Source: *The Business Times,* p23
Date: 3 March 2015

Singapore will still have to watch its health-care situation in terms of access, affordability and quality – and also in relation to its changing demographic and socio-economic conditions. It will have to consider, for instance, whether its government health-care services, financed mainly through taxation, is the sustainable route when the incidence of chronic ailments among its greying population goes up. PHOTO: KUA CHEE SIONG/ THE STRAITS TIMES

The public-private formula for universal health coverage

By Phua Kai Hong

A REFLECTION on experiences in health policy revolves around the key question on the government's role in relation to private sector engagement in the provision of health services, financing, regulation, and information management.

Is there conclusive evidence yet to determine the optimum mix that could best respond to the realities and emerging needs of all countries in the key dimensions of universal health coverage (UHC)?

A mixed framework needs to re-examine the active engagement of all sectors to establish a proper balance of the trade-offs between equity and efficiency in managing the UHC model.

However, the UHC concept is often confused with a one-size-fits-all approach of financing through a universal health insurance (UHI) scheme. There are, of course, other forms of financing, and the government's role in facilitating revenue collection and transfers – whether through taxation, savings or insurance – could be complemented by private means.

In general, there is a need to increase UHC and to improve basic public health care, allowing for those who want more choice and higher quality, and promoting healthy competition among the various providers. Comparisons of health-care public-private partnerships show the extent of policy changes in government functions, which are being managed in partnership with the private sector. These partners include non-profit bodies that offer engagement in four components, namely, service provision, financing, regulation and public education.

To understand the interplay of these roles, basic factors need to be considered. One is the changing role of the state versus the market as countries make the transition from one stage of development to the next.

Another is how public- and private-sector interests influence financing. Public-sector practitioners also need to assess their roles and priorities in meeting domestic needs vis-à-vis the external market. The rise of the aging population requires an expansion of health systems to include social care and extended roles of the family and community. Admittedly, there is no "perfect" model of UHC and mixed systems are therefore dependent on a balance of stakeholders' interests in a particular country context.

There is consensus that countries should commit to UHC and improving health systems so that the whole population can access care without suffering crippling financial costs. This issue is more pressing during times of economic inflation and electioneering, when political parties jostle for popular votes, and increasingly when the aging electorate demands more health care and welfare support.

Achieving UHC globally is therefore a noble ambition that could potentially transform more lives than any of the anti-poverty schemes promoted by the United Nations. Some100 million to 150 million people each year suffer financial catastrophe as a result of having to pay high prices for medical care, forcing governments, families and individuals to choose between health and housing, schools, and even food.

But sadly, the signs are that many countries will end up over-promising and under-delivering. This is because many well-meaning proponents of UHC tend to conflate and mix it up with UHI, in which all citizens subscribe to a single national insurance fund, topped up with government revenues. Such funds are often the dominant or sole models among countries moving towards UHC. But UHI is seen by many ideological groups as the magic bullet to address the woes and pains of the health-care system, by promising equality of access for all people, regardless of wealth, while giving extra money for patients, doctors and hospitals. Governments have to address the health policies of what, where, how, and how much to provide in UHC (efficiency issues), and who pays and who benefits? (equity issues).

REFORMS COME FIRST

Free health care is certainly politically alluring, but many countries and politicians are jumping on this bandwagon without first undertaking necessary reforms of their health systems. Giving people free access to care is useless if clinics and equipment are decaying, quality is low, and doctors and nurses are too few and poorly paid. Can bringing more insurance money for risk-pooling but not managing its proper use lead to greater efficiency and equity in providing health care?

But this is the unfortunate reality in most developing countries, a situation compounded by poor governance and corruption. It is well known that many public medical systems function with kickbacks from suppliers and illegal payments to decision-makers and doctors, as easy financing may come from the sales and consumption of drugs and medical devices. Capacity problems are exacerbated if seemingly "free" national health programmes unleash tidal waves of new demand without accompanying health-sector reform. This is what has happened in many countries when new national insurance schemes are poorly implemented, without effective balancing on the supply side.

That is not to say that UHC is an impossible dream for all countries in seeking an optimum mix in health care. But instead of just instituting politically popular but unrealistic UHI, governments need to think carefully about how limited public-sector resources can best be deployed. One policy option would be for governments to increase their spending on basic public health measures, such as improving sanitation, vaccination and maternal and child health services. This would be of enormous benefit to the poorest and most vulnerable, who suffer a disproportionate burden of preventable infectious diseases. Limited public resources should focus on supplying essential services to vulnerable target groups, instead of trying to offer everything for free to everyone.

