and shall not create any inconvenience for you."

The voluntary blood donation movement : Initially we had no voluntary blood donation programme. One year later, on promotion to 3rd year class we were placed at the Blood Bank desk of the hospital. Then the Head of the Blood Bank was Prof. Habibur Rahman. It was from him that we came to know how the blood banks of developed countries were operated and how the people donated blood there. Then and there we decided to introduce the 'voluntary blood donation programme' under the auspices of Sandhani. The news of our blood donation programme of 2nd Nov, '78 with our photos was published the following day under banner headings in all the newspapers. In the successive days the newspapers and magazines praised our programme with editorial comments encouraging us. Thus the voluntary blood donation programme eventually turned into a movement in Bangladesh. This has been definitely proved by the fact that when Sandhani appealed through television for voluntary blood donation after the Jagannath Hall tragedy and the Tongi Railway accident, it received blood in quantity many times over than actually required. The credit for popularising the widespread participation of people, especially students and youth, in the voluntary blood donation programme goes to the Sandhani and Sandhani alone. As a recognition of this the Government of Bangladesh declared 2nd November, the first day of voluntary blood donation by Sandhani, as 'National Voluntary Blood Donation & Posthumous Eye Donation Day'.

Sandhani in the movement for voluntary posthumous eye donation : The movement for voluntary posthumous eye donation by Sandhani was introduced much later. We, all the founders, by then had finished our student life and became physicians. Thanks to this programme many blind persons are now regaining their eye sight. For this programme, Sandhani gained recognition internationally in different countries including Sri Lanka and USA.

Sandhani and other NGOs : Most of the NGOs that are working in Bangladesh for the welfare of the masses are of foreign origin. Sandhani alone is the internationally recognised voluntary organisation that originated in the soil of Bangladesh. It is the pride organisation of all the people of Bangladesh. Students and doctors of all medical colleges are specially proud of this as it was born in the courtyard of a medical college. At the sight of its flourishing state, understandably I cannot suitably express in language the joy and delight of all those who are, from the beginning, directly associated with all its actions and activities.

The writer is a founder-member of Sandhani.

Oversize Overtures

by A Husnain

WATCHING from the balcony the Eid crowd strolling by, an observer would wonder at the latest fashion of wearing oversized (readymade) garment by the male gentry, young and old. Our son, a University student, does the same. Perhaps he has some plausible excuse: he is tall and ultra slim, and underweight, and is concerned with his form by using loose dress. The pleasure of a perfect fit cannot be described in words.

There is another explanation : the market is flooded with readymade garments designed for export. These have two distinct characteristics: on the average the sizes are meant for larger body frames of the customers in the temperate zones (where the affluent countries are located — the Americans and the Europeans); and, the materials for the dresses are thicker and heavier for cooler temperatures compared to the tropical heat and mild winters, where cotton and light textures are mandatory.

The young generation, with tighter wallets, are not accustomed to the right and correct fitting of the (ready-made) garments they wear, considering the additional cost of tailoring made-to-measure or made-to-order dresses, and the better quality tax-free fabrics imported for the export industry, which are not easily available in the market at the retail level.

Watch the shirts or the T-shirts of the pedestrians. Very few are of correct fitting, and most are oversized. The jeans and the trousers are too long and too filling. This trend has now been transferred to the local punjabi kurta buyers. The palms and the fingers disappear into the extra long sleeves, and the length of the kurta has now reached nearly the ankle level (is it the *jamai-baboo* look?). There is another coincidence: the male kurtas are beginning to resemble the ladies kameez or kurta in length. The male kurtas are more boldly colourful now with not so sober printed patterns. This is not a trend towards unisex clothes.

After the above observation and introduction, let us come to the main point of this commentary. The way we work on our jobs, generally speaking, is also oversized — and loose (the pun is intended). The work of operation has to be planned to be tailor-made for the job in hand (and not vice versa). That is, the job has to be done exactly in the way it should be done (professionally). But the bug of amateurism (and inefficiency and corruption) lurks behind almost every step, and we are faced with the familiar symptom of *systems loss.*

This sad national loss can be easily detected in all sectors, especially in the public sector. Note the general standard of goods and services, and the speed of service. Watch what is happening in the SOEs (the state-owned enterprises) and the nationalised banks. The constancy in poor output is stable, to say the least.

In the private sector, there are two glaring shortcomings: internal efficiency and quality control. The competitive factor is low; at the international level, and while competing with imported products. R&D (research and development) lower down the scale is almost absent — it is difficult to persuade the smaller managements to allocate some funds for R&D.

In politics also, the oversize philosophy prevails; holding back the nation. The politicians are well ware of the subtle techniques employed, but it is difficult for the general masses to detect the tricks of the trade. It would be an interesting study if some think Tank organisation would work out the system loss in politics in Bangladesh and the LDCs, for the enlightenment of the devoted and artless voters (vote rigging is a different and specialised profession).

The civil service is a classical example of oversized dressings (pun intended). The inputs and outputs do not match, and the internal and overall system loss in the highest in the world. The government offices are very well informed, as the feedback arrangements are theoretically there but not utilized properly. Anonymity dilutes the fixation of responsibility, and bureaucracy reigns supreme, regardless of the assets and liabilities, or change of regime.

