PMAC | PRINCE MAHIDOL AWARD CONFERENCE 2020

STRONGER COLLABORATION WITH THE PRIVATE SECTOR FOR BETTER UHC

PMAC 2020 SIDE MEETING

29 January 2020, 9:00-12:30
Centara Grand & Bangkok Convention Centre
at Central World

STRONGER COLLABORATION WITH THE PRIVATE SECTOR FOR BETTER UHC

PMAC 2020 SIDE MEETING

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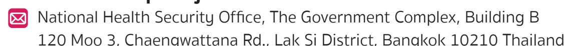
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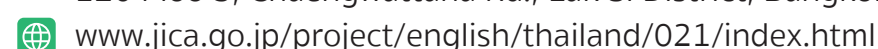
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Executive summary

The Thai Ministry of Public Health (MOPH), National Health Security Office of Thailand (NHSO), and the Japan International Cooperation Agency (JICA) / the Partnership Project for Global Health and Universal Health Coverage (GLO+UHC) organized the PMAC Side Meeting under the theme of "Stronger collaboration with the private sector for better UHC" on 29 January 2020 in Bangkok, Thailand.

With presenters from Kenya, Laos, Japan, and Thailand, around 100 domestic and international experts including officers from relevant ministries and agencies, academics, representatives of civil society groups, and representatives from development partners shared their practical experiences of multiple countries at different levels of development and Universal Health Coverage (UHC) on various themes including mechanisms, strategies, and challenges, and exchanged their views. The meeting highlighted various topics of discussion for achieving effective collaboration with the private sector concerning UHC. Topics discussed included the need for strong political commitment, mechanisms which enable the participation of all stakeholders, including individuals and civil society groups, human resources for health (HRH) management, data integration, incentives for the private sector, and accountability.

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Background

In 2002, the Thai government launched a nation-wide health insurance scheme known as the Universal Coverage Scheme (UCS) to cover individuals who did not have any health insurance. The UCS is the largest health insurance scheme in Thailand with national coverage at about 75%. This significant health reform enabled nearly 100% of the Thai population to be covered by one of the three main health insurance schemes.

Thailand has a worldwide reputation for achieving and maintaining UHC for nearly 20 years. Despite its rich experiences, Thailand is still facing a challenge that is common to many countries: the effective involvement of private healthcare providers. Achieving that would provide benefits to the community in ensuring constant availability and accessibility of health care as well as efficient and high-quality health services under the era of UHC for those who need it.

Not only Thailand but many other countries are also seeking better mechanisms to engage private healthcare providers into their UHC systems for maximizing the benefits to their people, on both the demand and supply sides. These mechanisms should provide a platform for the private healthcare providers to contribute to the UHC while maintaining that their businesses run smoothly. At the same time, a fund manager could engage existing private healthcare providers (mainly private pharmacies, clinics and hospitals) for providing services to its UHC members.

The PMAC 2020 Side Event provided a good opportunity for people to share their experiences on the current situation of engaging private healthcare providers in their country's UHC scheme, the challenges this may entail, and prospective strategies for stronger collaboration with private healthcare providers. The experiences of countries within various income groups will stimulate the sharing and learning experiences together.

The discussions from this event are expected to stimulate recommendations and suggestions from relevant international development partners and facilitate networking at the country, regional and global levels with the PMAC network and possibly beyond.

The PMAC 2020 Side Event had the following objectives:

1. to share the experiences of multiple countries on the role of private healthcare providers and how to engage them to contribute to UHC
2. to explore various mechanisms to provide a mutual benefit to individuals, public & private healthcare providers, and fund managers
3. to learn how to collaborate practically with private healthcare providers in achieving UHC
4. to discuss and identify prospective collaboration and support for UHC from the perspectives of countries and international development partners.

