Chapter 7

Discussion and conclusion

The study has tried to find a way to improve the under utilization problem of THC in rural Bangladesh and considers contracting out has the scope to fulfill the objective. In fact limited resource in the main barrier for contracting out for clinical services for rural Bangladesh. The study already showed that how limited the government budgets for health is and how limited budget for medicine and clinical services (Table 4.1 & Table 4.2). Furthermore, people's health seeking behavior and some other natural factors affect health care system of rural Bangladesh.

However, the study highlighted the causes of problems of under utilization of THC and focused on possible solution by public-private mix and contracting out identified as a possible way. Here the study would like to discuss how P-P mix can improve health care system in rural Bangladesh and how proposed models can play a positive role in health care system.

In reality, from health care utilization pattern of Bangladesh (Appendix, Table A.4) and from flow of fund (Appendix, Table A.6) it is noticed that household is the main source of finance in health care sector and people is using private sector more than public sector. There is already some P-P mixing in health care sector but unfortunately very unorganized way and unorganized P-P mix does not help to improve health care system. Therefore, the study has intended to highlight how P-P mix can help to improve health care system if performs in an organized fashion.

In rural Bangladesh, public (THC) is the main modern health care provider and is delivering care free of charge theoretically; practically free care does not satisfied people for various reasons that mentioned before. But the study thinks if there is organized P-P

mix that means combination of providing care between public and private or combination of financing between public and private that will be more fruitful. As people normally prefer private provider for health care (Table A.4) therefore, if public can contract private provider with in its premises the situation will improve, under utilization of existing facilities will diminish like "Purchasing model". Data also shows that household or private financing is the main source of fund in health care (Table A.6) therefore, patient can share in public premises also that "Purchasing model" proposed; part of recurrent cost will be shared by the user. Moreover, P-P mix is necessary in providing health care or/and financing health care to improve the rural health care situation otherwise in weak tax based health system going to be weaker.

In this study proposed solutions are "Purchasing model and Leasing model" types of negotiation between public and private provider and some important issues need to investigate carefully. These are:

- Equity-does the contracting out have ability to meet up the demand equitably? What is the solution for them who can not pay? What will be the effect in terms of accessibility for disadvantage group?

- Efficiency-is contracting out efficient enough to provide proposed care? And dose contracting out help to improve efficiency? How contracting out will be sustainable?

- Quality of care – is the quality of care unquestionable under contracting out system? How quality of care can be measured?

- Cost and benefit-how the additional cost will be managed? Does benefit exceed cost? And how government revenue can support additional cost and how new revenue will be distributed?

- Referral system-what is the role of referral system to make successful contracting out arrangement? How does it can work?

Equity-in this study equity issue mainly emphasized on equal access for equal need. Both Purchasing model and Leasing model encourage increasing accessibility, which is the basic idea of publicly provided health care. But both models suggest user charge that might discourage people who are not able to pay. Therefore, the study has provided few measures for those who are unable to pay in Purchasing model of contracting out or Leasing model. Possible measure for them can be to collect some additional money for "poor fund" from the richer part of the community and provide the poor. In Leasing model local NGO can help to serve the purpose also. There is a tradition of operating *Lottery* for collecting money for poor patient which is mostly done by some international NGOs like Red Crescent Society. The government can collect some funds for the poor patient like this way but again there is a question of administrative cost and advertising cost. The private providers also help to contribute his free service for one patient out of five and it should be formulate in regulation that the private doctor (contractor) will serve one patient freely out of five patients each day. In case of Leasing model, same regulation should be implemented to ensure accessibility of disadvantage group. Besides this, the government needs to allocate its revenue that will be collected. The study has mentioned before that 40% will go for doctor in purchasing model, 20% for other personnel, 10% for administration, 10% for incentives (P-P network), 5% for poor fund and rest 15% for supplies, utilities and others. Revenue reallocation will make the process more equitable for disadvantage group.

