The role of the private sector in healthcare financing

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World Health Organization

Achieving UHC: the critical role of the private sector

FINANCING

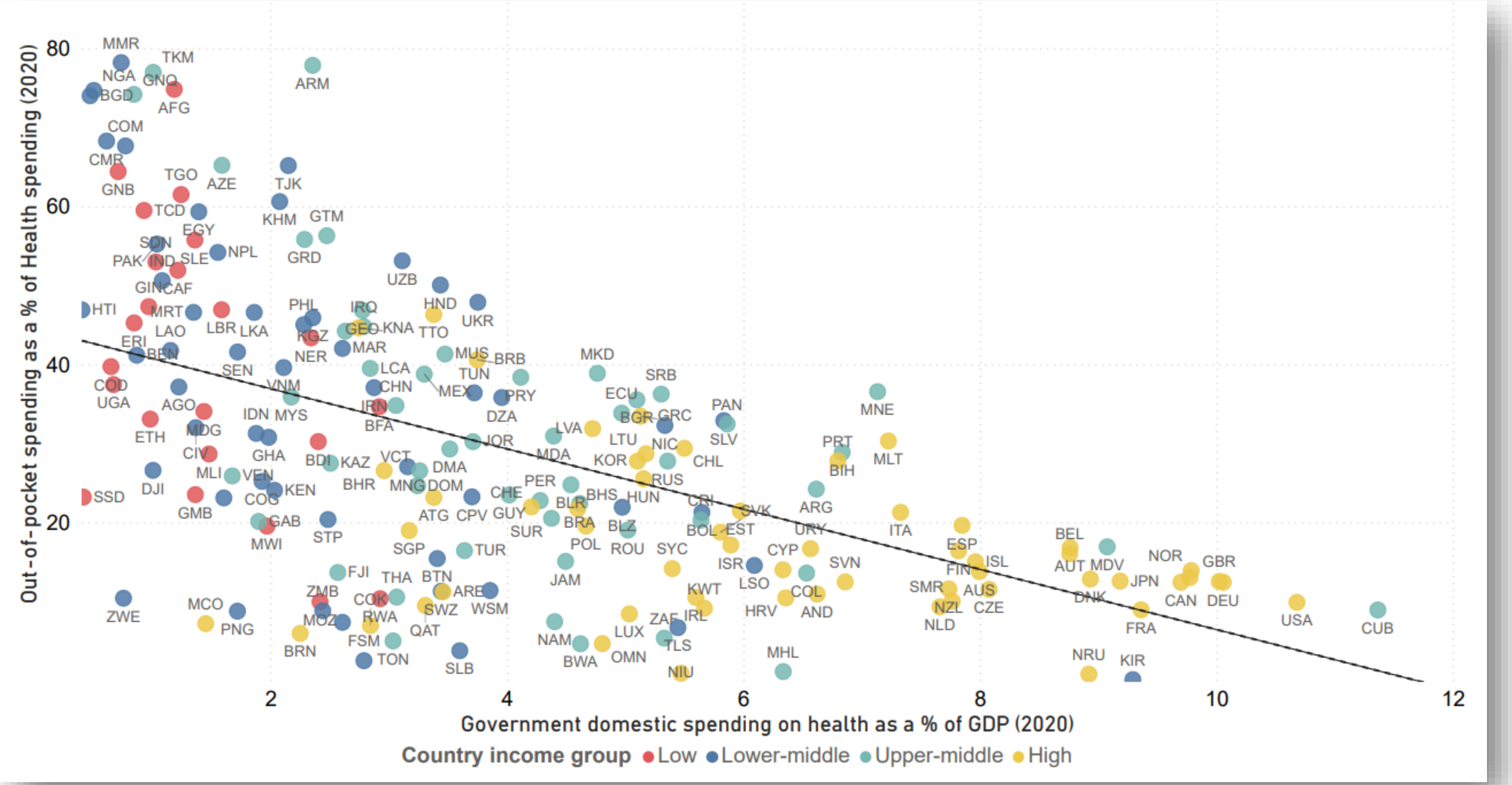
The key to sustainable financing for UHC: mandatory, pre-paid & pooled

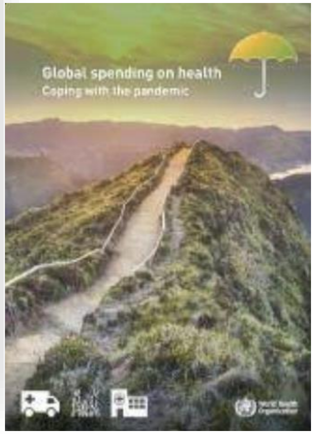
"Prioritize reaching full population coverage quickly, by providing a universal entitlement to a comprehensive (but affordable) package of publicly financed health services. This is preferable to creating fragmented health insurance schemes for different socio-economic groups and expecting people in the informal sector to pay health insurance contributions."

https://www.chathamhouse.org/2024/06/driving-universal-health-reforms-through-crises-and-shocks

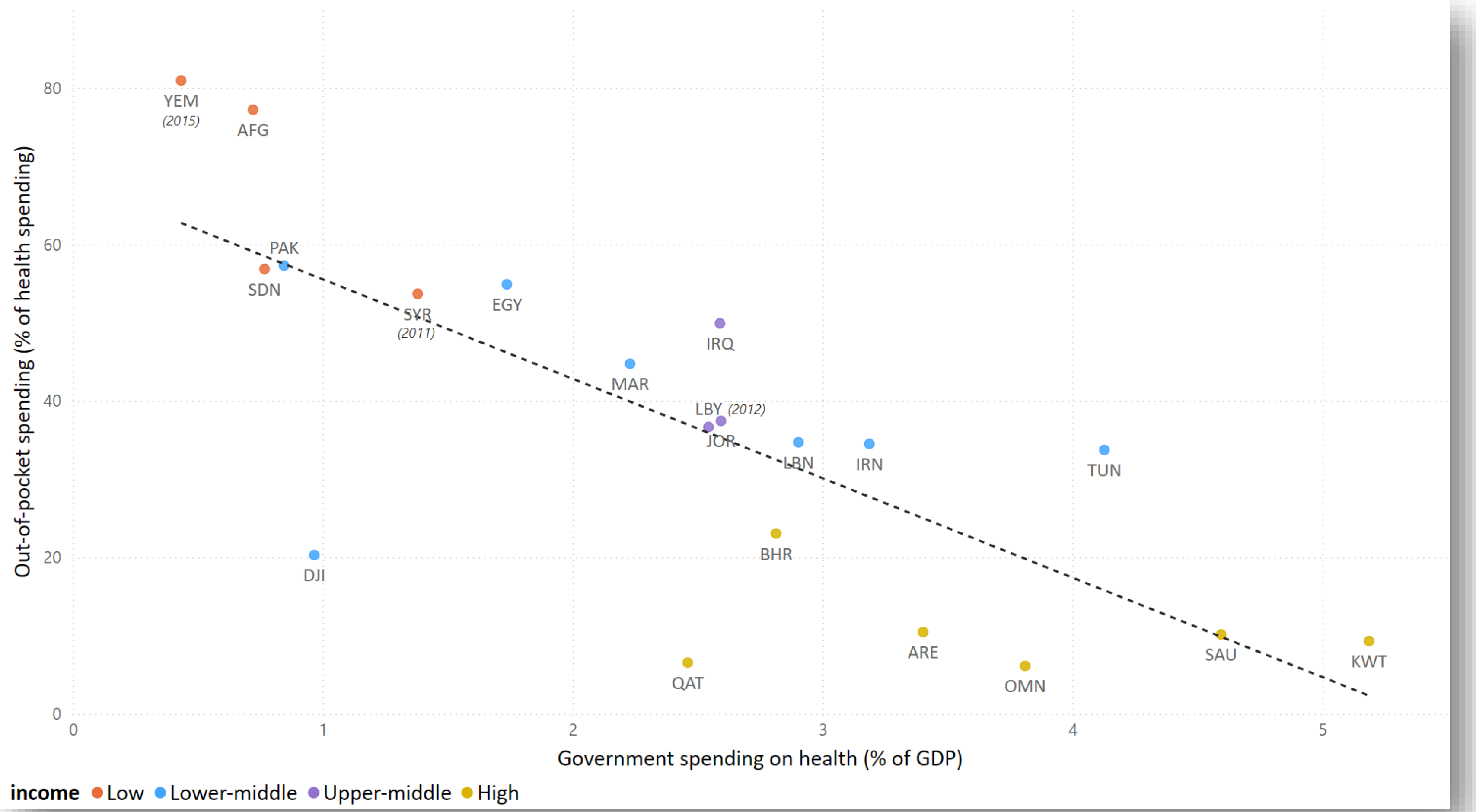
Public financing is central to UHC progress