Agenda

29 January 2020	
9:00 - 9:10	Introduction of the theme and objectives by the session moderator, Dr. Valeria de Oliveira Cruz, Regional Adviser, Health Financing and Governance, Department of Health System Development (HSD), WHO South-East Asia Office (SEARO)
	Welcome address by Dr. Jadej Thammatacharee, Deputy secretary-general, National Health Security Office (NHSO), Thailand
9:10 - 9:15	Group Photo
9:15- 10:30	**Country presentations**: Challenge to engage the private sector in the UHC system (10 minutes each with 5 slides) **Kenya** - Dr. Jacqueline Kitulu, President, Kenya Medical Association **Laos** - Dr. Dasavanh Manivong, Deputy Chief of Health Insurance System Management Division, National Health Insurance Bureau, Ministry of Health **Japan** - Dr. Yasuki Kobayashi, Professor, Graduate School of Medicine, University of Tokyo **Thailand** - Dr. Weraphan Leethanakul, Director of Region 13 Bangkok, National Health Security Office. **Q&A and general discussion** on country presentations (30 minutes)
10:30 - 10:50	Coffee break
10:50 - 12:30	The session moderator will facilitate the discussion on (a) Effective strategies for collaborating with private healthcare providers in UHC at the national level and (b) Collaboration and support to accelerate those effective strategies identified in (a); from the perspectives of • Participants • Country presenters (Kenya, Laos, Japan, Thailand) • WHO: Dr. Liviu Vedrasco, Programme Officer, WHO (Thailand office)
	Wrap up and take-home message by Mr. Tatsuya Ashida, Director for Health Group 2, Human Development Department, JICA and the session moderator
	Closing by Dr. Walaiporn Patcharanarumol, Director of International Health Policy Program, Thailand
	Group Photo with participants

Country presentations:
Challenge to engage the private sector in the UHC system

Kenya

Dr. Jacqueline Kitulu, President of the Kenya Medical Association, gave an interesting presentation on the structure of Kenya's health insurance system and the approaches used by its government to engage private healthcare providers in UHC.

Kenya piloted a UHC system in public hospitals in December 2018. Its Health Sector Strategic Plan specified the UHC framework in which secondary and tertiary care is to be provided by a public-private partnership (PPP) arrangement while primary health care is provided within the public sector. The Kenya Healthcare Federation (KHF), established in 2004, consists of professional associations, healthcare institutions, and corporate organizations, and plays an important role in promoting strategic PPP. KHF has around 160 members comprising non-state actors such as hospitals, insurers, and information and communication technology (ICT) players. These actors voice their opinions in unison to maximize the contribution of the private sector. KHF engages various committees and national government ministers through quarterly ministerial stakeholder forums and annual presidential round table meetings.

However, some challenges remain concerning UHC. First, a PPP strategy is unclear; there is a need to define PPP policies and procurement guidelines at the national and county level. Second, the UHC model and implementation framework is not well-defined and analytics and outcomes of the UHC pilots have not been shared with the private sector. Third, due to the lack of a national e-architecture

Key challenges of engaging Private Healthcare Providers in UHC

Despite a quarterly Ministerial Stakeholder Forum and Annual Presidential Round Table Key KHF challenges remain:

1. PPP Strategy unclear – need to define PPP policies and Procurement guidelines nationally and at county level

2. UHC Model and the implementation framework is not well defined and analytics and outcomes of the UHC Pilots not shared

3. Lack of a National e-architecture for Central connection for Electronic Health Records portability so no possibility for data sharing across all healthcare service providers & Health Insurance players for ease of reimbursement

for the central connection of electronic health records, data sharing across all healthcare service providers and health insurance players is unattainable. There are many areas that the private sector could contribute further such as health products, ICT and mobile health (mHealth), health workforce, health services, research and development, and health financing.

Laos

Dr. Dasavanh Manivong, Deputy Chief of the Health Insurance System Management Division, National Health Insurance Bureau, Ministry of Health, shared her country's latest approach for engaging the private sector in progressing towards UHC.

Laos aims to achieve UHC for all citizens by 2025 under the comprehensive Health Sector Reform Strategy. After the launch of a tax-based National Health Insurance (NHI) scheme for the informal sector in 2016, social health protection coverage has successfully increased to 94%. The utilization rate of public health facilities has also increased by 10% to 35% in the same period; however, it is still relatively low due to the limited service capacity and low quality of services. Out-of-pocket payment for health services remains high, especially for secondary and tertiary care services.

