

# The healthcare bill 2009

Dr. Sania Nishtar

Discussions around the Punjab Health Care Bill 2009 have intensified following some instances of alleged medical negligence in Lahore. The purpose of this comment is to clarify many policy and institutional implications of this bill in an attempt to avert a confrontation.

To begin with it is acknowledged that as the steward of the health sector, it is the responsibility of the government to ensure the provision of quality health services. Health being a provincial subject, it is also perfectly legitimate for the provincial government to legislate in this area. There is also a need for legislation in the quality regulation domain and imperative to create an institute focusing on quality, as this area has remained outside of the domain of planning. The need to bring the private sector within a normative framework is also acknowledged, as it is currently outside of the state's purview.

It is also true that quality of care offered by the private sector is heterogeneous, that rampant malpractices are commonplace, that citizens and the bona fide elements within the private health market suffer at the hands of the non-bona fide private health actors, which are burgeoning at an alarming rate and that there is lack of awareness regarding the law of tort and the remedies available under it. In view of all these gaps, the move to regulate the private sector with a view to ensuring quality of services as an endpoint is perfectly understandable. But is the envisaged strategy to be pursued through the bill the right approach? I will draw insights from past experiences to support my opinion in this connection.

First, for any regulatory framework to be effective, the consensus of stakeholders is a prerequisite. Lessons from the failure of NWFPs' policy on Institution Based Private Practice is instructive in this regard. This time around also the private healthcare community is not fully on board as is evident from the Pakistan Medical Association's categorical call to confrontation at the outset and subsequent, post-hoc consultations. Even if a regulatory strategy is well conceived--and the present one has many gaps--it will be inherently constrained if there is no stakeholder ownership.

Second, the style of regulation and quality control measures to be adopted through this bill are intrinsically--and inadvertently--structured for failure. Current regulatory systems are plagued with institutionalized rent-seeking where low paid inspectors collude with private entities. It would be extremely difficult for any new regulatory institution to ensure a level of remuneration for regulators that could play a role in prohibiting such behaviors given the current fiscal constraints.

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Third, even if resources are not an issue and a health care regulatory arrangement is created, the level of acceptability it will have in the present system should be brought to bear. From a broad health governance perspective, the creation of a Health Commission could represent the beginning of separation between three functions within the health administration. The commission could be mandated with a regulatory role, the Secretariat could retain a policy making function and implementation could be entrusted to the departments of health and the EDOS' offices. In theory this is a desirable model, but it needs long-term consistency of policy direction and robust technical capacity to institutionalize such a change. There are inherent limitations in this respect and resistance to change from stakeholders who have a vested interest in maintaining status quo. The saga of the Drug Regularity Authority is a case in point where action has not been forthcoming since 2005.

Fourth, Pakistan's history is replete with examples of 'independent commissions',

which have not delivered on the intended premise. We tend to think of institution creation as an end in itself. We don't structure the measures needed for institution building and often trade off design robustness in favor of structuring loopholes for controls. In fact some sections of the bill indicate an intent to factor-in discretionary powers, which can allow uneven application of the law at a later stage.

And finally, even if the government of Punjab created the ideal regulatory authority and even if had the money to do that, it must be remembered that institutions cannot be disconnected from their environment and that in isolation they are not a substitute for the many inefficiencies that pervade the health system in general.

It is therefore recommended that the government should reconsider its approach to quality regulation. Given the size and scale of the private sector and the nature of needed changes, a market harnessing form of regulation, which can incentivize the delivery of quality services appears the most feasible. The importance of this approach is that it can be mainstreamed at the same time as some other critically needed measures to harness the outreach of private providers. The latter are needed in Pakistan as 70 per cent of the healthcare delivery is by the private sector, whose potential to deliver public goods in health remains un-harnessed.

The decision to use private providers to deliver public goods in health entails the creation of a set of policy and regulatory norms. It is in tandem with these fundamental changes that incentives for quality can be built and with careful monitoring and oversight, can be successful in Pakistan's complex environment. Coercive measures in isolation cannot be a substitute for the needed reform in the health sector.

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