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View Point

What is fuelling privatization in health care in Nepal?

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Abstract

Health service delivery is now being controlled by private hospitals and pharmaceutical companies. Health care is being sold at private sectors. Out of pocket expenditure of household is increasing-sharply. Nevertheless, the government's spending on health is stagnant. The paper discusses on three reasons; stagnant governmental spending in health, lack of governmental control in private sectors and liberal policies as the reason for increasing privatization in health care in Nepal.The very cause for the increased private control of health service delivery is the liberal attitude of government to private sector. National Health Policy, 1991 opened the door for private sector to play in health. It occurred in the name of greater involvement of private sectors. Right to health is threatened now. Revitalizing primary health care and redefining PPP is necessary inthis condition. Exercise of higher degree of government control in private sectors coupled with greater investment in health by government is a necessity now. It may be hard for government to control private sectors with stronger rules and regulations. But if it is not done today it ought to be done the other day.

Background

Health is a human right. It should be available to the allpeople despite their ability to pay. Right to health has been clearly stated in article 25 of universal declaration of human right. Many of the countries have already agreed for right to health through constitutional provision while many countries are on the way to it. This has clearly been discussed among international communities in several conferences.(1)

The Alma Atta declaration in 1978 made the groundbreaking resolution to provide health services to all people by 2000 which was locally acceptable and affordable.(2, 3)But in the aftermath of five years, the world was divided to revert to selective primary health care(SPHC). The multinational companies, pharmaceuticals companies and powerful nationsclaimed CPHC not to be feasible option.(4-8)

The influence of globalization and liberalization on health is reflected in National Health Policy 1991. NHP 1991 opened the door for the private sectors in health care services with aforementioned provisions to welcome involvement of private sectors in health with greater degree of liberalization.

The term private sector represents variety of institu-

tions. It may be an individual like doctor, nurse or midwife or an institute like clinic or hospital or even the large multinational corporates like pharmaceuticals companies or surgical dealers are private sectors. The traditional faith healers are also one of the forms of private sector. But their contribution in privatization is clearly outnumbered by private sectors like voluntary organizations, trust, missionaries and I/NGOs. (16)Private sectors that represent the 'private for profit' e.g. hospitals, health centers and nursing homes which are run for profit are increasing in numbers in Nepal. Their influence is increasing both upon decision making and service delivery level. The latter has recentlybeen recognized by the increasing number of hospitals, private insurance companies in Nepal. Apart from this there is limited evidence on the private sector share of health-service delivery in Nepal. This inadequacy of data on private health care services may be indicative of the lack of government and public attention to and interested in such activities.

There is always a space for profit making private sectors to play on the heath sector as long as government encourages private sectors to be best partner in service delivery. This is a two prong strategy can never be poor friendly. The definition adopted by the government in the name of PPP is *"An agreement between the government (public sector) and non-government (private sector, for profit and non- profit)forthe purpose of delivering health services cost effectively and equitably."*(17)

The paper discusses the reason for increasing privatization and increase of private control of health services.

Stagnant governmental spending in health services

The governmental spending in health sector is stagnant with little increment in overall health budget in past decade. The budget allocated in heath is just eight percent of total budget. It increased by 5 percent from 1988s to 1990s.The major portion this budget went tocurative services, and a substantial in prevention and health promotion activities at community level. The share of budget in curative services has major part in staff salaries. Budget for increasing the number of health centers, their gradation is negligible. Still major portion of budget in curative services is spent in purchase of equipment's and medicines and training and deployment of health workers. In FY 2011/12 government had allocated is less 7 percent of the total annual budget for the health sector 65% of which are distributed to implement the programs under Department of Health Services.(18)

Lack of governmental control over private sectors

"Let it bewe can do nothing" This has been the case of governmental sectors in national health system. Lacks of supervision and control over existing health facilities that had already been working and absence of assessment of the facilities that are being open have been common in Nepal. The first author asked the District Health Officer or District Public Health Officer in one of the district of Nepal (district not specified due to confidentiality issue), "How many hospitals are there in your district?" The answer was be "I don't know. How many would it be? Actually we do not count this." This is real scenario in many other districts of Nepal. The DHO which should govern all the health facilities in the district does not know what the private sectors are doing. They never know this may lead to a threat to public health system, with devastating impact to the health people.