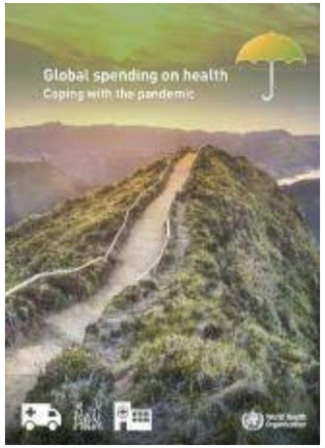
Financial protection



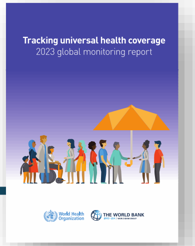


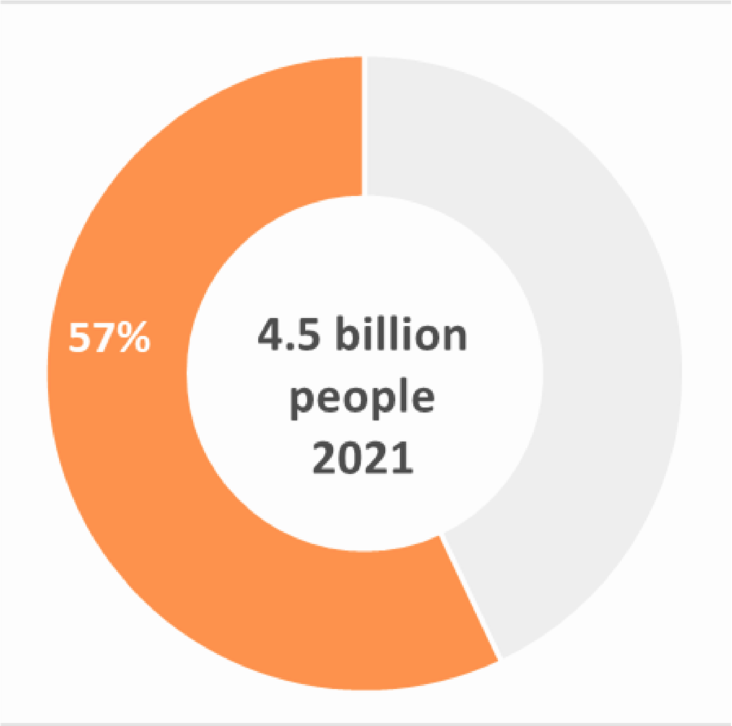
Similar pattern in the EMR countries



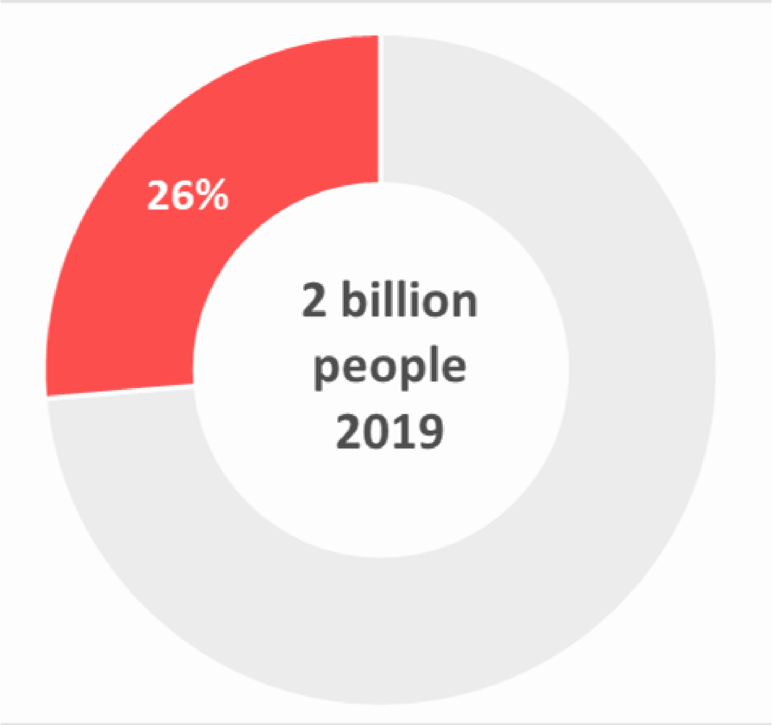


Overall, billions are left behind on the path to UHC !





Lack full coverage of essential health services

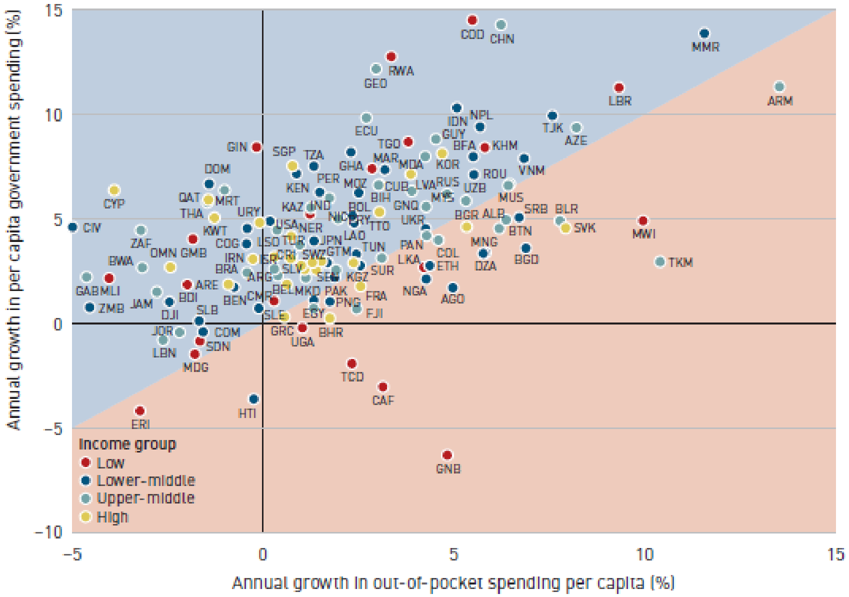


Face some form of financial hardship due to OOP health spending
(catastrophic, impoverishing or both)

Overall, billions are left behind on the path to UHC ! Why?

