Radda Barnen Becomes Radda

From Donor Project to Sustainable Local Healthcare

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The Price of Success

Dr. S. M. Kamal was waiting on the balcony to meet Kazi Fazlur Rahman, the Chairman of the Board of Radda. This was his third attempt this week to try to see Rahman. The last two times he had to leave because Rahman was too ill to sit for a meeting. He needed to see Rahman to ask him what to do about the latest pressure for expansion from their constituents.

Rahman was in his late 70s and although intellectually still very alert, his health was slowly deteriorating. As the Director of the Radda Centre for Maternal Healthcare, Kamal was in charge of the day-to-day operations of Radda but he still met with Rahman at least once a week to get his advice on running the organisation. Radda Board meetings were held once every quarter. However, Kamal kept Rahman abreast of regular happenings through these home visits.

Radda, taken over from Swedish donor management in the 1990s, was now a financially stable institution. Revenue coming in roughly matched the expenses for the year, bringing the organisation to the much desired breakeven point. This financial stability had not come easily, and Rahman's hands-on management was the essential ingredient. Now that the organisation had stabilised, more authority had been delegated to Kamal, though the meetings between Rahman and Kamal were still a necessity.

Recently, Kamal had been fending off a lot of questions on expansion from staff, clients and potential investors. In conversation, Kamal expressed his thoughts: "Rahman (and the Board) worked hard to get us where we are today. They don't want us to lose balance. They want us to remain low-key, but it is getting hard, this is the price of success..."

Radda's Origins

Radda was a non-profit, financially sustainable healthcare clinic in Bangladesh offering preventive healthcare to women and children at reduced rates. It had been setup originally as a donor project funded by Radda Barnen, the Swedish version of the organisation 'Save The Children' which was formed in response to the sufferings of European children after World War I. In 1973-74, Radda Barnen had started a large-scale operation in Bangladesh, with a focus on Maternal Child Health & Family Planning (MCH-FP) in the slums of Mirpur in Dhaka. The aftermath of Bangladesh's 1971 liberation war and the 1973 famine had been the starting point for many of the operations of international and local NGOs in Bangladesh. The situation was similar to Ethiopia, which saw a post-famine influx of international NGOs that came to do immediate rescue, but stayed on to build infrastructure[1].

Radda's Swedish operations in Dhaka had grown from 1974, and by 1990, they had projects in and around the city's Mirpur *basti* (slum) area with a staff of 220 serving 318,373 patients per year[2]. In the 1990 Annual Report, the organisation described programs such as the country's first report on child prostitution, studies on urban slum children, and child trafficking, promoting government ratification of the convention on Rights of the Child, photography exhibitions, poster campaigns, seminars and rallies. Some of these projects were of course in response to donor priorities at that time, and later in the 90s, the focus shifted away from emergency intervention (e.g., child trafficking) to long-term infrastructure building, primarily healthcare.

[1] Bahru Zewde, Siegfried Pausewang, "Ethiopia", Forum for Social Studies.
[2] Radda internal report

Radda was partnered at that time with many local organisations, including Surovi (domestic worker), UPOK (schools for working children), BODC (schools for tribal community), Fatema (destitute women), Chinnamukul (street children), Dharmarajika (Buddhist orphanage), ASD (slum girl child), etc. Radda had transformed into a supra-organisation that was acting as an umbrella organisation to support many women and child related development projects in Bangladesh.

Although a large organisation, there were many challenges due to the donor funding structure. The management of Radda Barnen comprised of 6-7 heads of departments (a mix of locals and expatriates) with no project managers. The local head was a Swedish manager, who reported to the Swedish Save The Children's Bangladesh representative. The Bengali staff had no organisational setup or organogram. There also was no formal practice of strategic planning, financial management, human resource management or operational efficiency measures.

During that time, cost-overruns were serious issues, especially with regard to salaries. Some Radda staff (including all the foreign staff) had very high salaries (vis-à-vis other not-for-profit organisations), thus creating divisions and nepotism. An example of salary mismatch between local NGOs and Radda, in the early 1990s, was the driver's salary. In the local market it was BDT 3,000/month, but at Radda, it was BDT 10,000/month. Personnel files were not maintained and some employees claimed qualifications they did not have. Rahman later commented that the Swedes sometimes lacked local knowledge, so they often could not measure performance well. A Swedish manager came for a two to three year tenure, and often would not catch up on the appropriate management techniques until the end of the tenure.

Radda had a representative office in Dhanmondi even though Radda itself was located at Mirpur (the two locations were distant). This meant that certain elements escaped close oversight. By 1994, Radda had come to own eight dedicated vehicles for staff travel. Rahman concluded his analysis of that period with these words, "Of course there is corruption and wastage in our local institutions, but there is a shocking amount of wastage in donor funded international programs."[3]

Although there were structural deficiencies and wastage, still in spite of these drawbacks, Radda had been accomplishing a lot in the area. Maternal and child health indicators had measured a steady uptick in the area since the 1970s. But while Radda was continuing its work, donor priorities were shifting. Sweden joined the European Union which meant that bilateral aid was being replaced by the EU's common fund, shifting funding targets. Some funding started to shift to sub-Saharan Africa. In healthcare in particular, AIDS prevention and education were emerging as new priorities in the 1990s. This soon had consequences for the Radda project.