As a significant share of health services is delivered by the private sector, their engagement is considered essential to achieve UHC. The prime requirement is to develop clear and comprehensive standards and frameworks on the private

4. Current challenges

The current highly public driven system faces challenges which the provider sector could have a major role in addressing it:

- **Inefficiency in service delivery / quality of Services**
  - Services delivery capacity is limited. Technical efficiency varies greatly by geographical areas
  - Low public health service quality and responsiveness questions the value for money invested through the NHI
- **Limited funding to adequately finance National Health Insurance (NHI) benefits package**
  - Limited political and financial commitment to fund NHI benefit package. This substantially delays the payment and fails to provide right incentives to providers
  - Public services and public health insurance schemes not "attractive" and "responsive" to the needs of the population
- **Limited availability and equity in service provision of package of services**
  - Ensuring adequate financial access of the most vulnerable is still challenging
- **Insufficient management capacity**
  - Limited managerial experiences, technological innovations, and investment
  - Limited monitoring and evaluation framework

sector. So far, Laos has started some interesting approaches for incorporating a PPP arrangement into its healthcare system. First, the Ministry of Health signed its first pilot contract with a private tertiary hospital to handle referral cases in 2019 in order to seek regulatory and financing incentives for the private sector's behavior. Another approach was assigning "private attributes" to public health organizations. This involved granting hospital autonomy for better HRH management and service quality. A PPP arrangement is also planned to be promoted further, for example, in family planning services with "accredited" private clinics/pharmacies and the lease of diagnostic equipment in health facilities.

Japan

Dr. Yasuki Kobayashi, a professor at the Graduate School of Medicine, University of Tokyo, shared Japan's "Hybrid" health insurance schemes of different origins and public/private mix of providers.

Japan achieved UHC in 1961, which now consists of five main insurance schemes and more than 1,500 insurance organizations. The type of insurance scheme an individual joins is largely determined by their occupation, dependent status, and age, but the structure of each insurance scheme is the same. In the UHC scheme, 80% of hospitals, 99% of clinics, and almost all pharmacies are private entities. Review organizations play an important role in the public-private mixed scheme. They were established about ten years before the UHC was achieved to check and review insurance claims made by providers and to make payments to providers.

Key challenges of engaging private healthcare providers in UHC

- To negotiate with the association of physicians for fee schedules, rather than individual physicians.
- To conduct regular price surveys and reflect them in fee schedules.
- To investigate the financial situation of private sectors and reflect it in the payment level
- Tax incentives (reduced tax rate) for providers is an effective option, though controversial.
- Public provision (an insurance plan's provision) of health services is needed in remote areas.

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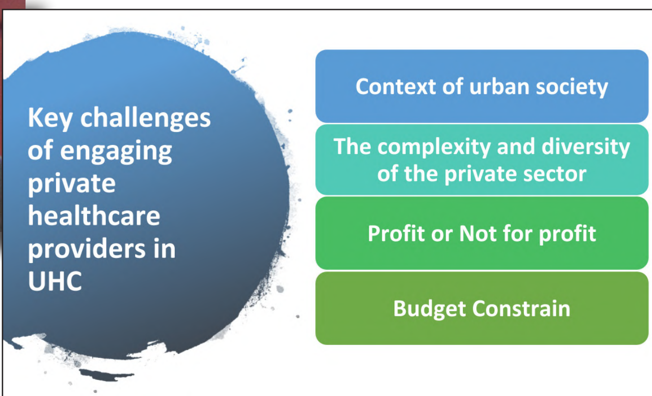
Japan successfully involved private healthcare providers, who preferred providing uninsured services, by increasing the payment of insured services by the government, and solving problems of complicated procedures and delayed payment by review organizations. Prof. Kobayashi shared an encouraging fact that as a result of these approaches to incorporate private providers, Japan's UHC reduced the maldistribution of physicians to an extent; from the high concentration in affluent areas to a distribution more proportional to the number of insured people in a particular area.

However, several challenges remain in engaging private healthcare providers in UHC. (1) to negotiate with the association of physicians for fee schedules; (2) to conduct regular price surveys and reflect them in fee schedules; (3) to investigate the financial situation of private sectors and reflect it in the payment level; (4) to determine appropriate tax incentives for providers; and (5) to provide public health services in remote areas.

Thailand

Dr. Weraphan Leethanakul, the Director of Region 13 Bangkok, National Health Security Office, gave a presentation outlining the current situation and challenges for stronger collaboration with the private sector for a better UHC system.