Most countries made efforts to invest more public money in health (2000-2019)

FIGURE 1.8 In most countries, annual growth in government spending on health in real terms was higher than growth in out-of-pocket spending (OOPS) from 2000 to 2019



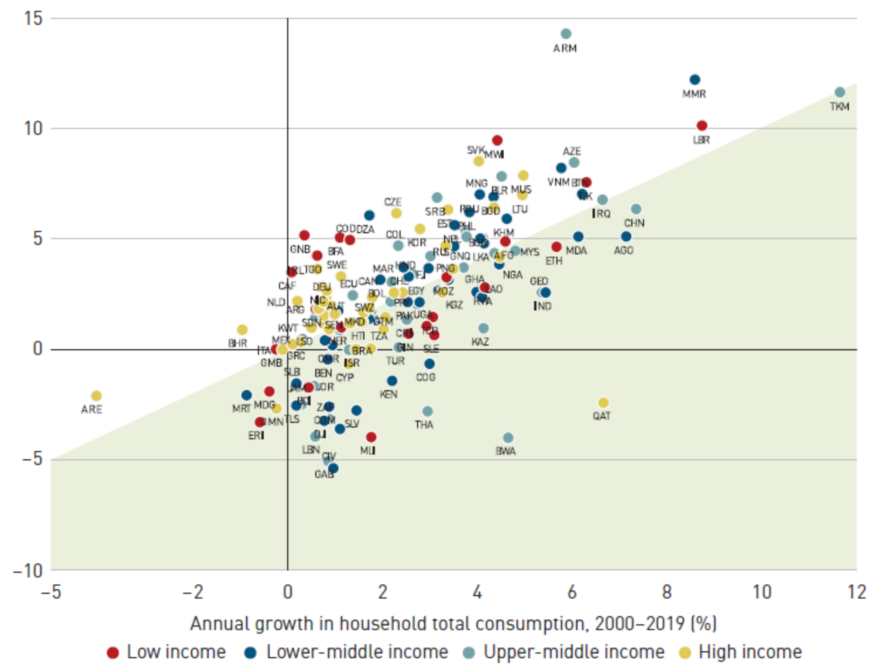
Note: Growth rates are based on per capita values in constant (2020) national currency units. Country-specific gross domestic product deflators were used to convert current values to constant values. Only countries with data for all years (2000–2019) are included. In countries in the blue shaded area, annual growth in government spending on health was higher than growth in OOPS; in countries in the red shaded area, annual growth in OOPS was higher.
Data source: WHO Global Health Expenditure Database, 2022.

but

- Evolving population needs and demands
- Government investment priorities
- Unaddressed inefficiencies
- Medicine price inflation…

Out-of-pocket health spending is absorbing a greater share of household's budget (2000-2019)

FIGURE 1.12 Out-of-pocket spending per capita increased in relation to household total consumption in half the countries analysed and decreased in the other half



Note: Annual growth rates are based on per capita values in constant (2019) national currency units.
Data source: WHO Global Health Expenditure Database, 2021.

Overall, billions are left behind on the path to UHC ! Why?

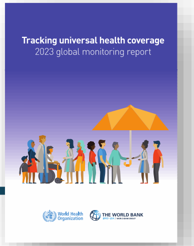
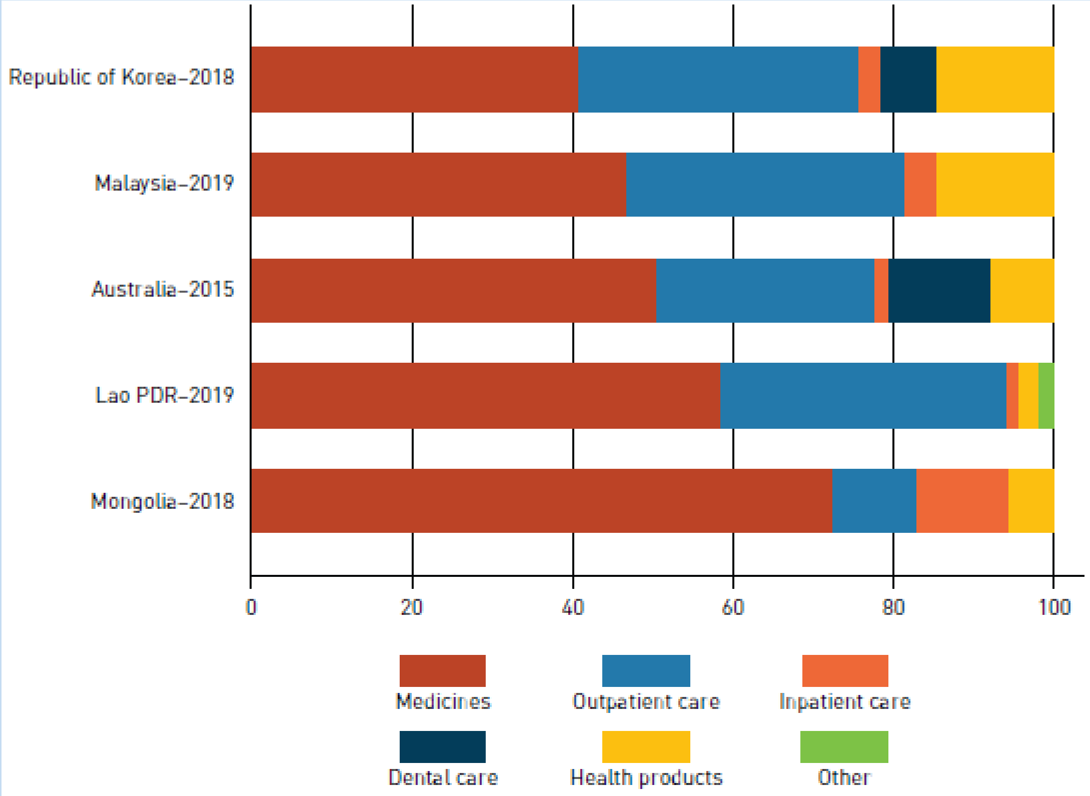


Fig. 4.8. Composition of OOP health spending, the latest year available, evidence from various countri

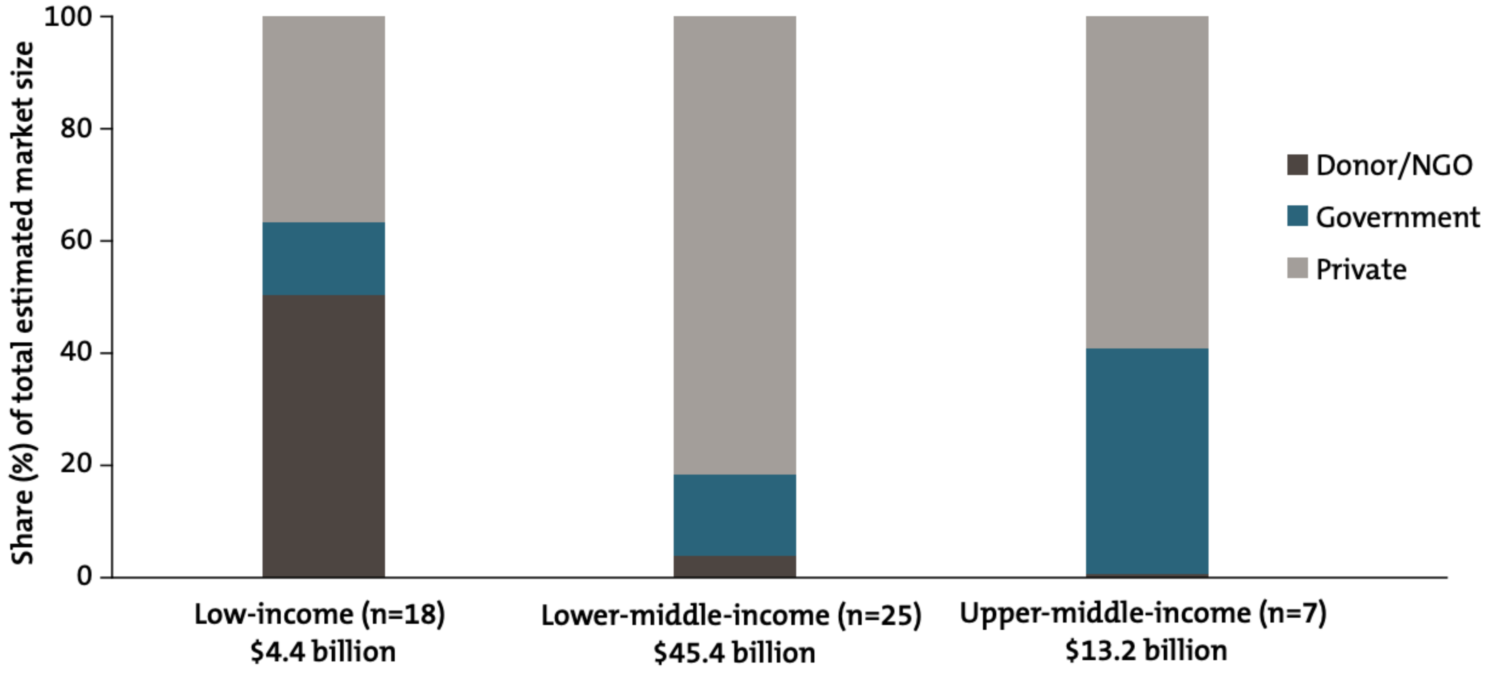


Source: Background data prepared by WHO for the forthcoming WHO Western Pacific Region report on financial protection *(90)*.

