Kalusugan Pangakalahatan:
A Private Sector's response to Universal Health Care

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Acknowledgements due to: Universal Health Coverage, Health Security and Resilient Health Systems by Banzon & Ho (2016), How Budgeting Practices on Health Care Equipment May Fail Government Hospitals by Banzon, Alcantara, Diez & Sayson (2016)

Executive Summary

- Define the roles and responsibilities of the government and the private sector in service delivery. Service delineation can minimize duplication and hence improve efficiency but providers must remain integrated.
- Capacity planning must involve the agencies of the national and local government working together with the private sector.
- Institutionalize a mechanism in selecting and incentivizing trusted partners in the private sector.
- Make capital outlay funding available to the trusted partners in the private sector. Health Facility Enhancement Program (HFEP) of DOH could potentially be a funding platform for Public-Private Partnerships – harnessing the efficiency and expertise of the private sector to procure equipment/instruments/supplies, build infrastructure, and deliver services.
- Costing of healthcare packages must cover general overhead and operating expenses.
- Expansion of NHIP (PhilHealth) Benefit Packages in cost and condition coverage with the private sector actively sharing data on actual healthcare costing.
- Expertise sharing on contract design and management, including definition of service-level agreement between the public and private sector in PPPs
- Management/Operational contracts for private sector to man and operate healthcare facilities
- Streamline taxation for hospitals.
- Board of Investments, in partnership with DOH, to ensure/negotiate tax and other incentives on behalf of partners in the private sector.
- Collaborate in the rapid and sustainable scaling up and rolling out of public health programs, where private sector can be involved both in education and delivery (e.g. private sector as a platform for vaccination, etc.).
- Review and streamline regulations to ensure that they support and incentivize fitting healthcare innovations.
- A hub-and-spoke model can be adopted in healthcare service delivery where the private sector can provide majority of the specialty and sub-specialty care while LGU can focus on primary and community care, with DOH overseeing, supporting and regulating quality, access and pricing of healthcare.

Knowing the Demand – "The role of the Middle Class"

Where there is demand, the private sector sees it as opportunity to expand its scope of operations. According to Credit Suisse Research Institute (2010), that special attention must be given to the behavior of the middle of the pyramid (MOP) as this has been seen and predicted to drive market forces. For example, suppliers were pushed to develop affordable products to meet the demands of the huge population of the Asian MOP as it does not have the same spending power of the Western MOP.

As it is in other industries, this will also be the trend in healthcare – to make healthcare affordable by reaching out to an expanding market, both in size and demand. This increasing demand provides more incentives for players in the private sector to design affordable and quality healthcare products.

What would be the best role for government and the private sector?

Box 1 – Premise Setting

Health is a shared good/value hence responsibility must be shared among key sectors as well. Consistent with the main thesis of the social determinants of health, perfecting service delivery is not the *be all and end all* goal as health is multi-faceted – affected by wealth index and education, just to name a few. Although there is inter-sectoral collaboration, much still remains to be done to ensure that key sectors are collectively committing and working towards the same or parallel goals. It must also have concrete definition of roles – a prerequisite to impose accountability. In order to achieve optimal healthcare, the continuous efforts of the Department of Health in improving the facilities, quality and regulation, and service delivery need to be supported by a national blueprint that involves the other key sectors. Kalusagan Pangkalahatan (KP) must not entirely be a deliverable of the Department of Health, but rather, a shared responsibility of the different agencies of the national and local government working together with the private sector. Having majority of the hospitals being owned and operated by the private sector poses a sufficient reason for government to work with the private sector and align them to the framework of KP.

KP Framework should institutionalize the discipline of accountability through role definition. To achieve real inclusive growth, capacity planning of healthcare should involve the private sector. There must be a cohesive mapping of the capacity of public and private sector – infrastructure, logistics and health human resources, as well as identification of areas for collaboration, and how development and non-government agencies can support these areas.

Capacity Planning

There should be a two-level planning – one at the national level, the other at the LGU. Capacity planning at the national level must not only include the identification of key sectors, but moreover define the role and involvement of the stakeholders, including the development and non-government agencies and the private sector. Although priority areas have been defined (Hi-5 – Maternal Health Care, Infant Care, Child Care, HIV/AIDS and the Service Delivery Network), more specific areas for engagement must be defined to eliminate duplication and to identify areas that need further reinforcement. These areas must be supported by measurable parameters.