[3] Author Interview with Rahman, February 2009.

The Swedes Leave

One morning in 1994, Rahman received a surprising phone call. It was an official of the Swedish Embassy in Bangladesh, asking him to come and meet with the Ambassador. In the past, while Rahman had been in the civil service, interactions with expatriates were routine. As a senior member of the Planning Commission and the External Economic Relations division, this was part of his job description. Rahman was the key official in charge of processing permissions for donor projects, and was known for efficient skills within a complex, and at times byzantine, system. But at that time, he had recently retired. He still knew the embassy and donor circles, but pointedly did not socialize, preferring to focus on a book he was writing. Intrigued by the call, Rahman agreed and showed up punctually for the meeting.

The meeting started with a small shock. After some casual comments, the Swedish ambassador announced that they were going to stop funding Radda Barnen in Dhaka. He went on to explain that the sentiment was that "we have done enough" and it was time to pull out. Although the conversation began casually, it soon became clear that the Ambassador had come to Rahman with an appeal for saving the project. Over time, Rahman came to realise that this was the beginning of a growing trend. The politics and priorities of aid projects were changing with the times. Economic fluctuations, vagaries of donor needs and global trends all had an impact. In Rahman's words, both "donor fatigue" and "aid fashion" were factors to deal with.

In addition to Swedish funding priorities, a misalignment with the Government of Bangladesh (GOB) had accelerated this decision. There was a tacit understanding that the GOB would take over the Radda Barnen project after several years of funding. This was a promise the government sometimes did not live up to. For example, German funders GTZ had run the National Institution of Population Research & Training in Bangladesh, but had an agreement that the GOB would eventually take it into their revenue budget (ongoing budget). However, the GOB took it instead into their development budget, which was subject to being reviewed annually with no guarantee of continued funding and as a result, many key doctors left the German project, not wanting to work in an unstable funding environment.

In the case of Radda, the GOB had been asked to take it over as far back as 1983. However, in a formal response to a query by the Health Ministry[4], it was concluded that the GOB could not manage the

[4] Mr. Sadequllah, Section Office, Ministry of Health & Population, 22 August, 1983. In a reply to a query by Secretary of Ministry. From the files of Radda MCH-FP.

Radda project. The government's failure to take over the management also contributed to the Swedes looking to either abandon the project, or transition to local, private management. This was where Rahman had come into the picture.

The worry for the Swedes was that they had not managed to build a self-sustaining organisation and they were worried about what would happen when the aid money ran out. For example, when the Ford Foundation had pulled out of Bangladesh, one victim was a small initiative to bring the nascent internet to readers via print. Similarly, Save The Children UK had funded many small projects in Bangladesh but when it withdrew funding, some of those local projects collapsed. The Swedish Ambassador wanted to avoid a repeat of these kinds of scenarios.

Coming out of that meeting, Rahman had gone to work assembling a team and subsequently, protracted negotiation began with the Swedish authorities. Even though the donors were relieved to find a "rescue team" created by Rahman, agreeing on terms was still laborious. It took three months to work out all the issues and reach an agreement. Radda had been a donor project, now it had to be turned into a legal entity outside of that definition. In Bangladesh, NGOs could be registered under the Company Act, Trust Act or Social Welfare Act - of these, the Trust Act was the most flexible. It was decided to register Radda as a Trust which also meant that there would be no shareholders, only trustees so that surplus earnings could be put back into the organisation, which was key for sustainability.

The Radda Barnen institution was a dominant presence in the Mirpur area, and "Radda Barnen" had by then become a local brand with most patients not considering it a "foreign" name. The new organisation was renamed "Radda", maintaining continuity. The only thing locals may have noticed was the exodus of foreign staff who were, unsurprisingly, one of the expensive elements in the total budget. The new management team was brought in, instituting a program of creating a streamlined organisation, cost-cutting and reduction of bureaucracy.

New Playbook

In describing the challenges they faced when they took over Radda, Rahman was forthright: "I have worked with most NGOs in the global arena, their management is often poor...[Radda] didn't have a good management system. Everything was very ad hoc."

The very first challenge was handling the culture shock of the new structure and situation. On the first day of transition, employees had to be told that it was no longer a foreign institution. The concerns about the Bangladeshi management were allayed by the composition of the Board, as the people chosen were locally respected and considered non-partisan. Although Board members were prominent members of Bangladesh society, within the structure of Radda, they were newcomers, handling a team that had been there for a long time. The most important challenge was that everyone needed to understand that a constant supply of reliable funding was no longer guaranteed. It now had to be a business, a situation of "sink or swim" in Rahman's words.