- **Publicly funded benefit packages are not comprehensive enough or services/treatments included not sufficiently readily available/accessible**
- **Medicines are the main drivers of household's out-of-pocket health spending**

Private (OOP) financing of commodities

Private, Government, and Donor/NGO Financing as a Share of the Total Estimated Market (Value) for Health Products by Country Income Groups



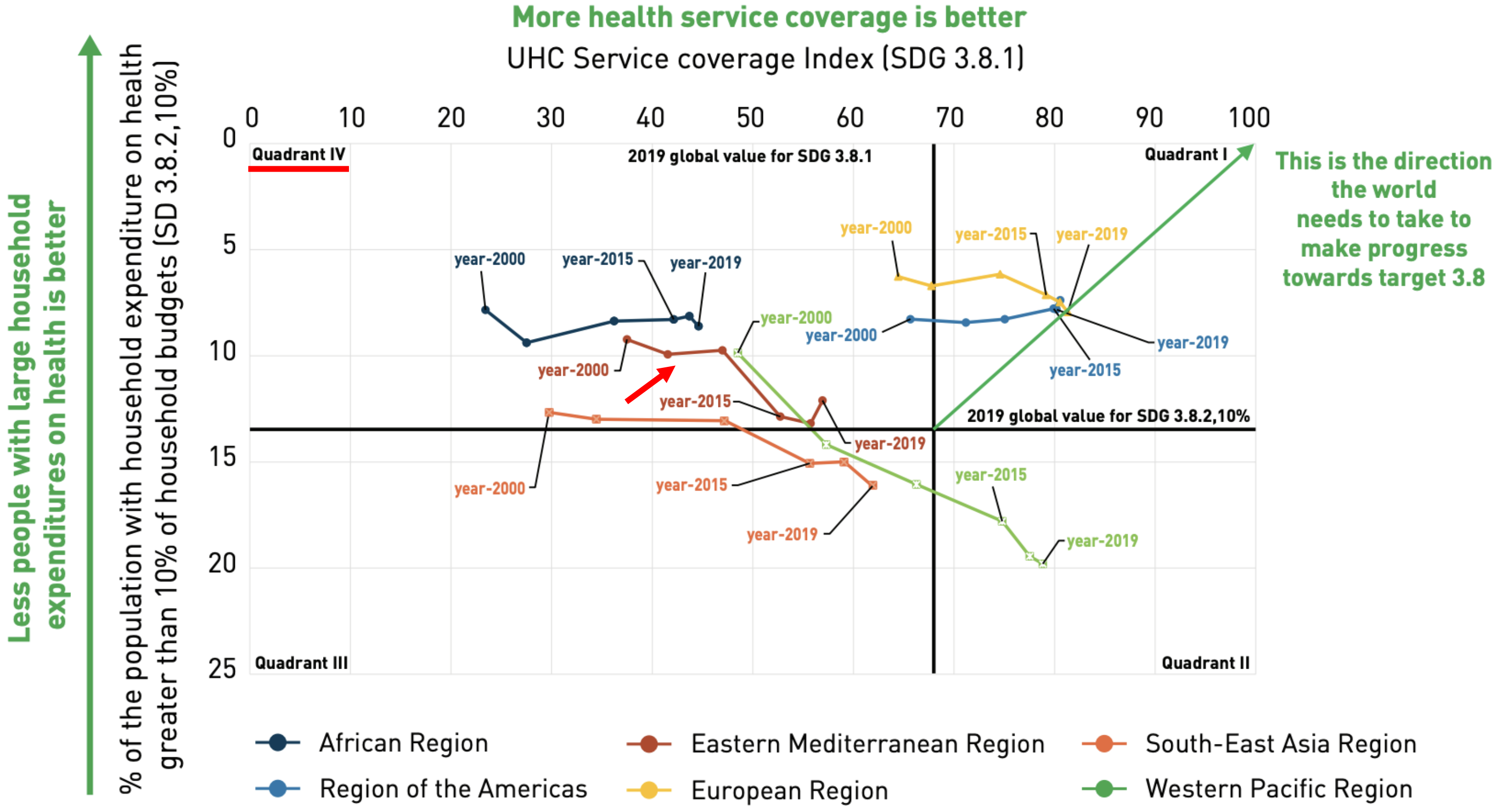
- There is nothing deterministic about transitioning to higher government share of financing commodities as countries become wealthier.
- In LMICs, the gap left by donors is picked up not by governments but by households

https://www.cgdev.org/sites/default/files/tackling-triple-transition-global-health-procurement-brief.pdf

What is the situation in the Eastern Mediterranean Region?

- The WHO African and Eastern Mediterranean Regions have relatively low service coverage and low catastrophic OOP health spending compared to the global values in 2019
- In EMR, the increase in service coverage was concurrent to an almost continuous increase in the incidence of catastrophic OOP health spending from 2000-19
- 89 million people (poor and non-poor) were faced with catastrophic health spending in 2019
- Medicines were the main drivers of OOP health spending in the LICs and MICs from EMR and accounted for over 50% in Pakistan, Afghanistan, Somalia and OPT.

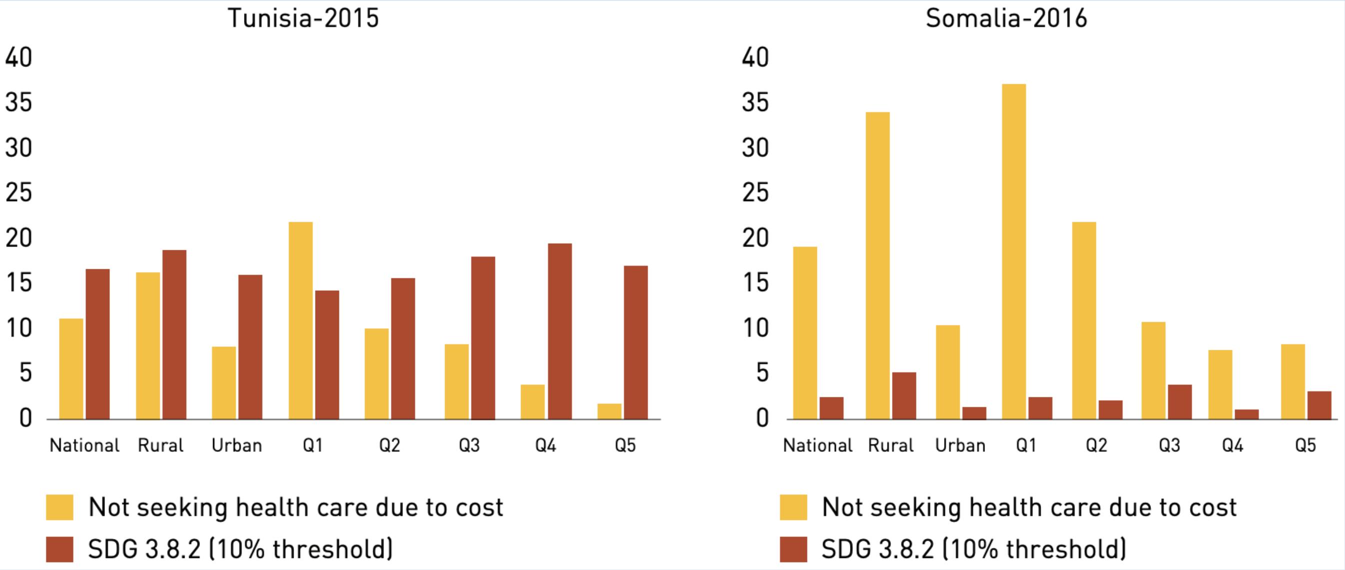
Fig. 4.3. Joint progress on SDG 3.8.1 and SDG 3.8.2, by WHO region



