Privatisation and Its Implication on HRD

One of the major contemporary health care reform strategies is the application of “market mechanisms” to the health care system. Particularly in this era of free trade and international trade liberalization, the advocacy of a “market mechanism” becomes much more intense. These movements proceed in spite of the fact of “market failures” in the health care system.

“Market mechanisms” may be partially implemented in the public sector. Examples include the “internal market” system in the National Health Services of UK, and the opening of non-official hours private services in public hospitals in Thailand. The private for-profit health care system is also a prominent feature in many countries. In Thailand, during the economic boom period of 1988-1996, there was a three fold increase in private hospital beds.

Application of market mechanisms in the health care system is claimed to increase the choice, quality and efficiency of services. More resources may be recruited to free public resources from curative services. This would enable scarce public resources to focus more on preventive and promotive care.

Nevertheless, experiences in many countries shows that without strong regulatory and appropriate financial mechanisms, the promotion and mushrooming of the private health sector results in increased costs, non-transparency, inefficient use of drugs and high technology equipment, and most important of all, inequitable distribution of health resources including human resources for health.

Experience in Thailand during the period of economic boom demonstrated this fact by uncontrolled mushrooming of private hospitals. At the peak of the economic boom, many doctors migrated from rural public hospitals to the urban private hospitals. In April 1997, 21 district hospitals in rural areas were operating without a single medical doctors. Ample evidence also showed that private medical practices increased the irrational use of high technology equipment, e.g., CT-scan and MRI. Furthermore, private services both in private and public hospitals resulted in irrational increases in surgical interventions. A paper in this issue of HRDJ on the high rate of Caesarean Section among private practitioners both in public hospitals (private wards) and private hospitals is a very good example of such surgical practices.

Increases in private practice services and the high fees charged also increase expectations from the patient. This in turn contributes to the increased rate of malpractice litigation as evidenced in some developing countries. In Thailand, the rate of malpractice litigation considered by the Medical Council increased more than four fold in the past 20 years.

Implications on HRD from privatization are thus numerous. Unnecessary, inefficient and irrational use of technology and interventions, lower ethical standards of medical practice and most importantly of all, the internal brain drain all result in more inequity.

International health organizations, like WHO may have to work more closely with advocators of market mechanisms, such as development banks, in developing tools and guidelines including the application of appropriate financial measures to support better regulation of the private sector in developing countries. Capacity strengthening among public sector policy makers and administrators as well as technocrats is essential to mitigate the negative implications on health care systems including HRD.

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