In Bangladesh, successful businesses co-exist with a challenging backdrop of unfulfilled basic needs of the majority population, who are the urban and rural poor. Basic needs were fulfilled partially by the government, but also in very large volume by the non-profit (sometimes called non-government or NGO) sector. Bangladesh was considered one of the world's successful "laboratories" for non-profits, and the country had the largest number of NGOs in the world[5].

As the private sector first started developing in the 1980s, many non-profits had attempted a hybrid model of entering the for-profit sector. Grameen Bank had become partners with a for-profit telecom (Grameenphone, majority owned by Telenor Norway). Prabartana, which had started as a biodiversity group, now had a retail shop. The most successful NGO was BRAC, which had the Aarong retail handicraft stores, a vegetable export firm, fish hatcheries, tea estates, dairy farms, a private university and the country's leading small & medium enterprise (SME) focused bank. The new Radda management decided to attempt to replicate this growing trend of a hybrid model in the NGO sector.

The first order of business for the new Bangladeshi management of Radda had been to write all the rules and regulations, including an accounts manual, staff rules, salary scales, vacation rules, codes of conduct, grounds for dismissal, etc. In the absence of clear rules, every decision was a new and discretionary decision. All the heads of departments were then placed on the management team—they attended each Board meeting, which fostered ownership and transparency and assisted with saving on costs. Working papers were now provided by the Radda management before each Board meeting. From day one, the objective of the new management had been to save as much money as possible. A consultative process had been instituted and most of the savings ideas had come from the staff and management. The purchase of medicine, in particular, had required calibration. In the past, medicines were bought in bulk and stocked for long periods of time. As these purchases required a significant cash outlay, delaying the purchase of medicines until they were needed freed-up cash which could then earn interest in a bank. Inventory management was instituted with "just-in-time" purchase principles.

Next, salary rationalization had to be undertaken which was complicated as cutting the high salaries could have caused unrest within the organisation. The work culture and the spectre of labor disturbances had limited the options available to the Board for salary revision. Rather than quick cuts, a gradual phasing out of higher levels of salaries was done over time. Other changes included giving

[5] 27,717 active NGOs in 2009 (*Source:* Daily Star, July 11, 2009), including the largest NGO in the world namely BRAC (Bangladesh Rural Advancement Cooperative, 37,000 staff reaching 69,000 villages), a pioneering health NGO Gonoshastho and a famous micro-credit organisation Grameen Bank..

the staff an allowance instead of dedicated vehicles, which were then gradually phased out and sold off.

There was also a lot of inspiring by example. At the time of the transition, the Swedish management had insisted that the Board of Trustees all take a salary. But within a short time, the new Board amended those salaries down to nil. Rahman explained, "We must inspire by example. How can I make cuts elsewhere, if I don't cut my own area?"

The cutbacks for the staff were compensated by the extension of staff welfare provisions, which affected all staff equally, without favouritism. Staff welfare had been a priority for the Board. Seventy percent of staff was women but in the past, no childcare centre had been provided for nursing mothers and children. A childcare centre was quickly added at a small incremental cost. A Staff Welfare Fund was created for emergency requirements (medical, family etc.), particularly essential for the large ratio of female staff. In addition, a Provident Fund was set up where staff members contributed 10% of their basic salary which was then matched by Radda. This was required by Bangladeshi law, but somehow this had never happened. Maternity leave rules were also formalised. Rahman observed, "Donors talk so much about women's liberation. If you ask for money for a seminar on breast-feeding, you will get that. But it didn't occur to anyone to set up maternity leave for staff. This is what happens when you are not thinking long-term."

In the NGO sector, Radda now became known as a generous employer, factoring in non-cash benefits. In this matter, staff welfare provisions and a generous vacation leave were crucial (all the staff were eligible for leave up to a total of 40 days per year, as well as two-day weekends and government holidays).

Staffing transformed into a very hands-on process at Radda. At the beginning of the takeover, there had been a public meeting with all the staff once a month, to foster total transparency. At year-end, the Board would meet with the staff and show exactly how much had been spent, and how much the earnings were. Therefore, any salary increments had to be based on this. In the new system, they had both general wage increment at different levels tied to the cost of living, as well as special increments for performance. There was a new focus on performance with 10% of the staff eligible for a performance bonus.

Although it had been important to let the poor performers go, the Board had managed this delicately. No firings were done initially as it would have created, in Rahman's words, a "negativity trap". The firing of low performers was thus spread out, so that only a few were let go over the first few years. Because the departures were staggered over time, it had not impacted staff morale. The staff were let go typically because of personal misconduct, lack of professionalism and missed deadlines and deliverables. Thus an impression of systematic firing was avoided.

Another challenge for Radda was finding the right candidates for day-to-day management. Finding a competent chief was quite a challenge, and three were tried unsuccessfully. They were either not a good fit, or ultimately Radda could not (and did not wish to) match their salary expectations. Finally, Dr. Kamal took over as the Executive Director, and had been in that position for the last seven years. By 2009, operations had stabilized and Rahman now only visited Radda once a month. Talking about why he chose Radda over more financially rewarding options, Executive Director Kamal pointed out that the opportunities for management experience and career growth were crucial for him, as well as

the support of the Board which allowed him management autonomy. "This is my seventh NGO. But the environment I found here I cannot find anywhere else," he remarked.

