Private Sector: Strategic Partner(s) in Mixed Health Systems

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HA Convention (7 May 2014)

Outline

- Universal health coverage
- Mixed health systems in Asia
- Role of private sector in mixed health systems
- Leadership and governance role of government in managing mixed health systems
- Instruments and strategies for engaging the private sector

Universal Health Coverage

"Everyone should be able to access health services and not be subject to financial hardship in doing so"

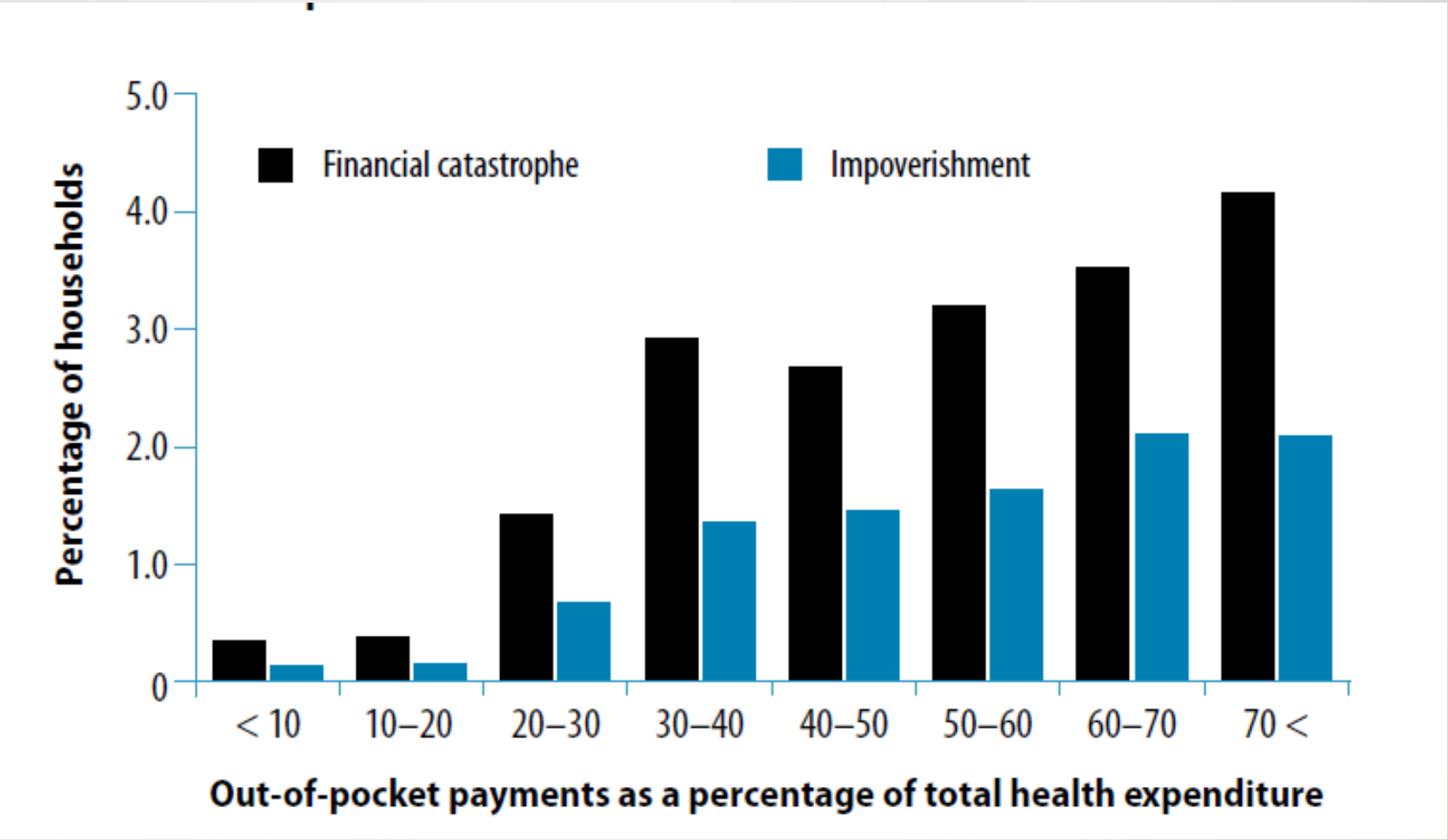
World Health Assembly (2005)

Financial Risks an Barriers to Access

- A high proportion of the world's **1.3 billion poor** estimated to have **no access to health services**
- **150 million people suffer financial catastrophe** each year *(defined as paying more than 40% of household income directly on health care after basic needs)*
- **100 million are pushed into poverty** because of direct payment
- In USA, **illness or medical bills contributed to 62% of bankruptcies** in 2007

WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

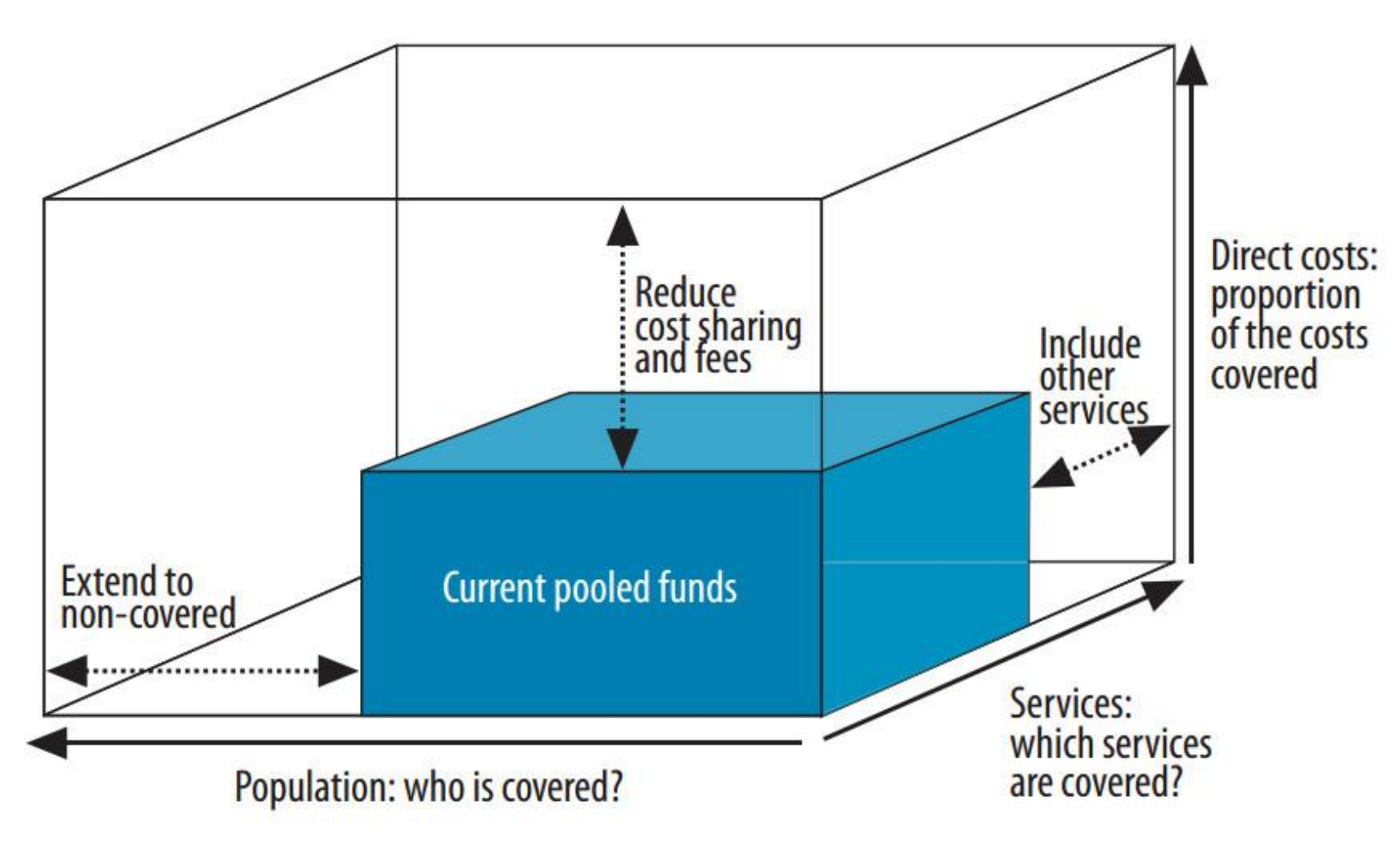
The effect of out-of-pocket spending on financial catastrophe and impoverishment



WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

Universal Coverage

Three dimensions to consider when moving towards universal coverage



WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

Health Care Financing

Three Critical Areas

1. Raise sufficient money
2. Remove financial barriers and reduce financial risks
3. Make better use of resources

WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

Health Care Financing

Key Technical Components

- Revenue collection
- Pooling
- Purchasing

WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

Agenda for Action

Action 1	**Establishing the vision**
Action 2	**Situation analysis – understand the starting point**
Action 3	**Financial assessment**
Action 4	**Constraint assessment**
Action 5	**Develop strategies and targets**
Action 6	**Implementation, including organizational structures and rules**
Action 7	**Monitor and evaluate**

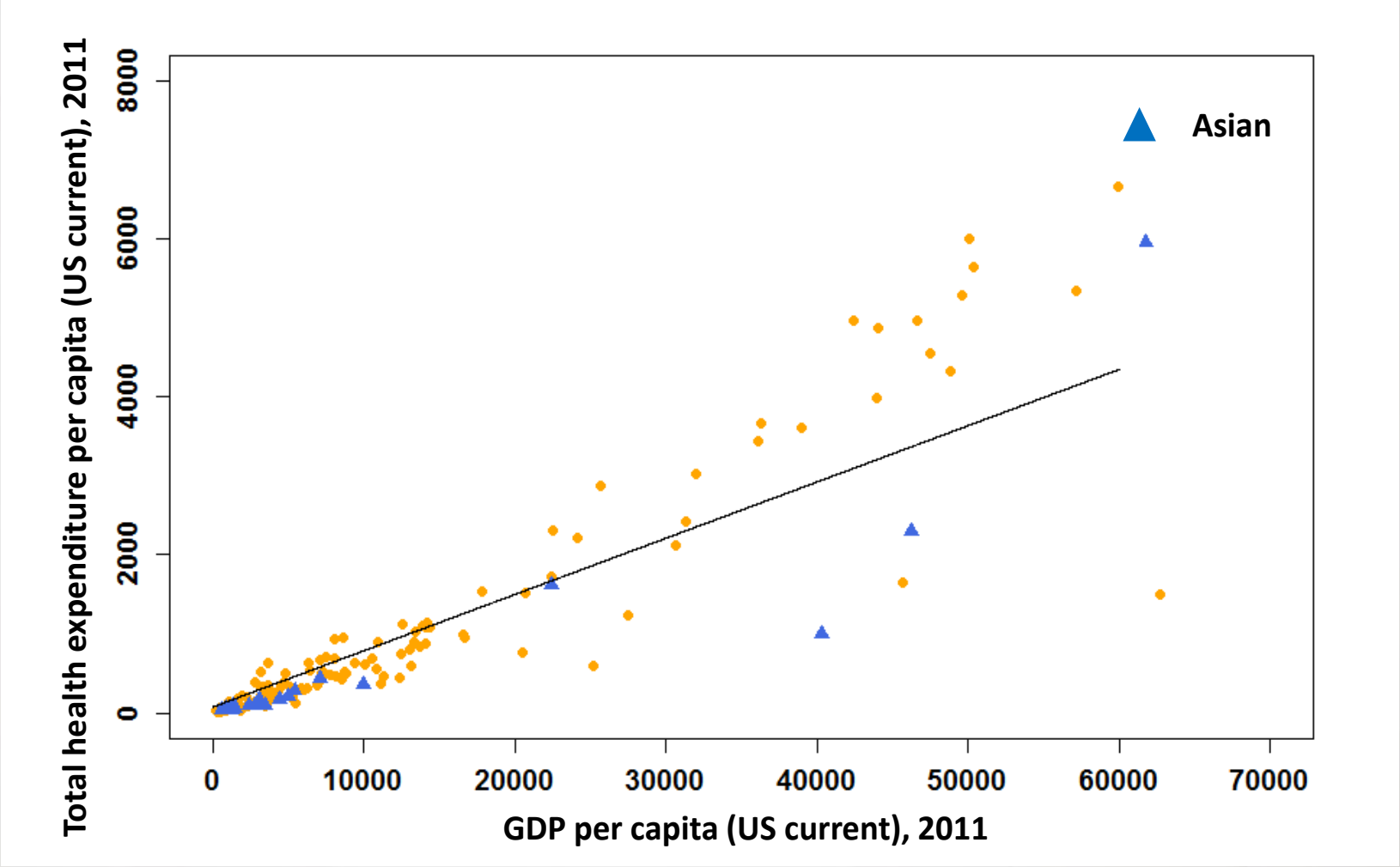
WHO (2010) The World Health Report: Health Systems Financing – The Path to Universal Coverage