It is difficult to change the current speed of this huge flywheel generated by the bureaucratic system. This is why there have been so many PARCs (Public Administration Reforms Commissions). The latest PARC has issued a set of Questionnaire for public response. It is worth studying — fine-tuning the vicious circle of officialdom.

There is a difference between working dress and leisure wear. The two modes of dressing are not interchangeable. How to redress (not redress) the nation?

Drugs Become Dear in Delhi

Dev Raj writes from New Delhi

Between 1970 and 1996 production by the Indian drug industry grew from 62 million dollars to 2.3 billion dollars and had turned into a major earner of foreign exchange as well bringing in 550 million dollars in hard cash annually by the late '90s.

INDIANS who now pay the world's lowest prices for medicines are bracing for a massive hike in drug prices after this country accepted Exclusive Marketing Rights (EMRs) for pharmaceutical companies through an ordinance.

"The bureaucrats who pushed the ordinance through might have waited till the budget session of Parliament begins this month," said Muchkund Dubey, former foreign secretary who had opposed India's signing the Trade Related Intellectual Property Rights (TRIPS) because it affected cheap drug availability.

India has till Apr. 19 to bring the legislative changes to its outdated Patents Act although there is small chance of Parliament rejecting too many changes effected by the ordinance since that would invite retaliatory action against Indian exports.

Already India has lost a case filed against it in the Dispute Settlement Body of the World Trade Organisation (WTO) by the United States for not meeting patent change commitments with agrochemical and pharmaceutical transnational knocking on the doors of a vast untapped market.

According to Dr Mira Shiva, a consultant on drug policy at the Voluntary Health Association of India (VHAI), a leading health NGO, although new patented drugs may take two years to reach drug store shelves prices have already begun to go up.

Dr Shiva said with India signing the TRIPS agreement, years of work on rational drug use initiated by the World Health Organisation (WHO) had gone down drain.

"India produces and sells drugs at the lowest prices anywhere in the world but the levels of poverty are such that less than 30 per cent of India's one billion people can afford medicines even at current prices," Dr Shiva said.

Dr Shiva said linking commitments under TRIPS to the health delivery systems in a country like India spells nothing short of disaster not only in terms of drug prices but also sheer availability of basic drugs.

"India is still battling with vector and water-borne diseases and no pharmaceutical company would be interested in producing or marketing drugs against these because of low profit margins," Shiva said.

On the other hand, the TNCs are already vying to corner the growing market for life-style drugs such as viagra mood elevators and useless tonics and vitamins and threatening to overturn the whole concept of essential drugs, she said.

Shiva said she was particularly concerned about what would happen to women who were already receiving the short end of the social stick in India. "Seventy-five per cent of Indian women are anaemic and which multinational is going to be concerned with it?"

But the worst losers are going to be India's domestic pharmaceutical industry which has thrived on the 28-year-old old Patents Act which protected process rather than product patents.

Between 1970 and 1996 production by the Indian drug industry grew from 62 million dollars to 2.3 billion dollars and had turned into a major earner of foreign exchange as well bringing in 550 million dollars in hard cash annually by the late '90s.

According to Dr B K Keayla, convenor of the National Working Group on Patents and Intellectual Property Right, the switch to product patents would in all probability result in the Indian pharmaceutical firms getting bought out by the transnational.

The experience of countries which have accepted product patents is alarming with drug prices shooting up five or six times over those like India which have process regimes.

Blood pressure patients from the West are delighted to discover while travelling in India that a 30-tablet strip of the drug Ranitidine costs less than 0.05 cents when the same would set them back by as much as 25 dollars.

India has the option of not accepting product patents till the year 2005 but has to accept the EMR regime on all products patented after January 1995 right away.

One reason for the cheapness of drugs in India is the fact that Indian pharmaceutical companies do not invest in research and development (R&D) but simply resort to reverse engineering.

According to Dr Ramesh Mashelkar, chief of the Council of Scientific and Industrial Research (CSIR), India's pharmaceutical industry cannot grow unless it invests in R&D. "And why not given that this country has the resources and cheap but skilled manpower?"

Seeing the writing on the wall, some Indian pharmaceutical companies such as Ranbaxy and Dr Reddy' Laboratories are already moving out of reverse-engineering and into research-based growth and into the expanding area of testing and clinical trials.

Recently, Dr Reddy's laboratories developed an anti-diabetic drug but then licensed out the molecule to Novo Nordisk a transnational because it did not have the funds or expertise for marketing and testing.

But Dr Shiva thinks that no matter how competent Indian pharmaceutical companies are it will be a long time before they catch up with the entrenched TNCs which have huge resources at their disposal and control the global market.

According to Dubey, one particularly bad feature of the EMR law is that a TNC which has a patent on a drug in any country which is signatory to the World Trade Organisation (WTO) can demand automatic EMR for it in India.

But if India opts for product patents right away (it need not do that till the year 2005) it can examine each and every application and be satisfied that it is genuine whether or not it is patented in some other country.

Indian also stands to lose out on its vast traditional knowledge of herbal medicine and while it has successfully challenged patents taken out in the United States on turmeric, it may not always be so lucky in resisting biopiracy. Dr Shiva said.

According to her, TRIPS is unsound if only because it was based on drugs based on petrochemicals rather than plant-based drugs which are increasingly taking over the field of pharmaceuticals. "It is particularly bad news for India," she said.

— IPS/APB