Investment Strategy

In the original transition plan, a funding pool was to be left by the Swedes, which was to be withdrawn over a period of 10 years, during which the local entity had to build-up local sources of revenue. The rate of annual reduction was not set at the time of negotiations, which later led to the need for annual re-negotiation—something that ended up being quite onerous. A consultant report[6] recommended a 5% annual reduction in funding, which would require 20 years for pull-out. But the Swedish authorities and the Bangladeshi management mutually decided to go for a faster pull-out of funding.

With a portion of the funds from the Swedish transition period, a 'Sustainability Fund' was created. This was invested in a Bangladeshi investment scheme, and the returns on this fund acted as a safety net. This fund could be considered the equivalent of an angel fund that did not have to be paid back, a unique structure in the case of Radda. The Board monitored cash flow closely with a focus on getting surpluses and savings, to be put in the bank to earn short-term interest. This was something that had never been attempted before. Under the Swedish management, whenever funds were disbursed, there had been no pressure to try to earn interest.

The Bangladeshi team initially invested the Sustainability Fund in a Post-Office Fixed Deposit to earn interest, and then later put it into various banks at higher rates of interest. The fund had started at BDT 30 million (USD $500K) and had become BDT 120 million (USD $1.8 million) by 2008. The net result was that, by 2005, foreign donation had dropped to nil, and although the Sustainability Fund was still being used for draw-down, this was being done at diminishing rates. Finally, by 2008, local income had reached break-even point so that additional Sustainability Fund draw-downs were no longer needed.

Moving To Sustainability

[6] Dr. Samir Choudhury, Carin Yngvesson, Melinda Ojermark; Assessment of the Cooperation Radda Barnen-Radda MCH-FP Centre & Plans for Radda Barnen Withdrawal, March 12-31, 2000.

Radda's primary focus had so far been on preventive (primarily immunization) and curative healthcare, with a focus on mothers and children of low-income families. Preventive healthcare was not a high revenue part of general healthcare in the country. In the booming private hospital industry, it was surgery, high-end diagnostic tests such as MRIs, pathology lab tests and medicine dispensaries that brought in significant revenue. Thus financial sustainability was a challenge for Radda, as it did not provide high-end services such as surgery due to lack of facilities and staff for such services.

When Radda had first started, there had been a series of government-mandated vaccines – these were categorized as EPI (Expanded Program on Immunization). As per Bangladeshi law, WHO-approved EPI vaccines were provided by the government, free of cost. The most typical EPI vaccines were BCG, Oral Polio, Measles, and Hepatitis B. In 1994, the first three categories alone had accounted for fifty two thousand cases of vaccination at Radda. Over the years, Radda had expanded into the area of non-EPI vaccines, which were not government-provided and needed to be purchased by the patient. These vaccines were equally crucial for preventive care and included such vaccines as Hepatitis A, Hib, MMR, Typhoid, Chicken Pox and ARV. However, many of these vaccines were, and remained, unknown to the patients visiting the Radda centre. It was the "health education corner" at Radda that all patients had to pass on their way to get assistance that had to provide patients with this information. Although there were many posters in the centre as well as literature in some of the popular print media, many of the visitors were illiterate and therefore not aware of these vaccines until informed. Thus a persuasive and trustworthy health professional was needed to make a strong argument for a full set of vaccinations.

By 2007, the number of vaccinations had risen to seventy-three thousand cases of vaccination. As the volume of this Non-EPI category had grown (from nil in 1994 to seventeen thousand cases in 2007), this had become an important source of revenue for Radda. As per the 2008 balance sheet, the fees from vaccination were more than 45% of total income.

The growing popularity of (sometimes elective) procedures like ultra-sonogram provided another attractive optional revenue stream for Radda. In India, the rise in ultra-sonograms had become controversial due to an alleged link to female infanticide (in fact, pre-birth feticide) due to a societal preference for male offspring. But in Bangladesh so far, according to healthcare professionals, female infanticide was not a local cultural practice, and the focus on ultra-sonogram had only been for ensuring good prenatal healthcare. Having ultra-sonograms was a significant change in mother behaviour, driven by broad education regarding the need to take active care at the prenatal stage. Radda had decided to provide such ultra-sonograms and these were the most expensive procedure now available at their facilities, although it was still cheaper than many other clinics. Ultra-sonograms now generated as much income as laboratory tests.