Mixed health systems in Asia

Health Expenditure

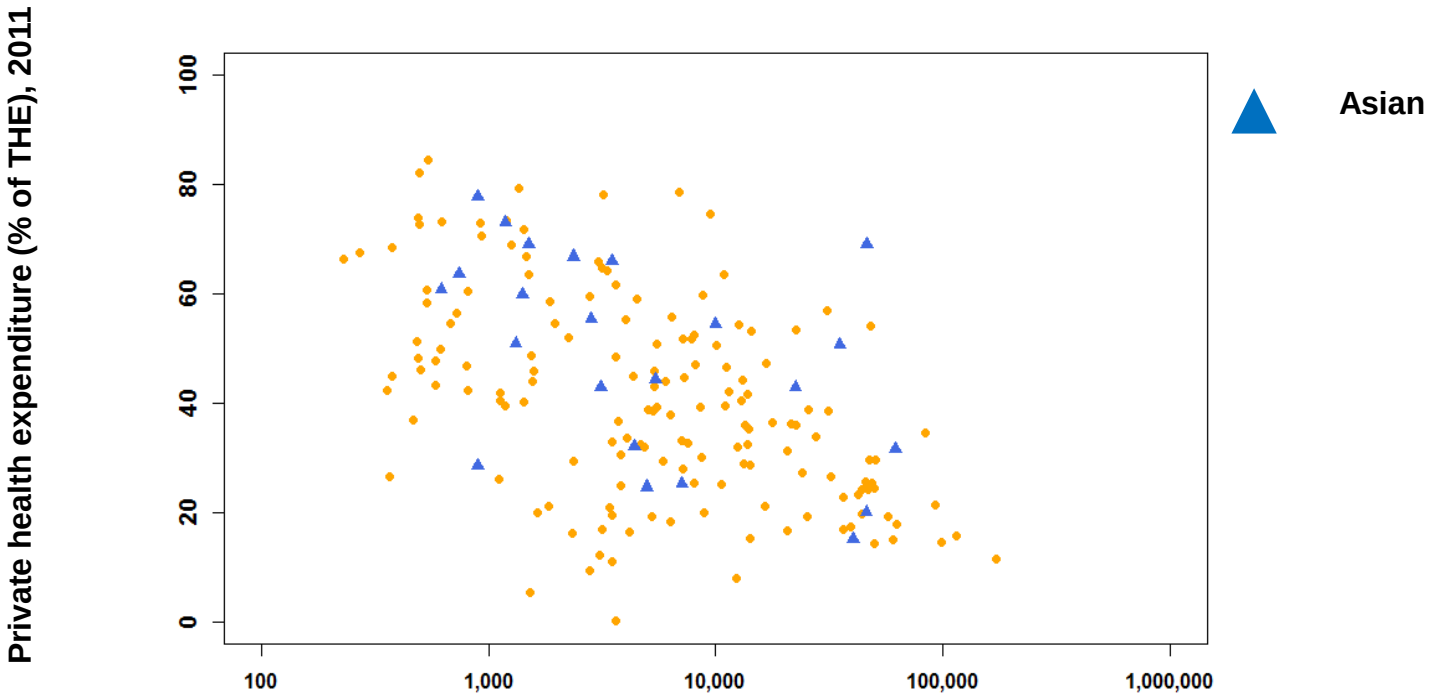
- **The proportion of GDP allocated to healthcare in Asian countries was 4.5% on average**, compared to 9.5% in Organization for Economic Co-operation and Development (OECD) countries.
- **The public share of total health expenditure was 46.6% in 2010**, rising only marginally from 44.4% in 2000. The corresponding figure in OECD countries was 72.2%.
- **Private expenditure accounts for 53.4% of total health expenditure in Asian countries**, with household out-of-pocket payments accounting for most of this and a very much smaller contribution from private prepaid medical insurance plans and from philanthropic source.

Health Expenditure versus Gross Domestic Product Per Capita, 2011



Data source from World Bank WDI (World Development Indicator) Database

Correlation of Private Health Expenditure with GDP per capita



Source: World Bank WDI (World Development Indicator) Database

Mixed Health Systems in Asia

	THE as % of GDP	Government Expenditure as % of THE	Private Expenditure as %of THE
Myanmar	2.0	9.7	90.3
Lao PDR	4.1	19.1	80.9
Cambodia	5.9	27.3	72.7
Bangladesh	3.4	31.7	68.3
India	4.2	32.8	67.2
Pakistan	2.6	32.8	67.2
Philippines	3.8	34.9	65.1
Viet Nam	7.2	38.7	61.3
Singapore	3.9	41.1	58.9
Malaysia	4.8	44.8	55.2
Sri Lanka	4.0	45.2	54.8
Hong Kong	4.8	49.2	50.8
China	4.6	50.1	49.9
Indonesia	2.4	51.8	48.2

>60%

40-60%

	THE as % of GDP	Government Expenditure as % of THE	Private Expenditure as %of THE
Timor-Leste	12.3	71.0	29.0
Fiji	3.4	73.6	26.4
Thailand	4.3	75.8	24.2
Tonga	6.2	78.9	21.1
Papua New Guinea	3.1	79.0	21.0
Japan	8.3	80.0	18.5
Vanuatu	4.0	81.9	18.1
Kiribati	12.2	84.7	15.3
Mongolia	4.7	85.2	14.8
Micronesia	13.8	90.4	9.6
Solomon Islands	5.4	93.8	6.2
Marshall Islands	16.5	97.5	2.5

<40%

Total Health Expenditure (THE)

WHO National Health Accounts Data (2009) & Hong Kong Domestic Health Accounts (2007/08)

Role of Private Sector in Mixed Health Systems

Private Sector in Health Systems in Asia: Demand and Supply

Patients (rich or poor) look for

- Better quality
- New technology
- Convenience
- Accessibility
- Responsiveness

National Population

Government

- Neglect of investment in health care services
- Inadequate investment
- Policies stimulate and enhance enabling markets

Demand ⟷ **Supply**

Patients are concerned about

- Quality
- Cost
- Convenience
- Responsiveness

International Patients

Private sectors

- Response to the existing market
- Response to the new market
- Response to the government policies

Evolving Role of Private Sector in Health Systems in Asia

- Capital
- Investment
- Provision
- Entrepreneur
- Intermediary
- Regulator
- Financing
- Insurance

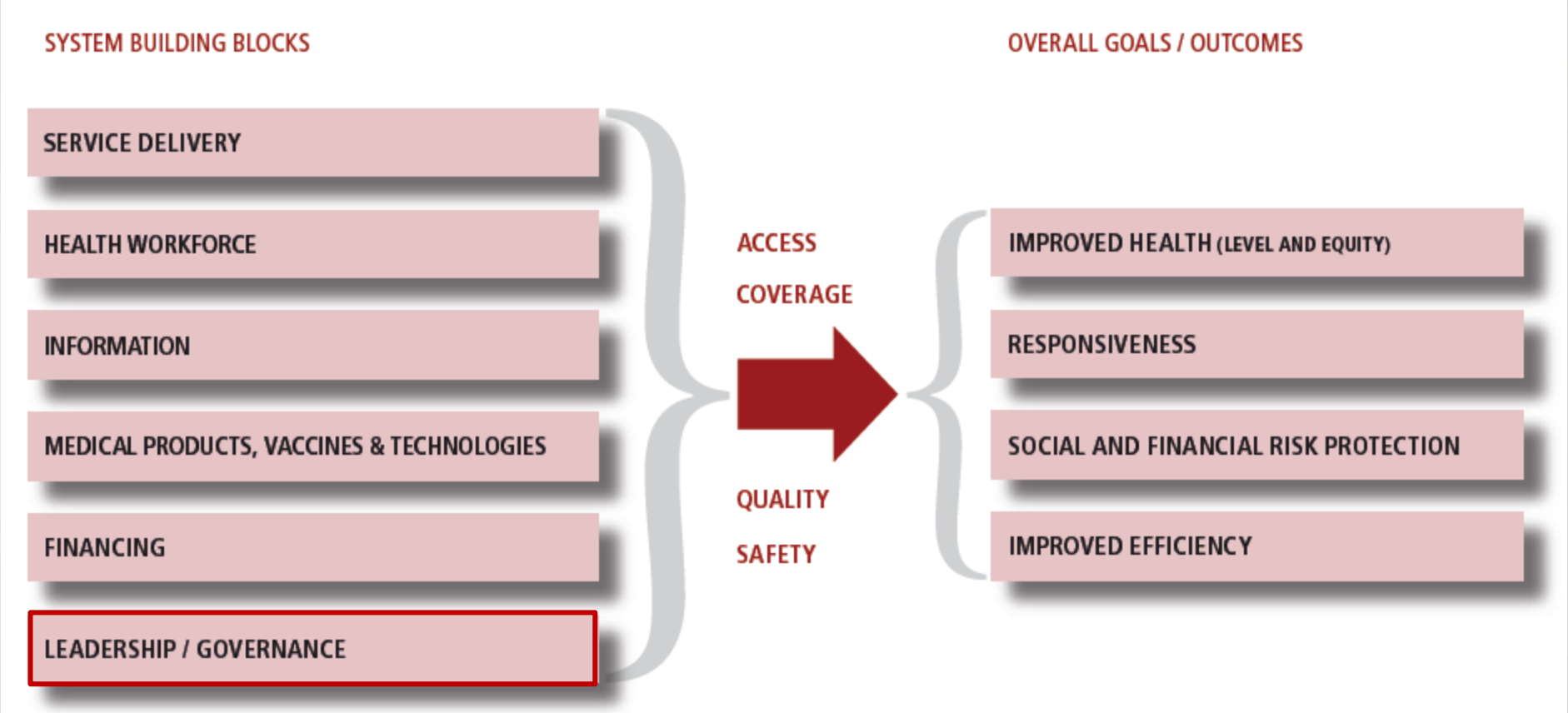
Strategic Role of Private Sector in Mixed Health Systems:

A Systems Approach

Health System: Complex Adaptive System

- Component interrelated
- Relationship not predictable
- Interact in unexpected way
- Open - exchanges with environment

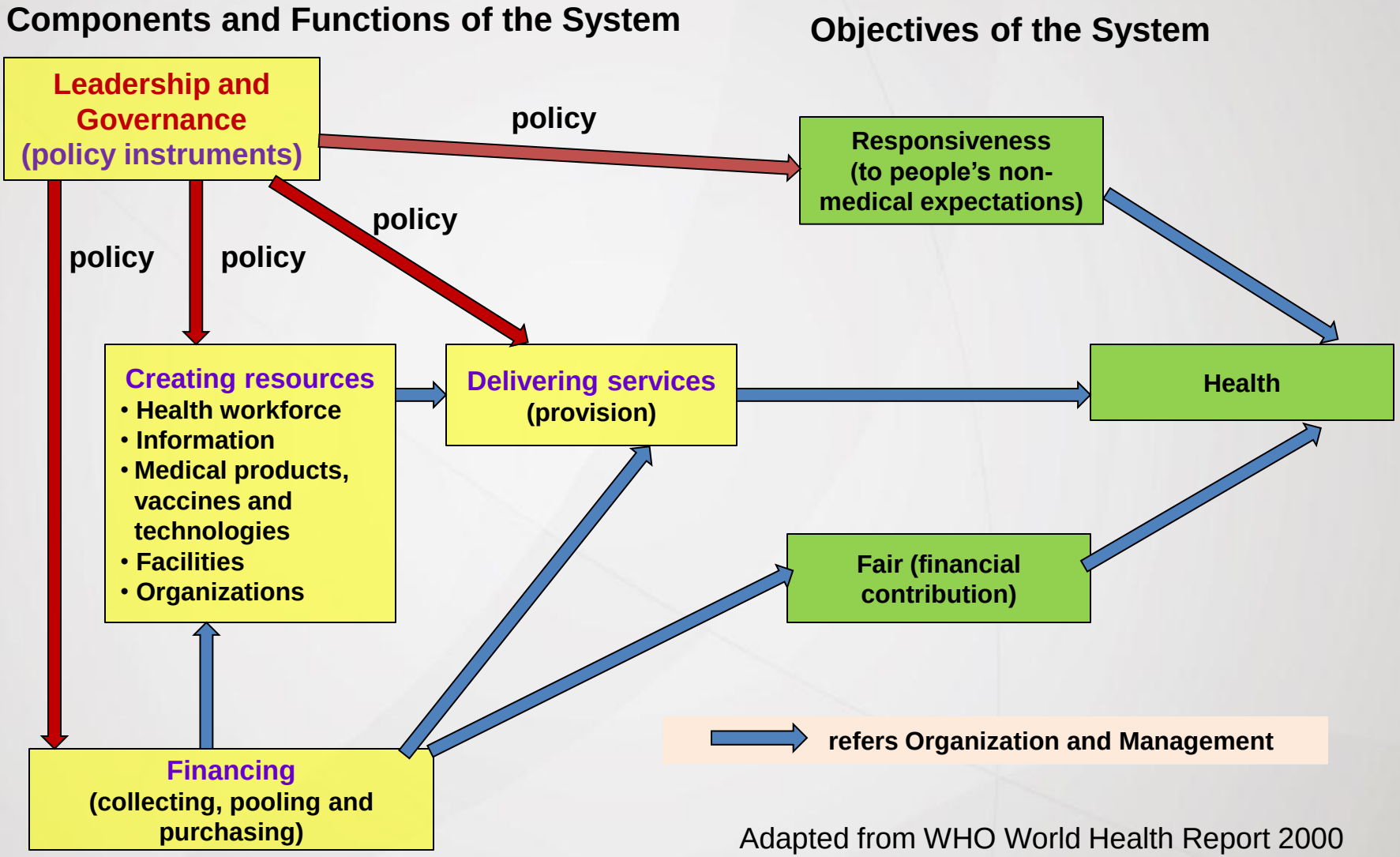
The WHO Health System Framework



WHO (2007) Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, WHO.

Leadership and Governance Role of Government in Managing Mixed Health Systems

Relations Between Components & Functions and Objectives of a Health System



Adapted from WHO World Health Report 2000

Leadership and Governance

- The leadership and governance of health systems, also called *stewardship*
- Role of the government in health and its relation to other actors whose activities impact on health.
- Involve overseeing and guiding the whole health system, private as well as public, in order to protect the public interest.
- Requires both political and technical action

WHO (2007) Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, WHO.

Leadership and Governance: Key Functions

Six Key functions	
Policy guidance	Defining goals, directions and priorities, developing strategies, and establishing the roles of the public, and private sectors and civil society
Intelligence and oversight	On responsiveness, financial protection and health outcomes of the health system, policy options, effects of policies and reforms, and on trends and differentials in inputs, access, coverage and safety of health services
Collaboration and coalition building	Across government, and with civil society and the private sector, to facilitate action which improves health and to generate support for health policies
Regulations and incentives	Should be designed, and fairly enforced to support strategies, goals and priorities;
Systems design	To ensure a fit between strategy and structure, minimizing duplication and fragmentation
Accountability mechanisms	To be applied to the all components of the health system, transparency being a prerequisite

WHO (2007) Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, WHO.