The private (including the voluntary non-profit) sector has important roles, but many proponents of UHI tend to downplay their importance. In Africa, nearly half of patients now use private or non-state providers, as do three-quarters of the poorest children in Asia. Instead of trying to duplicate their services in a misguided pursuit of social equality, governments should ensure the private sector serves the interests of the poor, through more effective collaboration and partnership. Without such continued participation, UHC is incomplete and will remain inaccessible to many.

Although having developed public-health systems that are closest to attaining UHC, the former British colonies in our region – Sri Lanka, Malaysia, Brunei, Hong Kong and Singapore – will still have to watch the health-care situation in terms of access, affordability and quality, and in relation to changing demographic and socio-economic conditions. With the rise of chronic diseases among the rapidly-aging population, are the government health services that are financed predominantly by taxation sustainable to a more demanding public? Many non-profit providers (including voluntary welfare organisations and faith-based or religious bodies) are driven by welfare objectives – to mobilise scarce resources towards new needs of the poor, vulnerable or marginalised, identifying and closing gaps that the state or market cannot address. They provide checks against excessive profit-seeking and a moral compass for the attainment of higher social goals for both public and private sectors.

Empirical evidence attests to the potential benefits to be derived from an optimum mix of public and private care, particularly in improving accessibility, efficiency and quality. While stronger government regulations and better governance can contribute towards achieving equity in implementing reforms for UHC, sustainability must also be a prime consideration. But what should be public and what should be private in health-care allocation? Should the bulk of the public purse go towards displacing out-of-pocket expenses and for what levels of care? Could essential public health and primary care be optimally provided as a public good, separate from costly catastrophic or chronic care that are suitably risk-pooled under some form of social health insurance?

Comparative studies of health systems show varying choices and organisational modalities in the public-private mix in health. A past World Bank study of public hospital reforms in 18 countries showed that the National Health Service model of predominantly tax-financed and centralised health services is the common model to be reformed. There are limitations in privatisation models which have increasingly evolved into hybrid models. Malaysia, Singapore and Hong Kong, with some of the most advanced hospital reforms, adopt what can be considered as autonomised and corporatised units. A major lesson from the World Bank studies points to the need for a coherent incentive scheme to influence the supply side, to cover critical elements of human resource and financing. Stakeholders need incentives for them to have effective partnerships. Complementary reforms also have to take place alongside incentives, in areas of stewardship and good governance, performance-based purchasing, and information systems.

PUBLIC-PRIVATE-PEOPLE

The risk is without optimal integration and public-private-people sector involvement, the drive towards UHC will only create insurance bureaucracies that cost a lot but achieve little.

By contrast, reform-minded countries with political will and good governance have shown that UHC can be achieved without spending a disproportionate amount of the budget, while balancing the goals of efficiency and equity in their health systems.

UHC should involve the public and private sectors with the rest of civil society, including voluntary organisations and individuals. As countries democratise and globalise, governments have to manage the expectations of the Third Sector in providing avenues for its involvement. The key is applying the right touch in the adoption of a tripartite model. Governments must examine areas of competition and assess not only where the market fails but also its own shortcomings. The public role should clearly balance equity with efficiency in UHC, provide affordable social protection for the needy and vulnerable, finance public-health services and regulate basic standards. Moreover, governments need to consider an important but often neglected role – the provision of public information regarding the use, costs and quality of care to enable better allocation and more informed utilisation.

In conclusion, there is a need to increase health coverage throughout the world, but this can be attained with governments sharpening the allocation of their limited tax dollars towards the public health services, while shifting the provision of more consumptive procedures to a complementary private sector. By concentrating on the improvement of basic public health care facilities while allowing for more public choices and promoting healthy competition among the three sectors in public-private-people participation, the goals of maintaining UHC may be more sustainable. Governments should therefore take an inclusive "whole of society" approach to expand the scope of UHC in balancing critical components of the health-care system, while integrating policy levels for the participation of all sectors.

Dr Phua Kai Hong holds a tenured appointment in Health and Social Policy at the Lee Kuan Yew School of Public Policy, the National University of Singapore. The above is excerpted from a paper he presented at the WHO ministerial meeting on Universal Health Coverage in Singapore in February