As these profitable forms of healthcare had gained popularity and become a significant share of Radda's activities, concerns about equitable access to affordable health for the poor had arisen. In order to address concerns about access, the Board of Radda had come up with two solutions. The first was the setting-up of satellite centres at the major slums of Mirpur (within 3-12 km radius, which justified going to satellite centres rather than the main clinic). The second was a two-tier pricing system between the main centre and the satellite centre. As of 2000, the satellite locations charged a 50% lower rate for all services, tests and vaccines. Over time though, the discount to satellite locations had been shrinking, as basic costs had gone up. In many cases, tests were still given free of charge at satellite locations, and fell under a program of "pay-as-you-can". In this program, if a patient was

unable to pay a fee, the staff had the discretionary power to waive it. According to the Radda management, this service was availed of by a small fraction of visitors (30% of patients took free or lower than discounted prices at satellite locations, 5-7% did the same at the main clinic).

Although the majority of Radda's patients were poor slum dwellers, it was not known whether the gradual increase in fees over the years had resulted in any of the ultra-poor stopping use of the facility. This was because Radda had not captured and compiled patient data through the years, thus making it impossible to analyse the changes over time. However, analyzing sample survey data from the slum centres for the previous year showed that 93% of the patients were in the lower-tier income groups (US$7-US$50 per month; see Appendix for details).

In addition to healthcare, Radda also started a new revenue-earning service, the provision of healthcare training. In the initial years of the new management, partnerships were struck with the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDRB) and the Human Development Foundation (HDF). HDF gave funds while ICDDRB was a fee-for service partnership whereby Radda would give their premises and staff for ICDDRB projects and be paid a fee in return. The new management had embraced such resource double-utilization (and a new revenue source) wherever possible, a practice that was missing in the past.

Because many NGOs now had healthcare units and were hiring staff rapidly, healthcare training was at a premium, especially if it could be paired with on-site clinical experience. With a steady daily pool of out-patients, Radda was well placed to bring in large groups that could get training and direct access to patients. This maximized the use of existing facilities, and as a result, allowed the spreading of overheads across a variety of programs. Since 2007, Radda had been providing skills practice and management-oriented training for healthcare workers and paramedics, and basic and refresher courses on "Safe Home-Delivery" for Traditional Birth Attendants (TBA). The organisations that sent staff to Radda for training included top-level NGOs such as BRAC and Mary Stopes, as well as Engender Health, Smiling Sun Program, RTM International and Worldvision. Some other organisations insisted on managing their own staff's training, but rented out Radda's facilities. This included Save The Children USA, SARH and SATHI.

In 2008, 1047 health professionals went through Radda's training course, a 50% increase over the previous year. Revenue from training doubled from the previous year, reaching BDT 5.4mm (US$ 81K), which was 17% of total revenue. This revenue stream had more potential than vaccinations and laboratory fees because the cost base was very low (similar to that for ultra-sonograms). The training unit had four trainers, and five additional staff. Kamal and two other staff also gave training, but their headcount was covered by the main centre's operations. As a result, total expenses for 2008 training were only BDT 0.98mm (US$15K), leaving a 453% profit margin.

Training service was thus a big focus in 2009-10 with emphasis on training on infection prevention for government-run District Hospital and Sub-District Health Complex staff, reaching approximately 1,850 health professionals. However, such expanded training did at times cut into the professionals' time to attend to the basic needs of the daily visitors.

The typical Radda patient came from the Mirpur slums where there was a degree of financial liquidity because all businesses in the area were cash businesses. Although the income of the slum inhabitants could be low, they did have cash in hand to pay for services, albeit in small amounts. A majority of the

Mirpur slum women worked. Radda estimated that a majority of the women visiting the centre were working in the following industries—garments factories, Benarasi sari work, informal market trade (vegetable and fruit sales) and domestic work (house help). The ratio was as high as 70% by one informal estimate. Therefore, women themselves had control of income and this had resulted in more of an emphasis, within poor families, on maternal and child healthcare, increasing the demand for Radda's services.

Healthcare Demand & an Expensive Private Sector

Bangladesh is a densely populated country of 155 million people, 12 million of which were in the capital city of Dhaka alone[7]. The country presented both an opportunity and a challenge for new models of governance and service provision. A majority of the population was under 30, and Goldman Sachs had recently listed it on the "Next 11" (N-11) list of countries[8] (Bangladesh, Egypt, Indonesia, Iran, Korea, Mexico, Nigeria, Pakistan, Philippines, Turkey and Vietnam) with the most potential to join the BRIC developing economies (Brazil, Russia, India, and China). Bangladesh's GDP per capita, based on purchasing-power parity, was $1470 in 2009— which was more than double the $631 level in 1994, the year that Radda Barnen had started the transition to local management[9].

Healthcare was a key indicator of a country's social stability and potential for human resources development. Traditionally, maternal and child health, as well as general health, had been a public sector function in Bangladesh, largely attended to by the government and non-profit sector. Tremendous improvements had been made in the provision of basic needs over the last three decades. Infant mortality rates were now lower than in India, Pakistan and Nepal. The under-5 mortality rate had dropped from 151 in 1990 to 61 in 2007[10]. The country had undertaken a strong movement towards eradicating polio and 97% of the population had access to drinking water[11].