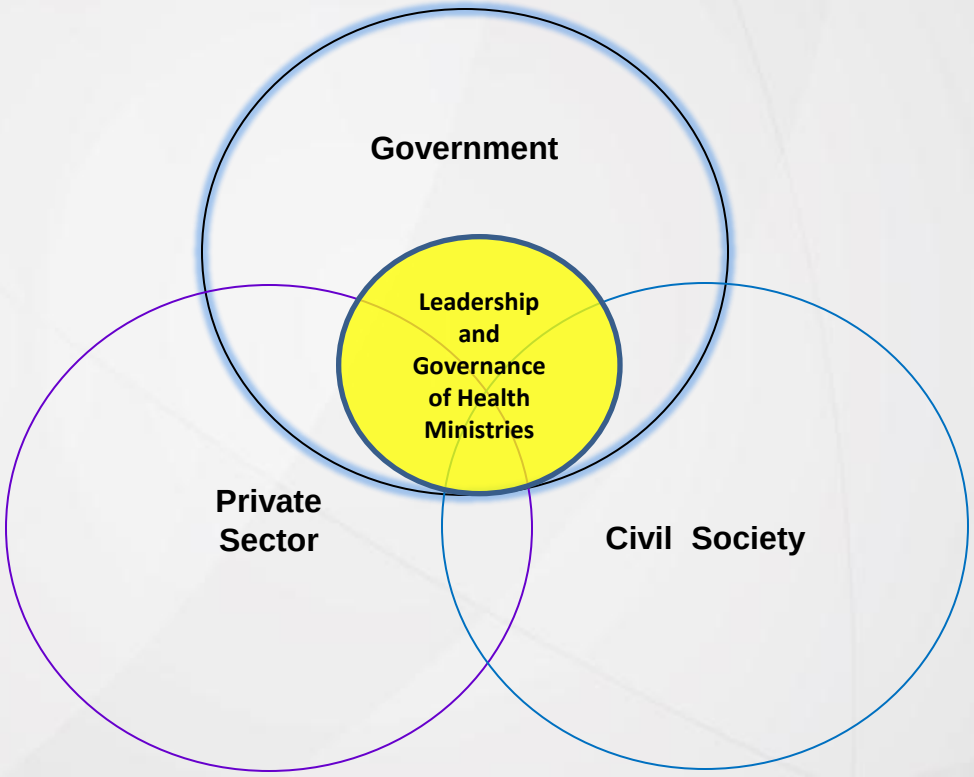
Public Health Governance

Health Governance concerns the actions and means adopted by a society to organise itself in the promotion and protection of the health of its population.

Dodgson, et. al. (2002)

Public Health Governance System

The Entities of Government, Private Sector, and Civil Society - Leadership and Governance of Health Ministries



Yeoh EK. Book chapter "Governance and Management in Public Health System and Public Health Organisation and Programmes". *Oxford Textbook of Public Health 6 ed. Oxford University Press. To be published in 2014.*

Instruments and Strategies for Engaging the Private Sector

Instruments for Engaging Private Sector

Instruments	By
Governing resources	Christopher Hood
Government tools	Musgrove
Policy instruments	Deber
Control knobs	Harvard University

Policy Instruments

Degree	Policy Instruments	Description
Least Coercive	**Exhortation**	Dissemination of information through persuasion and discussion
	Taxation	Encouraging or discouraging behaviors through manipulation of tax incentives / disincentives
	Expenditure	Government distribution of funds to achieve particular aims in the form of cash or in-kind support (provision of space / personnel / subsidizing activities)
	Regulation	Setting rules of behaviors backed up by directly by the sanctions (penalties) of the state
Most Coercive	**Public Ownership**	Government directly running the service in question

Deber (2004)

Policy Instruments (Government Tools)

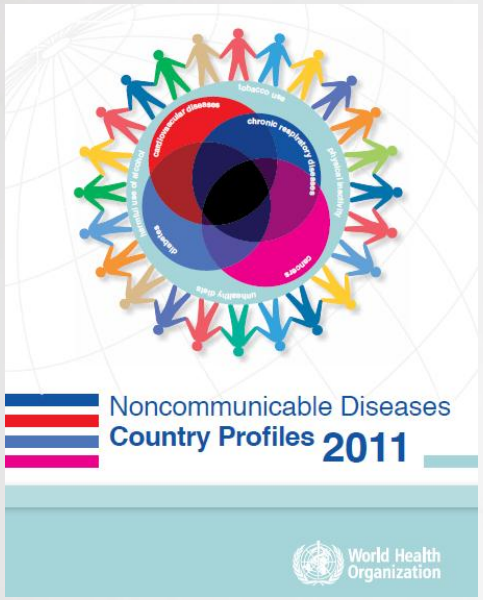
Policy Instruments	Description	Government Tools by Musgrove (1996) - Application
Exhortation	Dissemination of information through persuasion and discussion	• Research – product testing • Provider information – treatment protocols, recommended drugs • Consumer information – provider quality comparisons, consumers' rights, dangers of smoking, rehydration methods, birth spacing **(Information)**
Taxation	Encouraging or discouraging behaviors through manipulation of tax incentives / disincentives	• Taxation **(Regulation and Mandates)**
Expenditure	Government distribution of funds to achieve particular aims in the form of cash or in-kind support (provision of space / personnel / subsidizing activities)	• Budgetary support • Subsidies • Concessions • Contracting **(Financing)**
Regulation	Setting rules of behaviors backed up by directly by the sanctions (penalties) of the state	• Licensure • Accreditation • Employee health insurance • Required immunization of school children **(Regulation and Mandates)**
Public Ownership	Government directly running the service in question	• Rural public hospitals and clinics • Preventive services • Sanitation **(Direct Provision)**

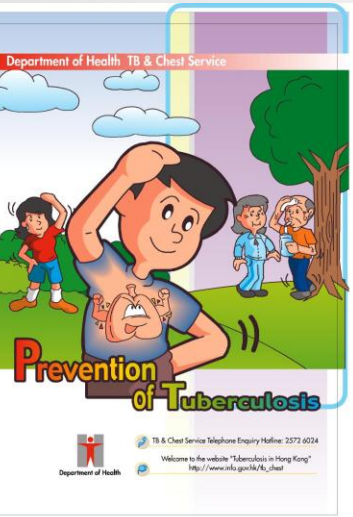
Exhortation/ Information

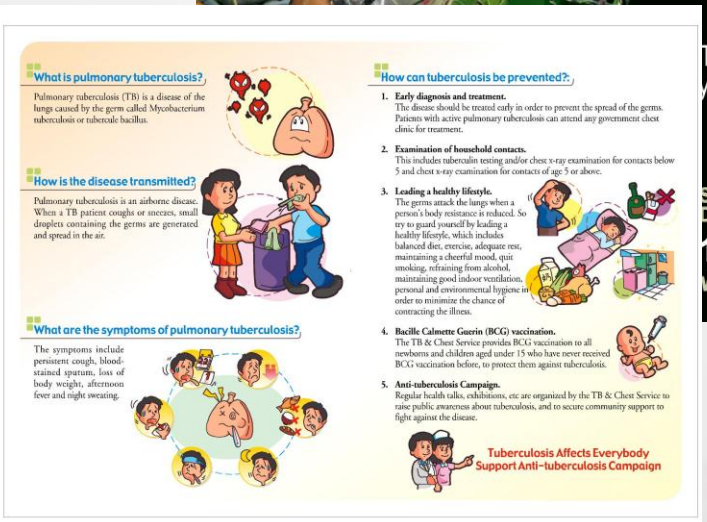
- The least coercive instrument – support and compliance are sought voluntarily, through persuasion and discussion
- Most appropriately used to address quality
- Inexpensive, politically and logistically easier to implement than other stronger instruments
- Useful first-level intervention

Montagu

Health Information







Department of Health of HK,
World Health Organisation

Taxation

- Practice of encouraging (or discouraging) particular behaviours through manipulation of tax incentives/ disincentives
- Forms of tax incentives
  - Exemptions
  - Waivers
  - Income tax contribution deductibles
  - Often in some combination

Deber (2004) and April & Preker (2003)

Australian Government Private Health Insurance Rebate

- Most Australians with private health insurance receive a rebate from the Australian Government to help cover the cost of their premiums.
- The private health insurance rebate is income tested.