In the years following Alma Atta, the vertical projects for Malaria eradication, Family Planning and Maternal Child Health improvement started to integrate in Nepal. Throughout the 1st, 2nd and 3rd periodic plans of Nepal, curative health services werein the main focus. These services were provided through vertical projects in different parts of country.Before Ministry of Health and Population was established in 1956, Malaria control project 1954 was initiated with the support from USAID (then USOM) in southern Terai belt of Nepal. In the subsequent plans, Malaria eradication project 1958,Smallpox eradication project 1967, Leprosy eradication project1965 and TB control 1965 was laid. In 1967, the integrated family planning and maternal and child health (FP/MCH) project was established. Within the ten years of implementation of vertical projects in Nepal, government and major actors; WHO and USAID had come around thinking of integration vertical projects in Nepal. Through the evaluation of two projects conducted in the name of Integrated Basic Health Services in Kaski and Bara in 1972 and 1975 respectively, health post were converted to integrated types and thus become the peripheral unit of health services. By1987 government decided to disband Integrated Community Health Services Development Project (ICHsDP), and integrated all the vertically run health programs.(9-11) This chronological view of

health system development in Nepal reflects the beginning, when government first started vertical projects to current National Health Sector Program Implementation Plan (NHSP IP II), the private not profit sector is encroaching upon health system. In this development process, the role of private for profit sector (profiting hospitals, nursing homes, private pharmacies) is almost negligible.There were only few I/NGOs working in Health before 1990. This may be because the policy then government was restrictive to the private for profit sectors. Established in 1959, Family Planning Association was one of the early non-governmental organizations working in Nepal. Similarly United Mission to Nepal started to work in 1954. Before 1990 was the time when the major government run economic structures was established including hospital, health centers and government run industries etc.

During the first plan period in 1950s,hospitals had total capacity of 149 beds, and around 79 health centers were established. At that time large number of people was suffering from Cholera, Small Pox, Tuberculosis and Malaria. As a result, the average life expectancy of a Nepalese was 32 years. The annual death rate was 21 and infant mortality was 244 per thousand. At that time only 7% percent of population was being served by Health Facilities. Only a few hundreds of health providers were available and the doctor population ratio was one per seventeen lakh (1/170000). In this scenario, though the government was not able to provide service to all, it did not suffer from dominance ofthe private for profit sectors.(12) But the scenario looks differentnow, private sectors share as much as bed as government hospital has. High class hospital has been established in Kathmandu, Pokhara, Chitwan and other major cities, clearly increasing out of pocket expenditure of people in health.

Liberal policies

The concept of involvement of private sectors in Health first surfaced in NHP 1991. The involvement refers any ongoing relationship between public and private sectors. The NHP 1991 have had the following provision for the involvement of private sectors in Health.(13)

a)If someone in the private sector wants to extend health services through the establishment of hospitals, health units, nursing homes, without any financial liabilitythe government on Nepal, such as institutions may be operated after having obtained necessary permission from governmentand subject to minimum standards as prescribed.
b)Non-government organizations and associations will be encouraged to provide health services under the president policies of this majesty's government.
c)Necessary coordination will be maintained at each level with the healthrelated sectors including agriculture,education, drinking water and local development.

Before the NHP 1991, seventh five year plan had made policy provision for encouraging private sectors participation in developmentof health sectors. The continuum of this was reflected in NHP 1991. The subsequent eight five year planformed after Peoples Movement in 1990focused private sector participation in health care services. In this plan new acts and regulations for establishment of health institution in their private sectors were promulgated.The Ninth five year plan directed NGO sector to provide services based on rural and geographical region." and increased private sector involvement in the development of specialist oriented health services.

The Tenth five year plan (2002-2007) has forwarded two strategies for engagement of private sector was the major; first "promotion and coordination with I/NGOs and private sector", second "improved regulatory mechanism". The subsequent interims plans are liberal to the involvement of private sectors to the health services as long as they contribute government effort to provide essential health services to the population at greatest need.(14) The provision of Interim plans includes:

a)Public private partnership concept will be implemented effectively to establish and run health institutes. Human, financial and physical resources provided by the government, private sector and NGOs to raise the quality of health care will be managed effectively.
b)Non-governmental organization will be encouraged to operate community based hospitals. New medical colleges will be opened in areas where there are no medical colleges presently.
c)A policy "Public Private Partnership" of health sector management with private sectors partnership will be initiated.
d)Considering the success of community drug programme Community and Cooperative Clinic services will be encouraged. Health Insurance will be encouraged to bring every housed holds into the insurance network.

The Private and NGO sector involvement in health sector is also described in Output three of National Health Sector Policy Implementation plan (NHSP IP 2006-10). Defining appropriate public /private /NGOs /mix for each districts has been prioritized. NHSP IP has vision to set quality standards and regulatory mecha-

nism for private and NGOs sector in service delivery, establishment of district level health coordination committee of private and government sectors to streamline their work(15).

Discussion

The debate of the privatization is based on the philosophy of "marketing" but health is obviously not a product to bargain and sell in the small shopsin hospitals, clinics, pharmacy and laboratories. Health is a fundamental right of every citizen. It's the right of a person to live and enjoy the highest attainable standard of health irrespective of their ability to pay.Theoretically, the right has been also been insured by the interim constitution of Nepal in 2007. Thisdemands the guarding role of the state agencies to protect the right to health of people. It is not just intolerable but also unethical to call the profit motive and market oriented providersto share the state's obligations for health service delivery.