Philippines being archipelagic in nature must harness devolution (Local Government Code) to deliver KP by primarily defining and the streamlining the mandatory health services ought to be delivered in the different levels of local governments.

By understanding and defining the inclusions of service delivery per level, we can now identify which should or could be delivered by the private and public sectors. This service delineation will create a more efficient and sustainable delivery of care as it limits duplication and promotes the compounding effect of the unified and streamlined efforts in achieving parallel goals – more business for the private sector, KP delivery for the government.

Collaboration

These areas for collaboration must provide reasonable incentives and preferential treatment to the players of the private sector willing and committed to partner and cooperate.

Areas for collaboration:

- Data and information sharing
- Expertise sharing and cross-training of health human resources
- Shared logistics (e.g. procurement)
- Costing for healthcare services
- Service Delivery and Infrastructure Building
- Roll-out of Public Health Programs

BOX 2 – Specific Areas for Collaboration

- Health Facility Enhancement Program (HFEP) of DOH could potentially be a funding platform for Public-Private Partnerships – harnessing the efficiency and expertise of the private sector to procure equipment/instruments/supplies, build infrastructure, and deliver services.
- Expansion of NHIP (PhilHealth) Benefit Packages in cost and condition coverage with the private sector actively sharing data on actual healthcare costing.
- Expertise sharing on contract design and management, including definition of service-level agreement between the public and private sector in PPPs
- Management/Operational contracts for private sector to man and operate healthcare facilities
- Roll-out of public health programs, both in education and delivery (e.g. private sector as a platform for vaccination, etc.)

Incentivize partners in the private sector

The private sector would much welcome incentives, benefits and assistance from the national government through the Department of Health. To recognize its effort, inclusion in the priority list of the DTI-BOI is a much welcome motivation for the investors in healthcare; however benefit availment must be made intuitive. Mechanism to identifying partners in the private sector must also be institutionalized to encourage the private sector towards working with the government

The recommended areas may range from streamlining taxation to administrative assistance in processing licenses, quality certificates and/or PhilHeallth claims.

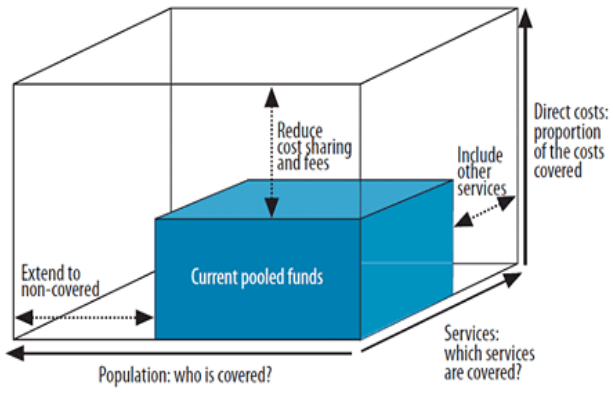
- Taxation. Streamline government tax policy on health facilities. Hospitals are non-VAT but are not VAT- exempt. 12% input VAT from suppliers and vendors can only be offset by output VAT in the OPD pharmacy sales and sublease revenues as these are the only VAT-able activities.
- Board of Investments, in partnership with DOH, may ensure/negotiate tax and other incentives on behalf of partners in the private sector. There is also a need to clarify other incentives like the duty free importation of capital goods given to BOI-registered hospitals, tax refund for senior citizen and disability discounts.
- Timing might be opportune to review regulations that can make room for dynamism to support and even promote innovations in the healthcare industry. National Government with the lead of DOH must evolve from being a just regulator to being an enabler in healthcare delivery.

The persistent high out-of-pocket expenditure

The impact of high out-of-pocket expenditure in health simply means that health is designed for and delivered to the paying population. Provision and design of services are merely based on the *demands* (which may be induced by the supplier) of those with the capacity to pay. And because only the paying could afford care, although it may be available, healthcare cannot be accessed by the majority of the population. The policy note argues that it is not market failure (unavailability of services) that is the center of the problematic service delivery but rather the inability to pay for these services. This is precisely why the government should engage the private sector in healthcare delivery. This is a recognition that private sector has the capacity to deliver care with the caveat that it is rationally policed and regulated.