However, in spite of these positive indicators, there were still large gaps in access to medical care. Roughly half the population was still outside the formal medical network, thus depending on traditional herbal, ayurvedic healers. In the formal sector, there were 366 hospital beds and 301 doctors per million people[12]. A 1998 study[13] had shown that the Asian average was 730 beds and 343 doctors per million people. Outside the capital city, preventive healthcare was provided by community health clinics, the sub-district health complex, government hospitals and NGO healthcare centres. More extensive tertiary healthcare and surgery was primarily provided in Dhaka, and some of the major cities of Chittagong, Rajshahi, Syhet, etc. For heart surgery, organ transplant and other major treatments, patients were always referred to hospitals in the capital city[14].

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[7] Bangladesh Bureau of Statistics, "Statistical Pocket Book-2008"
[8] Goldman Sachs, " The N-11: More Than an Acronym", Global Economics Paper No: 153, March 28, 2007; http://www.chicagobooth.edu/alumni/clubs/pakistan/docs/next11dream-march%20%2707-goldmansachs.pdf
[9] International Monetary Fund: 2009 World Economic Outlook; http://www.indexmundi.com/bangladesh/gdp_per_capita_%28ppp%29.html
[10] UNICEF, Bangladesh Statistics, 2009
[11] http://www.searo.who.int/en/Section313/Section1515_6922.htm
[12] DG Health, cited in Bangladesh Bureau of Statistics, "Statistical Pocket Book-2008".
[13] Kara Hanson & Peter Berman, "Private health care provision in developing countries", Health Policy & Planning, 13(3), 1998.
[14] Interviews conducted by Ahmed, Zakaria and Sajid; Asian Tiger Capital Partners, 2008.

A growing population and lack of adequate public healthcare had created a booming growth sector in hospitals, laboratories, pharmaceutical supplies and basic healthcare. Research showed that the profit potential had incentivised investment in medical infrastructure that the country would not otherwise have, with a trickle down benefit to the poorer patients. Among the large number of private hospitals established in the last five years, three were in the "five-star" category: Apollo, United and Square. In addition, there were numerous small and medium-scale private hospitals and clinics such as LabAid, Medinova, Ibne Sina, Samorita, Popular Diagnostics, Renaissance, etc. The conventional perception was that private hospitals were primarily for the wealthy. For example, in a recent magazine cover story on healthcare, the introduction read: "It is like entering a posh hotel. Outside the lawns are immaculately groomed...Large signs written in English tell you exactly where you can get the particular information you need. Smartly dressed attendants working round the clock make sure that not a speck of dirt appears inside the four walls."[15]

But in the same article, the author had highlighted that the lower income groups were also coming to private hospitals: "I don't trust the doctors at the hospitals at Feni (small rural town in Southern Bangladesh)," said Roushan-Ara, whose mother needed better medical care, "they don't care about us and if the patients are too poor they just leave them to die." At Apollo, the doctor had said that the mother would have to stay at the hospital for two days, get a blood transfusion and some other treatments and the bill would be BDT 35,000 (about USD$ 520). For the two sisters, the expense was too high, but they said they would be able to come up with the amount by selling off some of the land they owned. "It's my mother life," said Roushan-Ara, "I would do anything to save her".

Visits by the lower income population to private hospitals had created its own set of dilemmas. Firstly, the rates these hospitals charged could be exorbitant for the poor. Secondly, there was no system in place for a two-tiered system of payment, according to capacity and need. Although such a differentiated payment mechanism, based on capacity, had been used effectively in Latin America, these methods had not yet been attempted in Bangladesh. Thirdly, there was no universal healthcare model and 98% of Bangladesh's population was without health insurance[16]. Finally, by their existence and success, private hospitals had removed some of the societal pressure on the government to improve the public hospitals, which had further deteriorated with the growth of private healthcare. Top doctors from public hospitals often joined or moonlighted in the private hospitals, and the poor now faced sub-standard "remainder" medical staff at public hospitals.

Radda's Limits

Because Radda had kept costs within a manageable range, the demand for its services was constantly increasing. Some members of the management had made a case to the Board that if a full hospital were to be opened, providing tertiary healthcare, including surgery and more extensive laboratory testing, it might be able to sustain itself while charging lower than average fees. The challenge of course was that middle-class patients would also flock to such an institution, leaving inadequate facilities for the poor women.

The Board had however instructed that Radda would not expand, but keep their focus on the existing level of service. Rahman had very specific reasons for turning down the plans in this regard.

[15] Hana Shams Ahmed, "Changing Face of Health Care", Star Magazine, April 25, 2008.
[16] Ibid., Asian Tiger Capital Partners, 2008.

When areas of expansion were being considered, the management had explored providing assisted childbirth services. The Board had opposed this, as it felt that the organisation should not get into areas which required significant capital expenditure. Childbirth required round the clock operation (rather than Radda's current 9am to 5pm timings), which the organisation did not have staffing levels to fulfil. In addition, there were significant risks attached to childbirth, as complications could arise if the staff and facilities were inadequate.