Thailand achieved UHC in 2002 with the addition of the Universal Coverage Scheme (UCS) to complement Thailand's other existing public health insurance schemes, of which UCS is the biggest, with a coverage of over 47.5 million people. The private sector accounts for only 5% of healthcare providers joining in UCS nationwide, but they are the major providers in urban areas. In Bangkok, where 66% of all UCS subscribers register with private providers, the private sector provides 79% of



health promotion and prevention services, 55% of outpatient services, and 29% of inpatient services. The challenges of engaging private healthcare providers in UHC include (1) dealing with urban context such as traffic jams and environmental pollution; (2) understanding the complexity and diversity of the private sector, which requires different approaches between small individual providers and big business groups, or profit and not-for-profit organizations; and (3) budget constraints as the UCS is funded exclusively by tax whereas medical spending is growing due to population aging, increase of non-communicable diseases (NCDs), and high technology. Possible solutions include (1) political commitment to invite providers from the private sector to join in the UHC such as giving them tax reductions; (2) modifying the PPP structure with consideration for ownership of private providers, i.e. ensuring that their benefits are secured, otherwise they are removed from the UCS; and (3) developing a primary care trust system between the public and the private sectors as well as between different health professionals.

Current situation

In the health area, the private sector refers to all non-state actors including for-profit and non-profit organizations, religious or faith-based entities, hospitals, clinics, pharmacies, health insurers, and ICT companies. The scope of providers can range from a single individual to a large business corporation. In many countries, private health providers have a great service capacity with high-quality services and advanced medical technology, thus, many people prefer such private services. However, fees are high, and this often causes household catastrophic health expenditure when the private providers are out of a UHC scheme. Private providers can play a substantial role in UHC by providing much-needed health services and contributing to a stretched health workforce in the community. However, the effectiveness of their contribution will be tested when the public sector faces national budgetary constraints, limited capacity, and weak governance. In addition, the contribution of the private sector is expected to focus on pharmaceutical and health products, ICT and mobile health, and research and development.

The presentations made by each country's delegate concerning their unique experiences and mechanisms of engaging the private sector in UHC showed diversity in the extent of their government's involvement; from Japan with a "hybrid" universal health insurance scheme in which 80% of hospitals are private

entities, to Laos which has recently started a pilot contract with a private hospital with the aim to achieve UHC by 2025. The role or position of the private sector in UHC also differs among countries. Kenya's Health Sector Strategic Plan specified a UHC framework in which secondary and tertiary care is to be provided by a PPP arrangement, while primary health care is to be provided within the public sector. The opposite case is true for Thailand, where, in the capital city of Bangkok, private providers account for over half of health promotion, and prevention and outpatient services but only one third of inpatient services, although the situation is different in rural areas.

Countries on the way to achieving UHC envision a PPP arrangement as being an important driving force. However, success hinges on the existence of an explicit government policy that outlines the role of the private health sector with clear and comprehensive standards, guidelines, and frameworks. Countries that have already achieved UHC also seek to improve their engagement with the private sector in the face of changing medical demands and increased expenditure due to an aging population, a rising prevalence of non-communicable diseases, and advances in technology.

Issues and challenges

Migration of HRH from the public to the private sector

Most countries recognized the challenge to cope with the transfer of health personnel from the public sector to the private sector. The so-called "brain drain" syndrome has had a negative impact on many developing countries, where most of the health personnel are trained by public funds. In response, Thailand's mandate, which compels its medical school graduates to work in public institutions for at least 3 years, was accepted as a good solution. However, the equity aspect, where there is a disproportionately higher number of inexperienced doctors in rural public hospitals, remains a major challenge. This indicates that various motivational incentives should be considered, ranging from financial bonuses to capacity building providing training with high-technology medical equipment.

Part-time jobs, or so-called "moonlighting jobs," where doctors who are employed by public hospitals work at private entities – some opening their own private clinics - was also discussed as a common issue that limits service provision in public facilities and also affects the quality of services. The presenters shared

some practical solutions such as incentives for those who only work at public institutions, for example, Thailand provides its medical doctors with an additional bonus of 10,000 baht/month while Laos use the criteria as a necessary condition for promotion. Other solutions presented included improvements in the monitoring and controlling system, for example, Kenya's "Doctors plaza" opened next to a public hospital which enables easy monitoring. Participants also recognized the need for fundamental solutions by developing policies that address conflicts of interest and strong accountability mechanisms.

Unnecessary care

The prevention of unnecessary care or inappropriate care by private for-profit providers in a UHC scheme was raised as an issue relating to accountability and incentives. While a capitation system works well against this problem, especially for primary health care, Japan's solution, which uses a fee-for-services system, actually tends to incur unnecessary care and increases public health expenditure. To counteract this problem, Japan has utilized various methods, including audits by review organizations, increasing co-payment rates, and introducing a lump sum payment system called the "Diagnosis Procedure Combination," which is similar to the diagnosis-related group (DRG) classification system. The involvement of professional associations in the development of guidelines and self-regulation was also indicated as a helpful strategy to curb the overprovision of care.