With the fast growing needs of a market with rising affluence and access to data, disruptive innovations have become a household expression in this day and age. It may be timely for a paradigm shift in the way the national government looks at service delivery and funding – *from spending* for health *to making* health sustainable, *from an outright budgetary expense to investment with pre-defined parameters of returns*. This paradigm shift must also happen in the private sector – *from seeing only the direct impact of healthcare expenditure of its employees to the company's bottomline to seeing it as a long-term investment for higher productivity and less absenteeism.* The sheer size of the private sector demanding for quality and affordable care is more than enough to incentivize healthcare providers to deliver what they need.

There exists double (quadruple) financing in healthcare where funding for health comes from seemingly fragmented multiple channels. This dampens PhilHealth's stance as the health financing institution. Membership in turn becomes elective, and conversely results to lower premium collections – this makes expansion of benefit and cost coverage a challenge.



Three dimensions to consider when moving towards universal coverage

It is recommended that **health financing be channeled to PhilHealth**, but with the **involvement of private sector in creating, designing and costing for healthcare services.** PhilHealth should likewise have preferential treatment for medical facilities consistently delivering to pre-defined and mutually agreed-upon service level commitments. The government may also look into a PPP model for the national health insurance similar to the Daman National Health Insurance of UAE where it is 80%-owned by the government and 20%-owned by a private reinsurer. Daman offers three products: state-subsidized basic healthcare for expats in lower income brackets, extensive private comprehensive cover, and "Thiqa" for the local population. It also allows the Daman NHIP to have access to a bigger global risk pool under the Munich Health Brand. (http://www.globality-health.com/daman/)

Capital outlay funding options from the government should be made available to the members of private sector willing to deliver services within the priority thrusts of KP.

Conclusion

Majority of the points presented in the policy notes are valid, reasonable and evidence-based, backed up by statistics and experience. What becomes alarming though is that, these are not new. Policy notes, researches, and discussion papers have echoed similar recommendations (e.g. Universal Health Coverage, Health Security and Resilient Health Systems,. The more important question is – what do we do now? More than emphasis and reiteration, we need to take a step back and examine why all these sensible recommendations have received little to no traction.

- In terms of PPPs in health, there is no to very little expertise in contract design and management. The contracts in health are unique as the completion of the project should not only be the main goal but rather must be designed in a way to make the stakeholders deliver on improved health outcomes. This does not take just a year or so. This is a slow brewing of capacity and expertise building and sharing. It is suggested that we start with a dedicated multidisciplinary team to do post mortem on the PPPs in health. Opportunities and career pathing must also be provided for human resources who opt to build an expertise on this.
- There is also a need to create a more comprehensive communication plan for PPP to ensure that key sectors understand the real intention of healthcare projects. Likewise, an educated population becomes now empowered to ask for the supposed deliverable of the partnership. This decentralizes the focus and scrutiny from how services should be delivered (whether public or private) to what services should be made accessible. (Focus should not be majorly centered on who must deliver the services, but moreover must focus on the finding the most efficient and responsive channel to deliver quality and affordable services.)
- It has been noted that KP is poorly understood – this is not a new realization. What should we do then? Health needs a common goal, an overarching vision. That seems to be the failure of KP - it somehow failed to articulate a vision. Hence the approach, though with the effort of trying to integrate, seemed fragmented and unaligned. Yes, the way health is viewed becomes too simplistic, as in the way the vision of KP is communicated – health for all. It is not only a bit simplistic, but poses a too motherhood-and-catch-all statement for many. The articulation of the vision should have been coupled with the government being able to make key sectors understand and imbibe their roles and responsibilities to make health for all happen. But as it has been continuously argued, there is no clear cut role definition. There is a need for a capacity planning - a nationwide strategic planning. It is heartbreaking to see that because of the lack of one common goal, sectors become even more fragmented and unguided.
- Robust role definition should then have incentive mechanisms in place.

We need to start moving aside our differences and start working and building on the expertise needed. We should go beyond signing manifestos and pledges, but must be able to define measurable indicators of success attributable to specific key sectors.