Replication of Radda's services to other areas was another option considered. Offers had come to replicate the service outside Dhaka. However, the new locations could not be a sub-centre of the current main clinic, since this was already running at full capacity. As per the Board, the radius of service was where it needed to be, to be sustainable. And there were other factors hampering expansion.

In addition to a lack of capital for investment, the other challenge blocking Radda's expansion was the issue of land ownership. The land the clinic was situated on was once remote, but had now become a prime location - it was at the major intersection of a road artery, which connected to various business and trading hubs. Thus, many parties were interested in occupying this land, and land-grabbing was a widespread phenomenon in Bangladesh, affecting property, farmland, rivers and lakes. The Radda land belonged to the Bangladesh government, and was leased to the original Swedish funders, and later transferred to the Radda Trust. It was given as a free lease, at a very nominal and symbolic rent. But any significant expansion of Radda's operations, especially building new structures, would attract the attention of unscrupulous land grabbers, who could try to coercively grab the land.

Radda had three clinics which were leased, and community spaces and satellite areas which were given at no charge by the community. It was the leased spaces where challenges arose regarding ownership. Already Radda had "lost" a significant portion of land from their Mirpur-1 clinic, when local thugs had grabbed it. The local police of that area, in collusion with the thugs, had turned a blind eye to the entire operation. Land mafias which raised fees from traders faced-off with Radda, and eventually Radda had to surrender some land, where businesses allied with the land-grabbers and built a ten-storey market.

All of these events acted as an additional brake on any plans for expansion. Asking for permission to buy the land from the government, or to build more structures, would attract attention. If Radda tried to buy the land from the government, it could get out-bid by powerful business parties. The legal process of land ownership in Bangladesh was complex, time consuming and expensive. The Board had taken all this into consideration and finally decided not to expand the facilities.

Other Possible Models

While Kamal was aware of these limitations on Radda, as he was waiting to meet Rahman, he wondered if other models of healthcare provision around the world could provide inspiration to address these issues.

An innovative example of healthcare provision was the model of Lifespring Hospitals in India. According to research by Monitor Group[17], India's Lifespring Hospitals were an example of a "no frills" model, with lower costs through service specialization and standardized protocols, and greater

[17] Monitor Group, "Emerging Markets, Emerging Models", March 2009.

profit through high asset utilization. Lifespring was a six-hospital chain in peri-urban areas around Hyderabad. In addition to the maternal and child health that Radda provided, Lifespring also provided labour and delivery services. Doctor-attended deliveries were about 20-35% of the rates charged at comparable private hospitals. Lifespring also standardized protocols, staying limited to 90 standard procedures that could be managed by lower-qualification nurses. Narrow specialization allowed bulk purchases, which received discounts. Finally, multi-faceted marketing targeted key community decision-makers and used customer retention and referrals.

If the Radda model were to expand, they would need to reduce their cost base through specialization and standardization and increase revenue through higher volume customer throughput. One method for expanding the number of locations was through franchising. However, franchising was also not a path free of pitfalls as discovered by the Well-Family Midwife Clinic Partnership Foundation (WFMC) in the Philippines. WFMC had used the franchising model to expand to 230 clinics, but from 2005-2008, 100 of these had dropped out of the network. What appeared to have happened was that, after receiving training in provision of services and key intellectual property, these franchisees found that they could independently sell their services and leave the network. Franchising fees became difficult to collect, and after the end of USAID assistance in 2005, the franchisees saw less network benefit as the foreign aid was previously providing soft funding for their start-up costs.

WFMC's mishaps with franchising could however be countered by the example of RedPlan Salud (RPS) in Peru. Instead of charging a franchise fee, RPS sold discounted drugs to their franchisee midwives at a mark-up, which gave a profit margin of 20-40%. This margin substituted for franchise fees, and the midwives leveraged RPS' reputation to offer branded drugs to low-income households. RPS reached rapid sustainability within 18 months. While other markets may not see such a fast turnaround, and there were ethical challenges with high mark-up on drugs to poor women, there were certainly elements of this model that could perhaps be combined with the Radda experience.

Just then, Rahman came out to the balcony to greet Kamal. Looking frail and tired, Rahman gave Kamal a few minutes to brief him on the latest happenings at Radda.

Kamal made his case. He argued that Radda's story of a successful transition from donor dependency to self-sufficiency provided a template for those wanting to use limited donor funding to create sustainable enterprises. Radda was a success story worth spreading, in Bangladesh and elsewhere. A lot of people, both inside and outside Radda, would benefit from its expansion. Some had proposed that Radda should build a larger facility, hire more higher-end staff, increase revenue (while keeping costs down) and maximize resource utilization.

Kamal expected these possibilities to be considered favourably by Rahman. But on the contrary, Rahman cautioned against any new expansion. In addition to the concerns already mentioned about land ownership and attracting attention of land grabbers, there was also a desire to stay with core competence and not over-stretch to a breaking point or failure. Getting to breakeven had not been easy, and staying at that level year by year was not guaranteed. "We are at breakeven," reiterated Mr. Rahman, "but we don't have the capacity to expand. Stay with what you know, and avoid reversing financial stability with new expansion plans."