In Leasing model, though the management is totally private but the tenant can follow same procedure to ensure equitable treatment.

Efficiency-in considering Purchasing model, the public sector has to do the whole procedure and management from patient's motivation to treatment. Here, the public has

big role to improve disability condition as well as improve under utilization of THC by the help of private providers. Therefore, referral system has a great role to manipulate the procedure also. To make the Purchasing model worth while and efficient the THC with its existing facilities (both physical and human) must involve with their full effort, other wise the model will not work. Furthermore, in Purchasing model patient needs to share part of recurrent cost that will make the THC more efficient. In that case THC responsibility will more than before.

In comparing with Leasing model it can say that public role will changed in this model from providing care to monitoring care. THC will able to earn some revenue from leasing. It is obvious that financial burden of THC will be lesser in Leasing model, that will help THC to concentrate on monitoring the tenant's performance. The public sector might get chance to improve weak information system.

Comparing with providing side of both models it is clear that in Leasing model efficiency will more than purchasing model in terms of productivity, as it will alert about their investment and paying money for rent. On the hand, Leasing model should cautious about patient's charge other wise they will lose patients.

Quality of care-in case of Purchasing model, to maintain own reputation the contractor doctor normally will maintain quality and THC will try to monitor the quality other wise the purpose will not fulfill. How to monitor is the question now. Government's information system is still weak and manpower is not devoted enough. Lack of training in managing administration is another problem. However, to maintain quality and maximize potential benefit survey and questionnaire can play an important role. Patient can interview at the exit point of THC or can answer the questionnaire after returning home. For Leasing model the role of THC can be changed as an evaluator or monitor for controlling quality, efficiency and patient's satisfaction. The study hopes that in terms of quality of care both models will be uncompromising.

Cost and benefit-though additional cost and potential benefit highlighted separately on previous chapter but some points need to discuss more. Additional cost for Purchasing model is not too much in money term that the study provided (Table 5.7) but new policy implementation is necessary. To cover the additional cost from developmental budget the government should justify the potential benefit. In terms of efficiency some benefits like productivity can be measured but social benefit is non-measurable. It can assume that after operation how many years the operated patient will live according to life expectancy and what are the disability related costs. QALY (quality adjusted life year) and DALY (disability adjusted life year) comes into account and it is a very big issue again that cover a different aspect.

Referral system-actually, referral system is very important to play role to make sustainable contracting arrangement. If patients do not come from referral system who will sent them to operate? And if there is not a good network between public and private provider the contracting out will not be sustainable. To achieve sustainability of contracting out referral system has the key role both for Purchasing model and Leasing model.

Dual character of Bangladesh's health system is quite surprising because household share almost 48% of health sectoral budget (flow of fund in Appendix) but the money is going to private sector. It should be great concern for the government to provide appropriate care to mass people and make an effective relation to public and private sector. To make health sector as a fruitful sector contracting out of different section can contribute positive role. As resource is limited and people are poor therefore, unregulated competition can distorts the nature of public objectives and national goal. Equity will hamper dangerously. Equity and efficiency might not be attained at the same time but to make any plan it need to take into account.

The study has intended to chalk the possible ways of contracting out after considering budget constraint of the government and ability of the patients for paying health care. In conclusion it would like to say that the government should need careful consideration on this field to regulate the health care delivery system as well as financing part. Not only proposed type of contracting but other type of contracting out can come in to account if proper financing arrangement can be made which is the major fault of Bangladesh health care system.

Recommendations

- **Regulation**- despite resource constraints the government has an important role in the co-ordination of public and private sectors. Therefore, certain type of care can be fixed for public though private goods and certain types for care can be fixed only for private care.

- **Consumer education**- to educate the population on the relative worth of different types of health care and this will boost the demand for formal sector services and encourage non-formal private sector providers to upgrade their activities.

- **Financing facilities**- the government should reconsider its health budget framework. Altering the budget framework to financing THC also help to improve under utilization problem, as resources will reallocated.