Low rates of catastrophic spending are not always a good thing…

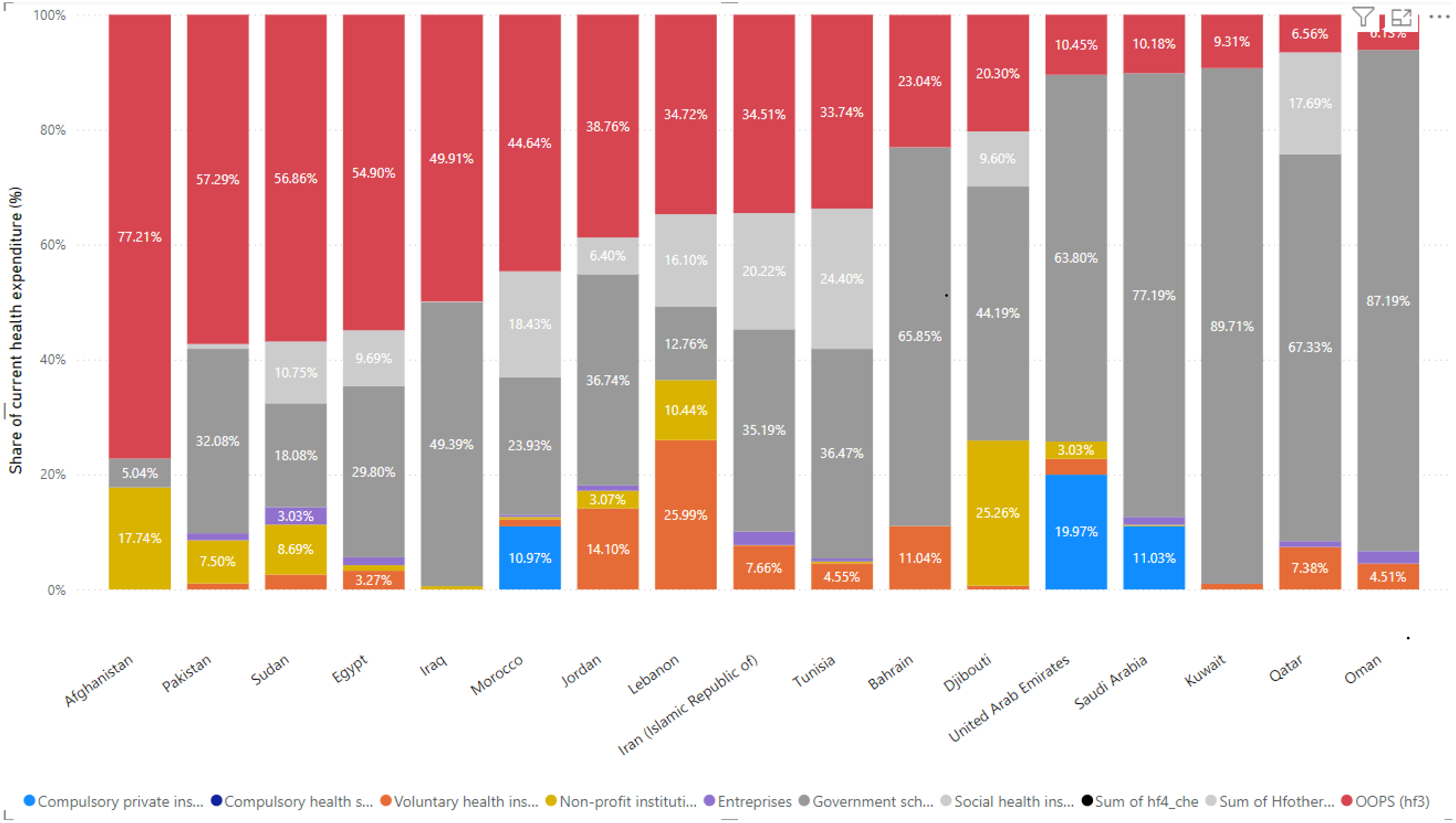
- Financial hardship indicators may be low simply because people cannot afford to pay for the health care they need (and things may have worsened during and post covid)
- The highest rates of forgone care due to costs were always found in the poorest (37% in Somalia, 4% in Tunisia) and rural areas
- Differences in the rates of financial barriers between the highest and lowest quintiles are much stronger than differences between rates of catastrophic OOP health spending

Fig. 4.10. Financial barriers and catastrophic OOP health spending incidence in Somalia and Tunisia



Health financing arrangements of EMR countries

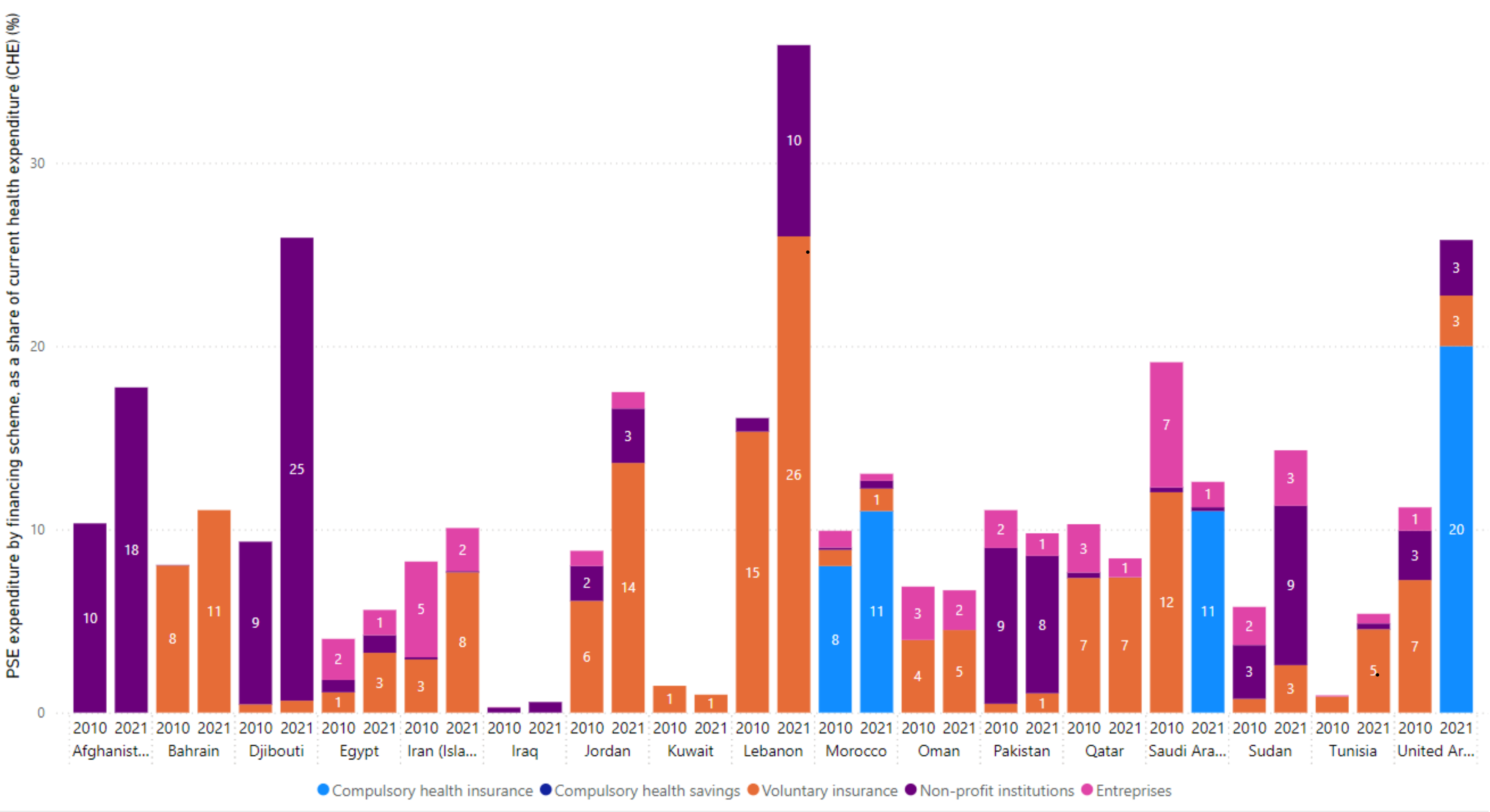
Composition of health spending by financing scheme