Kamal walked away from this meeting accepting this decision and making plans to move forward without any major shifts. But he knew this dilemma would come back. Studying the landscape, he

knew private hospitals would also start targeting his patient base at a future date. Although a recent ad campaign for a five-star hospital proclaimed: "Now you don't need to fly to Singapore any more", Kamal knew this exclusive focus on upper-income Bangladeshis would shift over time.

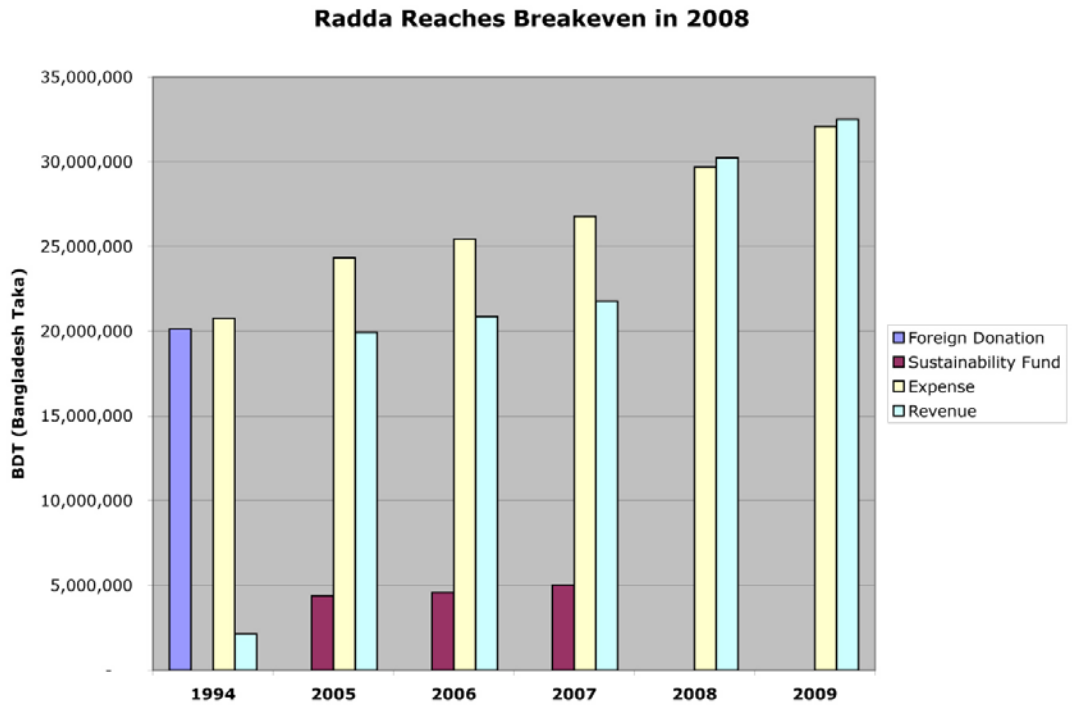
It was very much about trade-offs for Radda: how to maintain sustainability and harmony, while fending off the pressure for growth? At some point in the future the Board may also change, through the normal process of retirement. This would bring in different thinking and possibly a pressure for shifting goals. What would happen to Radda's strategic focus at that time? Would it continue to stay with what it knows, or expand?

Appendix

Pre & Post Transition Comparison

	Swedish Aid Era (1974-1994)	Locally Run (1995-2008)
Objective	Social good	Social good Financial Sustainability
Customer	Needy Unable to pay	Needy Unable to pay Can pay subsidized rate
Work Force	Foreign Consultants at High Wages Staff at High & Uneven Wages	Board at Nil Wage Staff at Slightly Sub-Market Wages, But Evenly Distributed Significant extra benefits, especially for women
Capital Source	Foreign Aid	Revenue Interest on Fund
Focus Area	Government Immunization Birth Control Outreach Programs	Government Immunization Non-EPI Immunization Laboratory Tests Ultrasonogram Training Programs
Marketing	Via Partners Word of Mouth	Marketing Collateral Referrals

Income & Expenses



Income Demographics

Monthly income	Number of patient	Payment
Tk 10000	622	100%
Tk 5000	1,167	100%
Tk 3000-3500	10,517	100%
Tk 2500-3000	13,480	50%
Tk 500-2500	2,249	Almost free of cost
Total	**28,044**	

(Jul '07 - Jun '08 Sample Survey)

- 100% is equivalent to paying 50% of service charge at main clinics
- The service charges were increased gradually
- The treatment costs are gradually going up

Acknowledgments

Radda: Kazi Fazlur Rahman, Dr. S.M. Kamal, Iqbal Majid, Dr. Zakia Sultana, Md. Rahmat Ullah, Dr. Mumtaz Rahman

Others: Dr. Sadia Chowdhury (World Bank), Professor Rumi Ahmed (University of Central Florida)

Note: *Organisational affiliation given for identification purposes only and does not indicate any endorsement of this study by these organisations.*

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