Data integration

Data integration, or creating a common data system that is accessible to all healthcare service providers and insurers, was pointed out as a challenge. Lack of integrated data between the public and private sectors makes it impossible to follow patient health and medication records when they use services out of the designated facilities or scheme. Another notable example is a loophole in infectious disease surveillance; in many countries, private providers are not included in the health information system and fail to report patients' information to public health authorities. A sensitive issue is patient privacy. This requires a sophisticated method of data anonymization as well as development of legislation.

Private service provision by public providers

Recently, there is a global trend where public hospitals created a "premium" wing (an exclusive area) for their private patients. These areas offer higher quality healthcare services than general service areas. The medical fee is cheaper than that charged by private hospitals because of the utilization of public resources, including HRH. The basic idea is that public hospitals with private wings can reinvest the additional gains from private patients to public services, which are often under severe budget constraints. However, the concern is that public hospitals – which are supposed to serve poor patients – may subsidize affluent private patients or private entities through this mechanism, devoting much needed public resources. The extent of cross-subsidization is not well measured in many settings. A lack of accountability was mentioned as an underlying issue. Managing and regulating this new trend remain challenges.

Purchasing and procurement

Group or bulk purchasing of pharmaceuticals and medical supplies is an efficient mechanism using advantages of economies of scale to reduce costs. In many countries including Thailand, the public sector benefits from this group purchasing system, but often private institutions have to buy medical products at a higher cost due to low volumes. However, the Kenyan private sector has gone one step ahead; it has established a member-driven pharmaceutical group purchasing organization. The PPP arrangement, in which the private sector joins

the public group purchasing system, may bring benefits in health service delivery as well as to the private providers themselves. However, clear policies and procurement guidelines are required.

Recommendations

The possible contribution of the private sector to UHC is significant both in scale and scope. A government should develop an explicit policy outlining the role of the private health sector, its framework, guidelines, and regulations, in order to promote the PPP and maximize their contributions. This may require reforms from a traditional public financial management system by introducing new provider payment mechanisms, thus also requiring a change in mindset to allow private players to reap the benefits under the public scheme.

An important point here is that the new mechanisms should be built based on the dialogue and collaboration among multiple stakeholders. There are many approaches to involve private healthcare providers, including negotiation and trust-building with professional associations, the introduction of effective payment systems, and financial incentives such as tax reductions offered to for-profit institutions. Participation of patients, the general population, and civil society groups is also essential to realize people-centered services; countries shared various approaches such as representation at the regulatory level, public hearings, and community participation on the distribution of information concerning new health policies. To strengthen the continuum of care, technical support by ICT experts on data integration is also necessary. It would also be useful to seek financial and technical support from international development partners. Considering that UHC links to various social issues such as social protection, human resource development, and industry development, the collaboration may need to extend beyond the health sector.

A key element to enhance these collaborations is to have an enabling environment. This should include the involvement of an organization that represents the private sector and a platform for collaboration. A good example of the former is the Kenya Healthcare Federation (KHF), established in 2004, which consists of a wide range of non-state actors including hospitals, insurers, and ICT players. KHF unifies their voice and maximizes the contribution of the private sector. An example of the latter is Thailand's National Health Assembly, which provides a process and a platform for policymaking with an emphasis on inclusive

participation from the government, academia, professionals and the general population. Timing is also an enabling factor: "Looking for the appropriate time is important when we need structural reform."

Lastly, a government and its health authorities should have a strong stewardship and prevent conflicts of interest to improve accountability and eradicate corruption in its UHC system.

Conclusion

The country presentations and subsequent discussions highlighted key elements for effective strategies concerning collaboration with private health care providers in UHC despite the different levels and mechanisms among the countries. Key elements include a strong political commitment, a mechanism that enables participation of all stakeholders including the general population and civil society groups, HRH management, data integration, incentives for the private sector, and accountability.

This meeting was a part of GLO+UHC project activities between Thailand and Japan, which aims to expand the knowledge and experience of the two countries to its partner countries. All participants of the meeting will be expected to follow and share the achievement and the new challenges on PPP continuously for better UHC around the world.

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The Partnership Project for Global Health and Universal Health Coverage (GLO+UHC)