Health spending through private sector in EMR countries

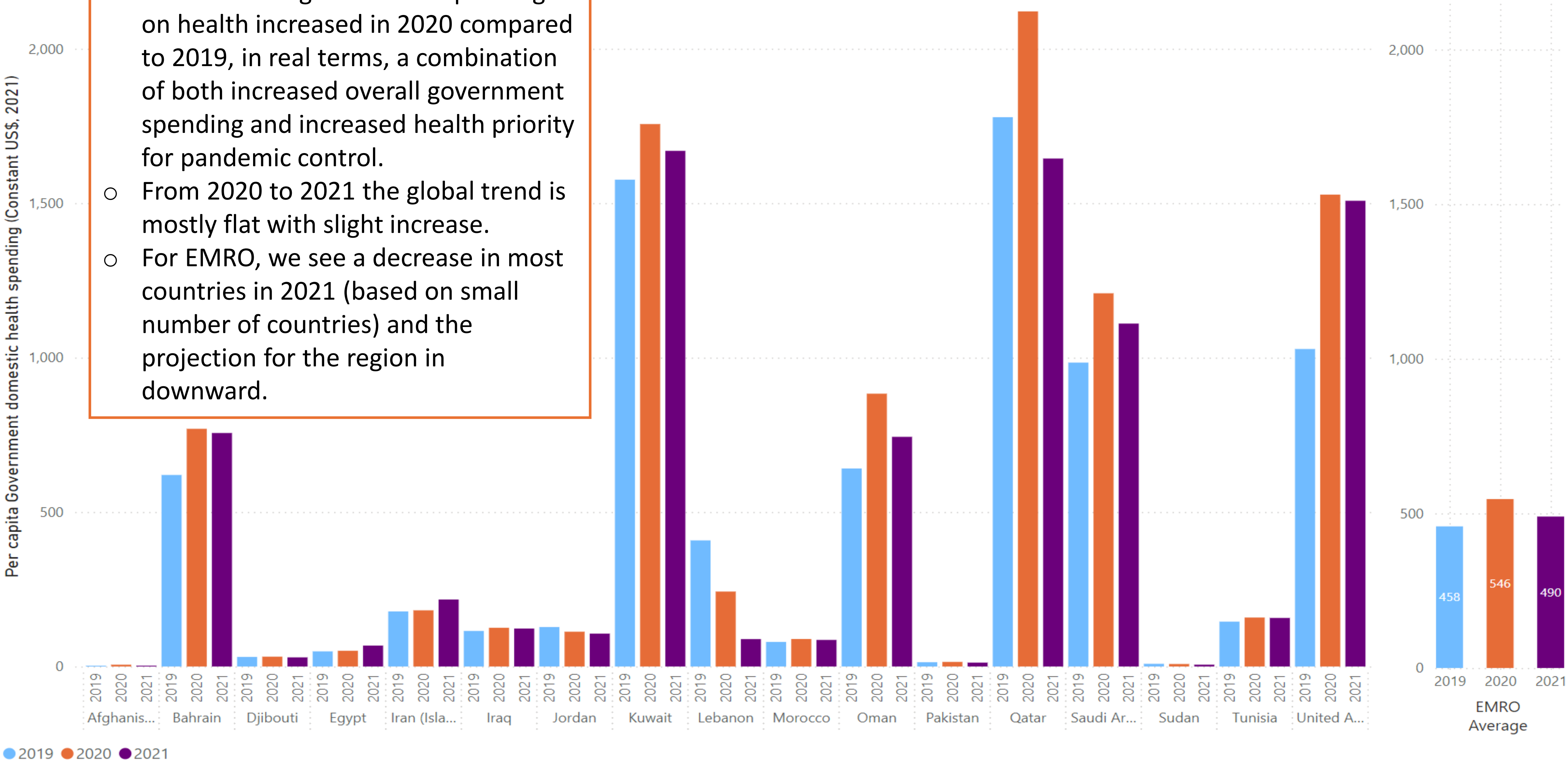
- Health spending channeled through private financing agencies increased in most countries in the past decade
    - Voluntary health insurance largely increased in Iran, Jordan, Lebanon, Tunisia
    - NGO schemes increased in Afghanistan, Djibouti, Sudan, and Lebanon (?)

Percentage of current health spending through private sector



Government spending on health from domestic sources: 2019-2021

- The domestic government spending on health increased in 2020 compared to 2019, in real terms, a combination of both increased overall government spending and increased health priority for pandemic control.
- From 2020 to 2021 the global trend is mostly flat with slight increase.
- For EMRO, we see a decrease in most countries in 2021 (based on small number of countries) and the projection for the region in downward.



Voluntary Health Insurance: negative spillovers (or, what to protect against!)

Healthcare workers shifting away from less attractive public sector posts

Two-tier inequitable system with middle classes opting-out from public/social insurance/taxation

Inefficiencies with direct or indirect (eg tax incentives) subsidisation resulting in public funds flowing to private sector

Fragmentation undermines strategic purchasing, weakens purchasing power with growing prices and OOP across the system

Clear regulatory framework to minimise harmful spillovers

Opt for complementary or supplementary (rather than substitutive) VHI

VHI often falls under domain of another ministry, with interest in private sector growth: align policy objectives across different health and other ministries.

Consider state subsidies for complementary HI for poorer households (eg France)

DELIVERY

When the private provider sector is big(ger than the public sector) and suboptimaly regulated…

Brain drain with HRH fleeing to better paid usually urban jobs and highly specialised training

Supply-induced demand can drive OOP spend and lead to impoverishment of poorer families

Uneven playing field in rate negotiations with payers(s) may undermine financial viability of public facilities

Private and MDB capital investment skewed towards private sector providers.

FINANCING DELIVERY

The private sector footprint is big and growing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ÉCONOMIE • MAROC

Au Maroc, la santé se privatise

Soutenues par des fonds d'investissement, les cliniques privées ne cessent de se développer. Elles représentent plus du tiers des lits d'hospitalisation du pays.

Par Alexandre Aublanc (Casablanca, correspondance)
Publié le 22 avril 2024 à 18h25, modifié le 23 avril 2024 à 08h47 · Lecture 4 min.

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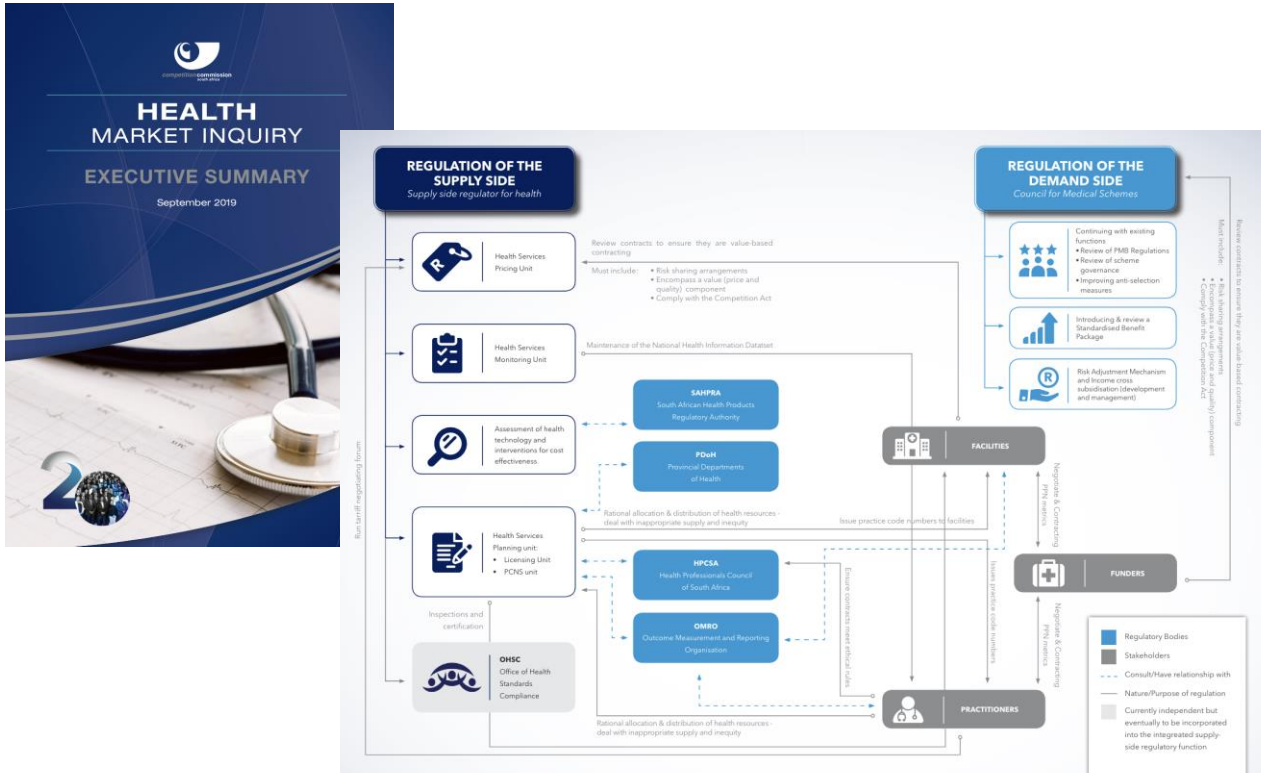
Article réservé aux abonnés