Unregulated growth of private sectors in the name of the public private partnership poses threat to the national health care system. The aforementioned policies before and after math of People's Movement of 1990 are liberal for private sector involvement in health. Private sectors are motivated by profit. There is concern that poor and those with limited ability to pay might be left out. Investors have identified health sector as risk business with massive profit with per unit of their investment. So, they lobby policy makers massively for the liberalization of the health service. Which authors think had happened in post NHP 1991.
Government's supremacy in health service delivery in Nepal is now challenged by private sectors. The exponential growth of the private institutions increases risk for rightto health. Privatization leads to the acceleration on the cost of the health care services, without improvement on the quality of care.(19)In addition, there is chances of lack of quality care, misconduct by the health care practitioners and inaccessibility of the wide range of services in the private institutions.(20)There is a misconception among the people that the service provided by the private institutions are of high standards, and much safer than the public services. It will be hard to control the quality of the care, ensure the ethical practices, and protect people being exploited by private sectors when government remains feeble. So, department of health services (DoHS) need to be powerful to check the unregulated growth of private sectors. In addition to that, government also has to increase the quality of services it has been providing.

Besides the issue of the quality care, increased financial burden due to health expenditure is the outcome of proliferating private sector. Migration of the human resources from public to the private sector is common in urban area is creating disparities in distribution of human resources.

The policy makers have different views on current trends in privatization of health care in Nepal. There are some arguments in favor for involvement of private sectors in Nepal(22)while most of them are against to it. Privatization of any forms, did not work as per the expectations of policy makers. The logic was that the state alonewill not be able to provide all kind of services to all people. This formed the basis for the public private partnership. Private sector is viewed as an ally to government sector to help in its works.

We may have also thought that the increasing number of private health institutions may increase people access to the health services. In reality, the opposite has been happening. It has created a wide gap between those who have everything and those who have nothing. This gap is more vivid uponunderrepresented and marginalized people, people in lowest wealth quintile compared with advantaged and wealthy people in Nepal. It is globally experienced that the people who need to pay more than 15% of their gross income impoverished them.This is well established that the introduction of the cost on the health care services itself is as a major barrier to the utilization of the health services.(21) In Nepal, we have not yet researched in this particular area.

Trade liberalization is one of the outcomes of Democracy in 1990. This formed the basis for pharmaceutical companies to proliferate their investment in health. The high"margin" they make on their sell of drugs in one hand is unethical, and in other hand is contributing high out of pocket expenditure in health for which poor people has no means to pay.

Treating health care as a commodity and selling in shops is the true example ofprivate for profit sector in Nepal. The investment in building hospitals, pharmaceuticals is increasing. Investors think that this has a guaranteed source of return. The private sector has affected healthat two levels. At micro level,increased numbers of pharmacies and clinics intowns and slums has contributed to the underutilization of peripheral health centers. While at macro level, private hospitals

has caused Doctors to flee to private hospitals. The salary Doctors get in government hospital is low compared to private hospitals. The chance of irrational use of drugs is also high leading todrug resistance inviral and bacterial diseases.

This study is based purely on author's views on privatization of health care in Nepal. Review of relevant literatures has also been added to the paper. Authors see the need for further research to measure public and private share of health care expenditure in Nepal.

Conclusion

Health service in Nepal is now being controlled by private hospitals and pharmaceuticals. Public expense in health is increasingsteadily. Nevertheless, the government's spending on health is stagnant. .

The very cause for the increased private control of health service delivery is the liberal attitude of government to private sector. National Health Policy, 1991 opened the door for private sector to play in health. It occurred in the name of public private partnership (PPP). In the aftermath of 1990, the side effects PPP has clearly been observed. But private sectors have become so big that the government has limited power to control their growth, and limit their activities. Low quality of service and absenteeism of health workers in government run health facilities is lowering the utilization of services by people. But, this in no reason could be the reason for private sector encroachment in health. The encroachment is expanding. In village areas, pharmacies and clinics are taking place of health centers. A majority of these are run by health workers from the same village development committee.

Right to health is now threatened. Redefining PPP is ought to must in present condition. The private for not profit sectors can only have the supportive role. Exercise of higher degree of government control in private sectors coupled with greater investment in health by government is a necessity now. Health cannot be brought nor can be sold.It may be hard for government to own private for profit institutions. If it is not done today it ought to be done the other day.

There have not been research studies to explore the coverage of public and private sectors in service delivery and their share in total volume of services delivered. Health system research to explore the loopholes in system should be brought with effective policy and program interventions. The government should revitalize that health systemneed to increase service coverage by adding service sites in rural areas. They need to build stricter policy to control private sectors, and their profiteering work. Rather, this paper strongly recommends government to own all the facilities run by private sectors so that nobody could make money by selling basic human necessities.

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