Singles Families	≤$88,000 ≤$176,000	$88,001-102,000 $176,001-204,000	$102,001-136,000 $204,001-272,000	≥$136,001 ≥$272,001
Rebate				
	Standard	**Tier 1**	**Tier 2**	**Tier 3**
< age 65	29.04%	19.36%	9.68%	0%
Age 65-69	33.88%	24.20%	14.52%	0%
Age 70+	38.72%	29.04%	19.36%	0%
Medicare Levy Surcharge				
All ages	0.0%	1.0%	1.25%	1.5%

http://www.privatehealth.gov.au/

Expenditure

- Moderate coercive – involves government distribution of funds to achieve particular aims
- Take the form of cash, and/or in-kind support (e.g. provision of space or personnel)
- Contracting is a form of expenditure linked to expectations about performance, and these expectations may be enforced and/or monitored through regulatory mechanisms

Deber (2004)

Examples of Contracting in Hong Kong

Elderly Healthcare Voucher Scheme *to subsidise elderly to use the primary healthcare services in the private sector*

Shared Care Programme *to subsidise chronic disease patients currently under the care of the public healthcare system to choose to receive comprehensive care from private doctors*

Regulation

Three basic categories

- Regulation as setting forth mandatory rules that are enforced by a state agency
- Regulation incorporates all efforts by state agencies to steer the economy… include state ownership and contracting, taxation and disclosure requirements
- Regulation to include all mechanisms of both intentional and unintentional social control

Saltman and Busse (2002); Baldwin et al (1998)

Regulation

- **Command & Control**
  - Limitations
  - Enforcement capacity and costs
  - Legitimacy
  - Effectiveness
- **Alternative / Complementary**
  - Incentive
  - Market – Harnessing
- **Spectrum of Government's Means to Influence – Control**

Australia: Medicare Requirements for Referrals to Specialists and Consultant Physicians

Referrals must be made in accordance with the regulations.

Health Insurance Act 1973

132A Regulations

(2) Where an item specifies a medical service that is to be rendered by a consultant physician, or a specialist, in the practice of his or her specialty to a patient who has been referred to him or her, the regulations may require that, for the purposes of the item, the patient be referred in a manner prescribed by the regulations.

https://ama.com.au/medicare-requirements-referrals-specialists-and-consultant-physicians#Rules

Public Ownership

- Most coercive policy instrument – involve government directly running the service in question

Deber (2004)

Set Up Hospital Authority

- A statutory body established under the Hospital Authority Ordinance in 1990.
- Responsible for **managing Hong Kong's public hospitals and their services** since December 1991.
- **Accountable to the HKSAR Government** through the Secretary for Food and Health

www.ha.org.hk

Instrument Choice

Choice	
Technical	• Effectiveness • Efficiency • Equity • Appropriateness • Simplicity
Political	• Resource intensiveness • Extent of targeting of policy • Political feasibility, desirability and risk
Context	Previous decision
Idiosyncratic	

Strategic Role of Private Sector: Mixed Scanning Approach

Healthcare Expenditure

Hong Kong

- Total health care expenditure (2009/10 figures)
  - 5.2% of Gross Domestic Product (GDP)
    - Public sector (49%)
    - Private sector (51%)

Hong Kong's Domestic Health Accounts (1989/90-2009/10)

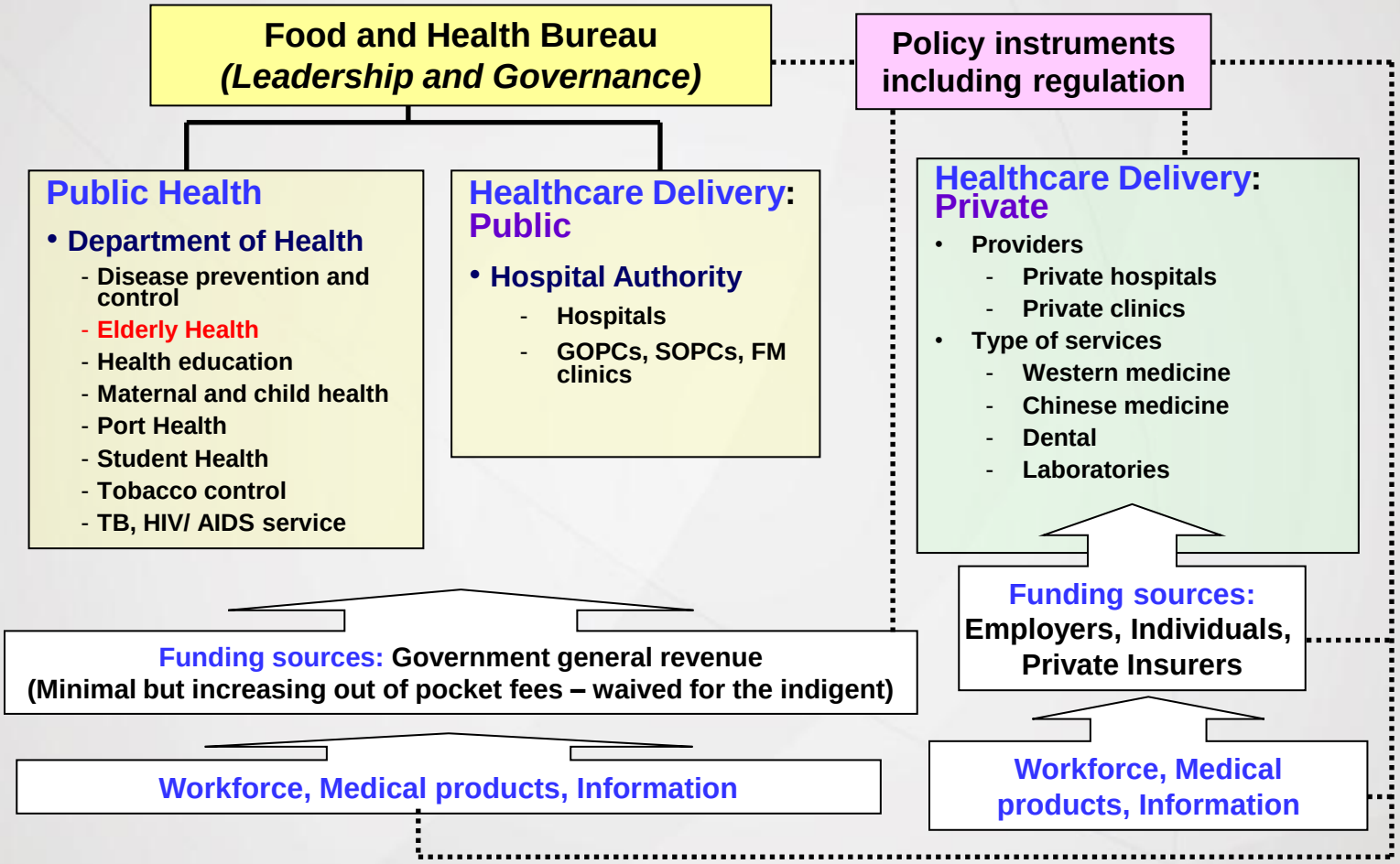
Sources of Funding

As percentage of total expenditure on health	2003/04 (%)	2007/08 (%)	2008/09 (%)
General Government	58	49	49
Social Security Funds	0	0	0
Private household out-of-pocket expenditure	30	35	35
Private insurance	12	14	14
All other sources	2	3	2

Hong Kong's Domestic Health Accounts, 1989/90-2008/09

Health System in Hong Kong

(A mix of public and private providers)



In-patients^:

- Bed days
  - Public 90%
  - Private 10%
- Admissions
  - Public 80%
  - Private 20%

Out-patients^:

- Public 30%
- Private 70%

Funding sources#:

- Government (49%)
- Out of pocket (35%)
- Employers (7%)
- Insurance (7%)
- Others (2%)

^: Thematic Household Survey, 2011

#: Hong Kong's Domestic Health Accounts, 2009/10

Models of Decision Making

1. Rational model
2. Incremental model
3. Two-stage “Mixed Scanning” model
4. The Garbage-Can model

1. Rational Model

- Series of sequential activities that would be undertaken
  1. A goal for solving a problem is established
  2. All alternative strategies of achieving the goal are explored and listed
  3. All significant consequences of each alternative strategy are predicted and the probability of those consequences occurring is estimated
  4. Finally, the strategy that most nearly solves the problem or solves it at least cost is selected. (Carley, 1980)
- "Rational" in the sense that it prescribes procedures for decision-making that, in theory, will lead to the **choice of the most efficient possible means of achieving policy goals**

2. Incremental Model

- Common elements of the “strategies of decision”
  a. Limitation of analysis to a few somewhat familiar policy alternatives … differing only marginally from the status quo;
  b. An intertwining of analysis of policy goals and other values with the empirical aspects of the problem (that is, no requirement that values be specified first with means subsequently found to promote them);
  c. A greater analytical preoccupation with ills to be remedied than goals to be sought;
  d. A sequence of trials, errors, and revised trials;
  e. Analysis that explores only some, not all, of the important possible consequences of a considered alterative;
  f. Fragmentation of analytical work to many (partisan) participants in policy making (each attending to their piece of the overall problem domain) (Lindblom, 1979)
- Decision-makers works through a process of ***“continually building out from the current situation, step-by-step, and by small degrees”*** (Lindblom, 1959)

3. Two-Stage “Mixed Scanning” Model

- A “pre-decisional” or “representative” stage of assessing a problem and “framing” it – which would utilize incremental analysis
- A second analytical phase in which specific solutions would be assessed – which would be more rational in nature

Voss (1998); Svenson (1979); Alexander (1979, 1982)

4. The Garbage-Can Model

- A garbage can into which various problems and solutions are dumped by participants. The mix of garbage in a single can depends partly on the labels attached to the alternative cans; but it also depends on what garbage is being produced at the moment, on the mix of cans available, and on the speed with which garbage is collected and removed from the scene.

Cohen, March, and Olsen (1979**)**

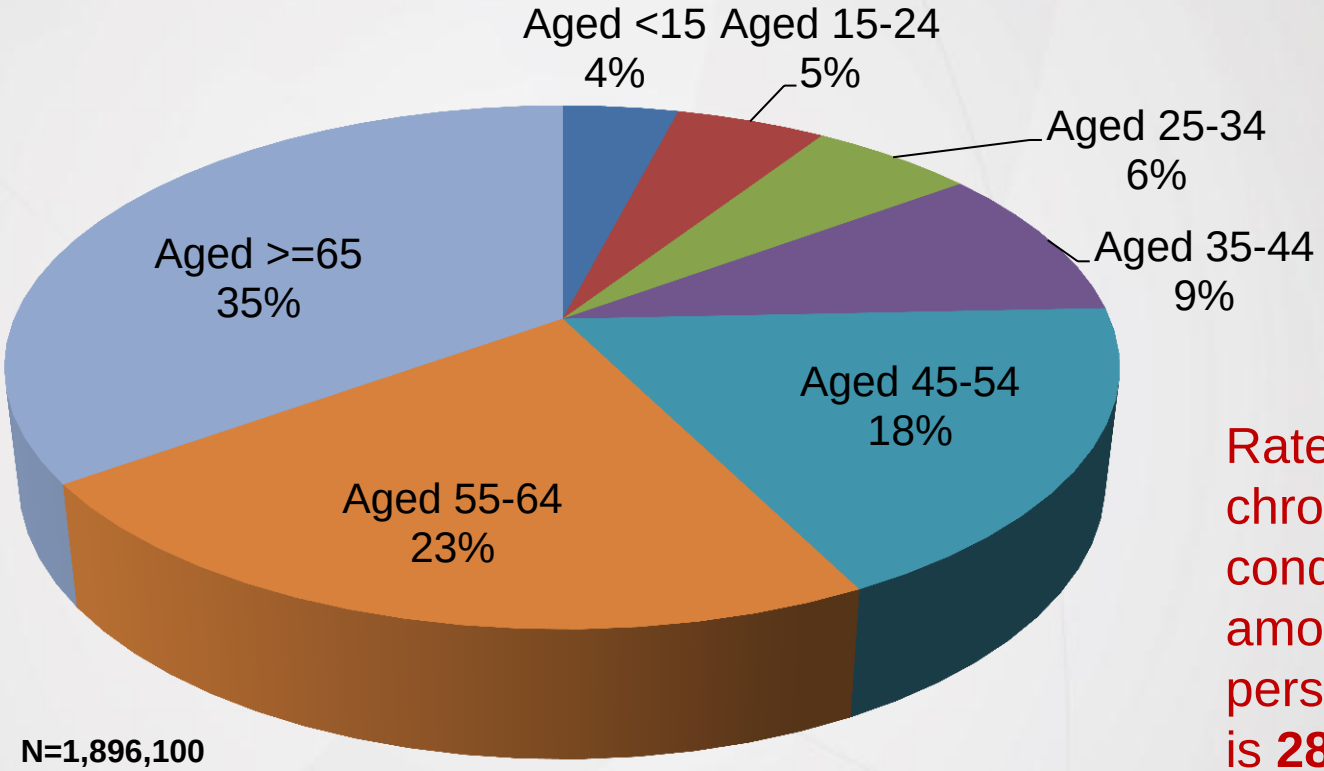
The Garbage Can Model

- Assumes that problems, solutions, decision makers, and choice opportunities are independent, exogenous streams flowing through a system *(Cohen et al, 1972)*
- Come together in a manner determined by arrival times
- Thus, solutions linked to problems primarily by their simultaneity, relatively few problems are solved, and choices are made for the most part either before any problems are connected to them (oversight) or after the problems are abandoned one choice to associate themselves with another (flight) *(March and Olsen, 1984, 1989)*

Mixed Scanning Approach

- **Problem**
  - Chronic disease burden
  - Poverty
  - Risk pooling and protection

Persons having Chronic Health Conditions by Age

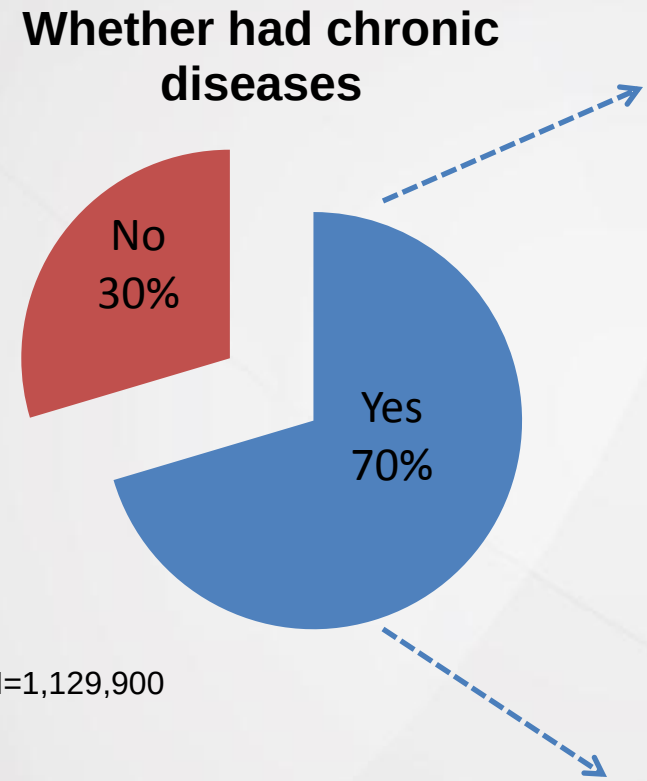


N=1,896,100

Rate of having chronic health conditions among all persons in HK is **28.1%**

Census and Statistics Department: Thematic Household Survey 50 (2013)