PUBLICITÉ

“More than 1/3 of hospital beds and 90% of PHC clinics are private”, Le Monde, April 2024



“In our review of the South African private healthcare market we found that it is characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilization without…associated improvements in health outcomes” Sep 2019

FINANCING DELIVERY

The case of South Africa: regressive subsidies

General News

NHI in sharp focus during SA's Health Budget Vote

Date: Jul 12, 2024

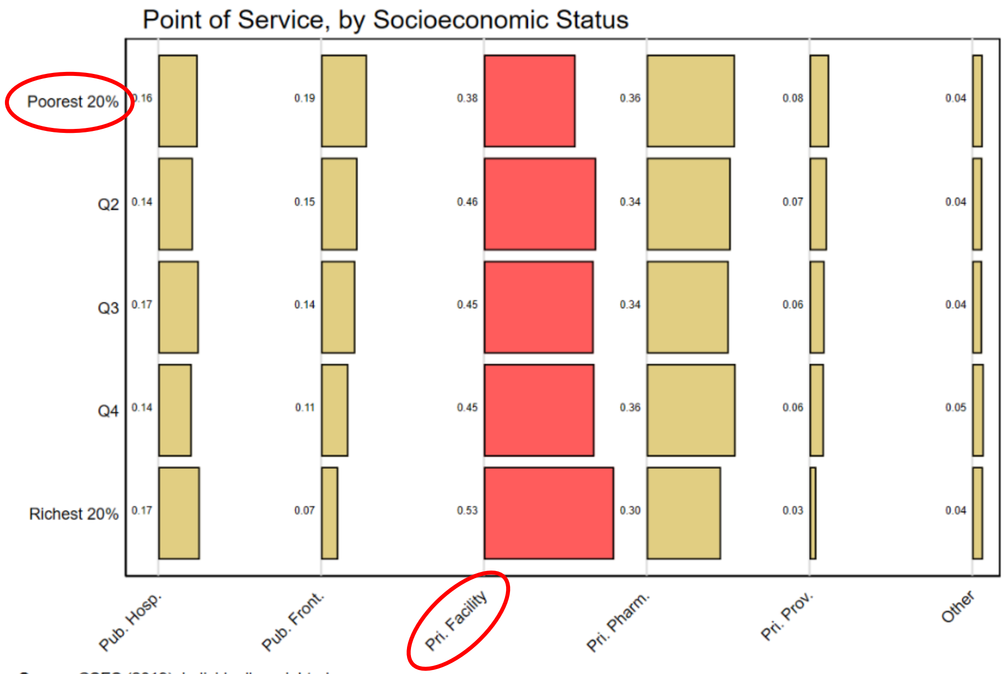
South Africa's Health Minister, Aaron Motsoaledi, says government is subsidising R70 billion ($ 3.89 billion) for private healthcare every year.

"Our government, the state, subsidises private healthcare for the rich in a way unimaginable:

- About 1.3-million public servants plus all Members of Parliament, and all the judges of our country are subsidised by the fiscus of this country to the tune of R70 billion ($3.89 billion) per annum.
- This comes in the form of medical aid subsidies in our salaries. And any person in our country who is on medical aid, regardless of who their employer is, gets tax rebates from South African Revenue Service. And I am made to believe that these tax rebates amount to R30 billion ($1.67 billion).
- Hence it's R100 billion ($5.55 billion) that goes out to subsidise us the rich and leave the poor out; and we all know that at the end of the day, we know that this money gets exhausted somewhere around at the end of Sep/Oct. And we the rich go back to the public healthcare system at no cost and demand help."

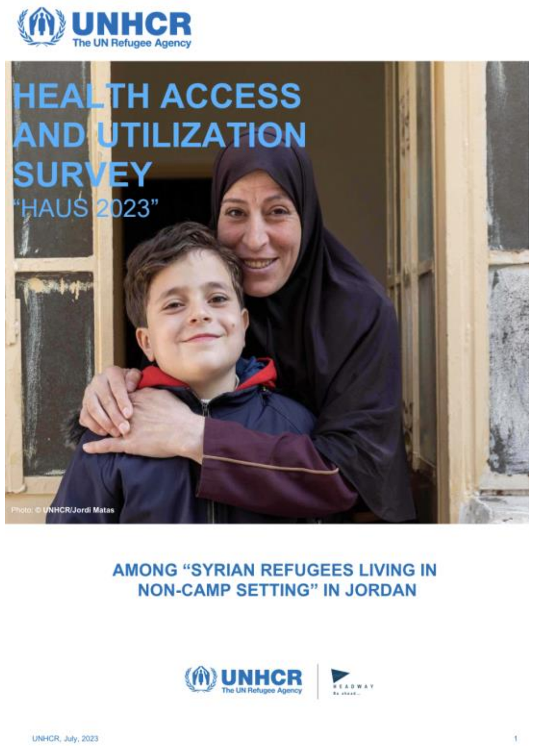
"But a poor person who doesn't have a medical aid, even if they have the need, which is in the private sector, they cannot go there. So, we the rich are double dipping."

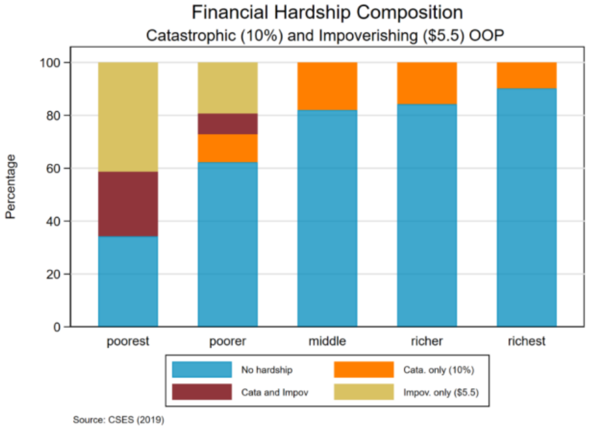
The private sector services the poor and displaced



Source: CSES (2019), individually weighted averages.
Note: Percentages are conditional on use of service.

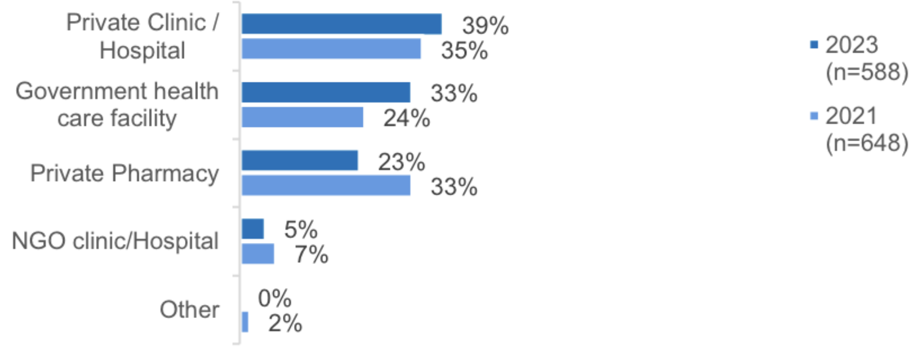
"For those who accessed healthcare services in 2023, 39 per cent went to private clinics or hospitals, 33 per cent accessed governmental facilities, and 23 per cent went to private pharmacies."