Kalusugan Pangkalahatan: Private Sector's response
April 2016

Answers to Guide Questions

1. In recent years, much of the discussion on healthcare financing has been centered on Universal Health Coverage (UHC) and PhilHealth. We can think about UHC in terms of 1) population coverage, 2) cost sharing, and 3) range of benefits/services covered. Knowing that Philhealth has now achieved 87% population coverage, **what should be the next step for PhilHealth to moves towards UHC?**
   PhilHealth should embark on accounting for realistic costing for healthcare services and expand its benefit coverage to include primary care and chronic diseases. In this way, PhilHealth can sufficiently substantiate increase in premiums should the need arises. This can be done by collaborating with trusted private hospitals and subject matter experts.

2. It was earlier recommended that we move towards more preferential spending for the poor/socialization of healthcare. **How realistic is socialization of healthcare/preferential spending for the poor?**
   In the very essence of universal healthcare, there should be equitable access to the same benefits and packages for all segments of the population. Fragmented offering of benefit packages (i.e. offering PCB only to indigents) defeats the goal of universalizing care. Instead of preferential spending for the poor, investments must be made in the context of economies of scales (population reach and demand) and sustainability (continuity of capacity to deliver care). The identification of who the poor are just increases admin cost – it politicizes provision of care because framework for identifying the poor can be very subjective, as experienced by the NHTS implementation.

3. As discussed, out-of-pocket spending is not necessarily a bad thing. From your perspective, **what would be the ideal cost-sharing/balance between different sectors (public, private, out-of-pocket) and why?**
   Ideal cost sharing is dependent on the segment of the population. Two things must be made into account – power of choice and ability to pay. This is however with the strong stipulation that the mandatory inclusions of the benefit packages are reasonably delivered.
   - **Zero-balance Billing**
   - **Fixed Co-payment – for those who want to exercise limited power of choice**
   - **Unlimited Co-payment**

4. We've spoken in detail about healthcare spending, but there also seems to be a need to increase/improve facilities and resources as a means to increase this spending. In fact, it was pointed out that the DOH returns anywhere between PhP400M-1B of its annual healthcare budget due to such issues. **How do we improve overall access in terms of facilities (whether primary or tertiary) and resources, specifically human resources?**
   Health is a shared good/value hence responsibility must be shared too among key sectors. However, although there is inter-sectoral collaboration, it is insufficient and no to very little definition of roles, a prerequisite to impose accountability. Kalusagan Pangkalahatan remains to be entirely a deliverable of the Department of Health.

   To achieve real inclusive growth, capacity planning of healthcare should involve the private sector. There must be a cohesive mapping of the capacity of public and private sector – infrastructure, logistics and health human resources, as well as identification of

areas for collaboration, and how development and non-government agencies can support these.

Nationwide hub-and-spoke Model

A hub-and-spoke model can be adopted in healthcare service delivery, where the private sector can provide majority of the specialty and sub-specialty care while LGU can focus on primary and community care, with DOH overseeing, supporting and regulating quality, access and pricing of healthcare.

5. For Dr. Edwin Mercado: **Is the private sector more equipped to provide affordable quality healthcare?** To what segment? How can the public and private sector collaborate more?

The private sector enjoys autonomy and lack of bureaucracy but is disciplined by its performance metrics (bottomline and profit margin targets). This environment pushes the private sector to be more efficient and judicious in delivering healthcare, not to mention imposing accountability to the members of its organization. Achieving economies of scales is critical in delivering affordable and quality healthcare. Looking at the economic and population growth trend, the Middle of the Pyramid (MOP) has been constantly expanding. Where there is demand, the private sector sees it as opportunity to expand its scope of operations. According to Credit Suisse Research Institute (2010), it said that special attention must be given to the behavior of the MOP as this has been seen and predicted to drive market forces. For example, suppliers were pushed to develop affordable products to meet the demands of the huge population of the Asian MOP as it does not have the same spending power of the Western MOP. As it is in other industries, this will also be the trend in healthcare – to make healthcare affordable by reaching out to an expanding market, both in size and demands.

Areas for collaboration:

- **Data and information sharing**
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- **Shared logistics (e.g. procurement)**
- **Costing for healthcare services**
- **Service Delivery and Infra**