Older Persons having Chronic Diseases



Type of chronic diseases	No. of persons ('000)	%
Hypertension	497.5	62.5
Diabetes	172.4	21.7
Arthritis	158.5	19.9
Eye diseases	143.2	18.0
High cholesterol	129.6	16.3
Heart diseases	115.1	14.5
Osteoporosis	69.6	8.8
Diseases of the ear/ nose/ throat	69.2	8.7
Respiratory diseases	46.4	5.8
Stroke	44.7	5.6
Overall	**795.8**	

*Older persons refer to those aged 60 or above

Census and Statistics Department: Thematic Household Survey 40 (2009)

PPP Programmes on Chronic Diseases

- Share out the pressure on the public healthcare system by tapping resources in the private sector in the longer term
- Foster long-term patient-doctor relationship under the family doctor concept

Tin Shui Wai Primary Care Partnership Project (2008)

Public-Private Chronic Disease Management Shared Care Programme (2010)

General Outpatient Clinic Public-Private Partnership (2014)

LC Paper No. CB(2)849/13-14(05)

Poverty

- 19.6% of the city's population be classified as poor, or 15.2% if regular cash welfare payments are included;
- More than half of those who fall under the poverty line have one or more full-time worker in their households;
- One in three elderly people - approximately 296,600 - are poor;
- One in five children - 208,800 youngsters - are poor;
- 235,600 people on CSSA welfare still fall below the poverty line.

A one-person household with less than HK$3,600 per month will be considered poor. For two-person households, the amount is HK$7,700 and HK$14,300 for four-person households (2012 Figures)

Commission of Poverty Summit (28-09-2013)

Old Age Living Allowance - Alleviating Poverty

- HK$2,200 per month to **supplement the living expenses of elderly people aged 65 or above who are in need of financial support** (means-tested)
- More than 400,000 elderly people (around 42% of elder population) received Old Age Living Allowance as at Oct 2013

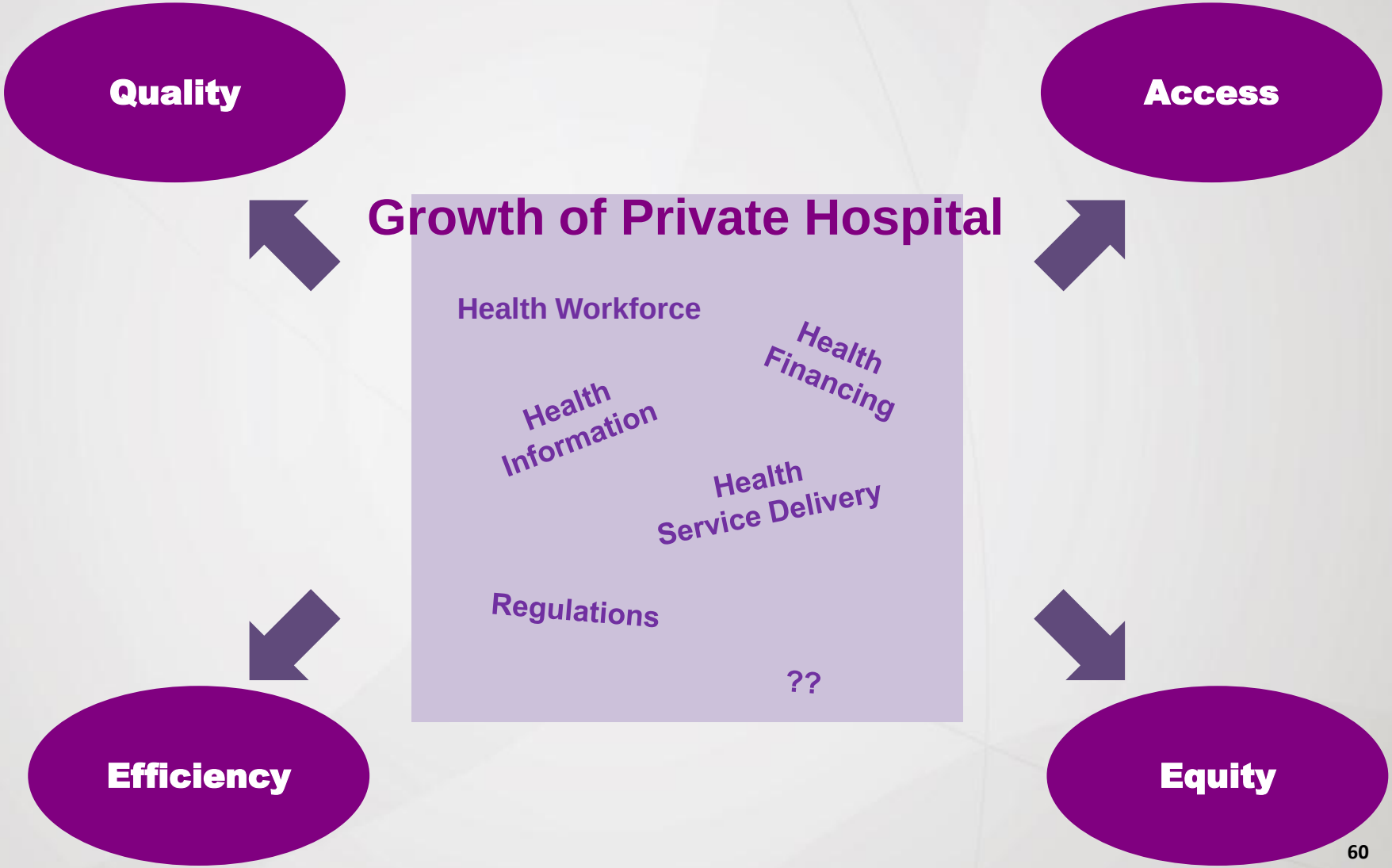
South China Morning Post (4 Oct 2013)

Health Protection Scheme (Hong Kong)

Proposed Minimum Requirements for Standard Plan	
Access to and continuity of insurance	• Guaranteed renewal • No “lifetime benefit limit” • Coverage of pre-existing conditions • Guaranteed acceptance and premium loading cap • Portable insurance policy
Quality of insurance protection	• Coverage of hospitalisation and ambulatory procedures • Coverage of advanced • Diagnostic imaging tests and cancer treatments • Minimum benefit limits • Cost-sharing restrictions
Transparency and certainty	• Upfront payment certainty • Standardised policy terms and conditions • Premium transparency

Legislative Council Paper (Hong Kong) No. CB(2)412/13-14(01)

Challenges of Engaging the Private Sector for Health System Goals



Leadership and Governance of Health Systems

- **Application of Government tools:**
  - Direct provision
  - Financing
  - Regulations and mandates
  - Information
- **In Ensuring**
  - Access
  - Equity
  - Quality
  - Efficiency
- **To achieve**
  - Universal healthcare coverage

Thank you!