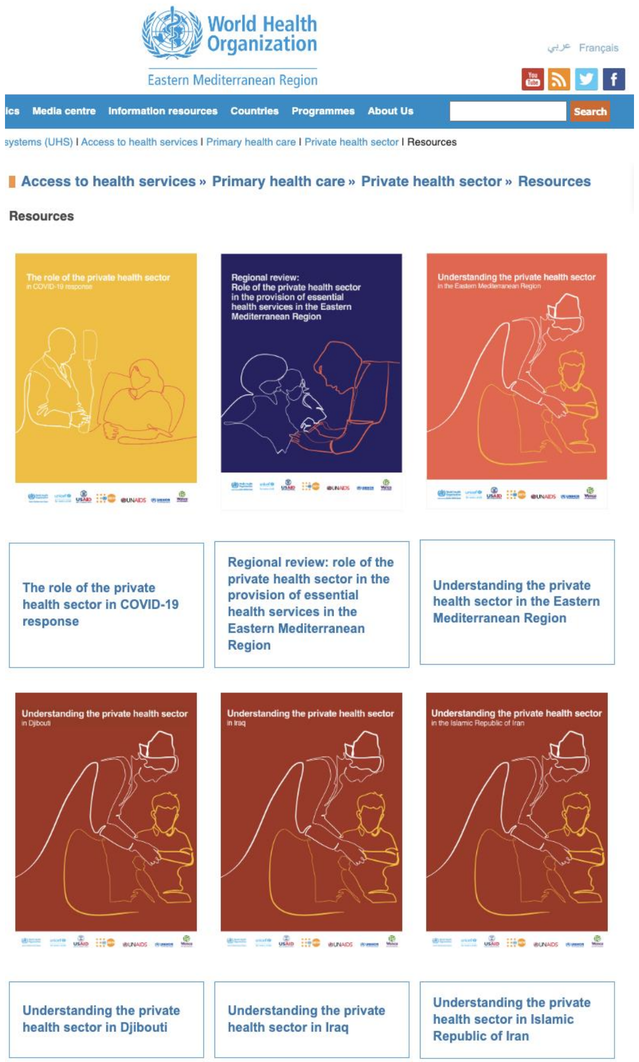


In Cambodia, most of the OOP distribution is however driven by service utilization going towards private facilities, and private pharmacies
(even among the poorest segments of the population). Asia HFF, Colombo, June 2024

Figure 17. First location the healthcare service was sought at
Percentage of household members who accessed healthcare facility in the past month



Engaging the private sector not an optional extra: understand, regulate, partner, learn



Lessons from the field

Health system performance assessment and reforms, Oman

Taavi Lai,[a] Qasem Al Salmi,[b] Kira Koch,[c] Alaa Hashish,[d] Hamid Ravaghi[e] & Awad Mataria[e]

Problem To prioritize key areas of action and investment for the next strategic cycle of national development plans (2026–2031) in Oman, we needed a holistic view of the country's health system and its main deficiencies and inefficiencies.
Approach Informed by the World Health Organization framework, our team of seven national health ministry staff and two international experts conducted a rapid health system performance assessment. We used already available data to identify system bottlenecks and their potential root causes, verifying our findings with key informant interviews.
Local setting Oman's 4.9 million population is relatively young (average age 28 years) but ageing, with a mounting burden of chronic diseases. While health-care services are free for Omani nationals, more than 1.5 million expatriates rely on out-of-pocket payments for health-care services. Strengthening primary health care, improving the quality of care, providing financial protection, and ensuring that public and private health-care providers operate within the same legal and procedural framework are recognized as key national priorities.
Relevant changes Our assessment highlighted the need to extend health service coverage to the whole population, strengthen private health-care sector governance, improve health education, increase financial investment, and expand the country's capacity for data collection and analysis.
Lessons learnt The assessment framework allowed us to identify areas where information is lacking and use already available data to analyse multiple health outcomes. As well as identifying issues that need to be addressed during the next policy development cycle, our findings have contributed towards the preparation of a more extensive assessment.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

Health systems are constantly changing; regular wide-ranging assessments of their performance help to identify and adjust priorities,[1,2] and inform actions for their robust and resilient transformation. Originally developed by the World Health Organization (WHO)[3] for this purpose, the health system performance assessment framework becomes an effective tool when combined with policy-cycle and strategic health system development plans.[3]

As part of Oman Vision 2040, the health ministry formulates the design and aims of the country's health system and submits these for consideration to the Oman 2040 Committee for inclusion in the successive 5-year national development plans.[4] The Cabinet of Ministers of Oman initiated the development of the next 5-year cycle for the period 2026–2031 in January 2023 by requesting its health ministry to report on the performance of Oman's health system by April 2023. This performance report enabled the identification of health system investment needs and guided preliminary discussion to develop goals and priorities for 2026–2031.

Here we report on the application and use of the health system performance assessment tool for the first time in Oman, with the specific aim of informing and focusing the planning of reforms in the health sector.

Local setting

The population of Oman was 4.9 million in 2023.[5,6] The population is relatively young (with an average age of 28 years) but is ageing.[5–7] Population growth is slowing[6,8] and the burden of noncommunicable diseases (e.g. diabetes) is increasing.[7] Omani nationals have access to health care from publicly owned health-care service providers. More than 1.5 million expatriates rely on out-of-pocket payments for their health-care needs. Continuous strengthening of primary health care (e.g. by increasing the number of health-care facilities and appropriately trained and funded staff); improving the quality of health care (e.g. developing and updating treatment guidelines); providing financial protection; and ensuring that public and private health-care service providers operate within the same legal and procedural framework are recognized as key national priorities.[9]

Approach

We chose the health system performance assessment framework published by WHO in 2022[10] to guide an assessment of the performance of the Omani health system. This WHO framework helps us to review health system functions and subfunctions, understand their interactions, and evaluate their impact on health system intermediate and final outcomes – including the collection and analysis of necessary data – in a systematic manner. Considering the deadline, the health ministry formed a small team to conduct a rapid health system performance assessment using only already available data.

Members of the national assessment team included seven health ministry staff members qualified in a range of individual health system (sub)functions – namely governance, financing, human resources, specialized and primary care

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533

WHO's Strategy Report

- Deliver strategy
- Enable stakeholders
- Build understanding
- Align structures
- Foster relations
- Nurture trust

A **well-governed health system** in which public and private actors **collectively deliver** on public health goals, health security, UHC and health systems resilience

Source: Dr S Dalil; https://www.who.int/publications/i/item/9789240018327

World Health Organization

Key messages

- The private sector is a **crucial partner o**n the journey towards UHC
- Public financing is **not** incompatible with private provision in the context of an equitable and efficient healthcare system…but there are **negative externalities the state ought to mitigate against**
- **MDB investments** should not fuel overcapacity which coupled with public subsidies can lead to inefficiencies, supply induced demand and escalating OOP costs.
- We must **monitor catastrophic OOP** alongside increased coverage
- Ignoring or refusing to engage is not an option and carries major direct and indirect opportunity costs, incl missing the chance to **influence, steer, partner with and learn from the private sector.**

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The perils and possibilities of the private health sector

Richard Horton • Stephanie Clark

Published: June 26, 2016 • DOI: https://doi.org/10.1016/S0140-6736(16)30774-7

”What we know is that the public and private sectors cannot be seen as mutually exclusive entities within a health system. Each depends upon the other, and the performance of one is often intimately linked to the performance of the other. Public and private sectors therefore should be viewed as entwined elements of a whole health system and managed as such.”