Service Delivery and HRH

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I. Why Service Delivery Matters?

UHC is achieved when (quality) service delivery is available for people to access

Efficiency in service delivery makes it less costly to achieve UHC and is a key to financial sustainability

Importance of **primary care** (low-hanging fruit for UHC):

Virtuous circle or vicious circle?

- Low quality of primary care -> By-pass, lower participation in financing mechanism or higher dropout
- High quality of primary care system -> Gate-keeping
  -> Effective delivery system -> Financial sustainability
  (coherence, coordination, responsiveness)

UHC reduces financial barrier to health care and increases demand. When the increased demand is met by

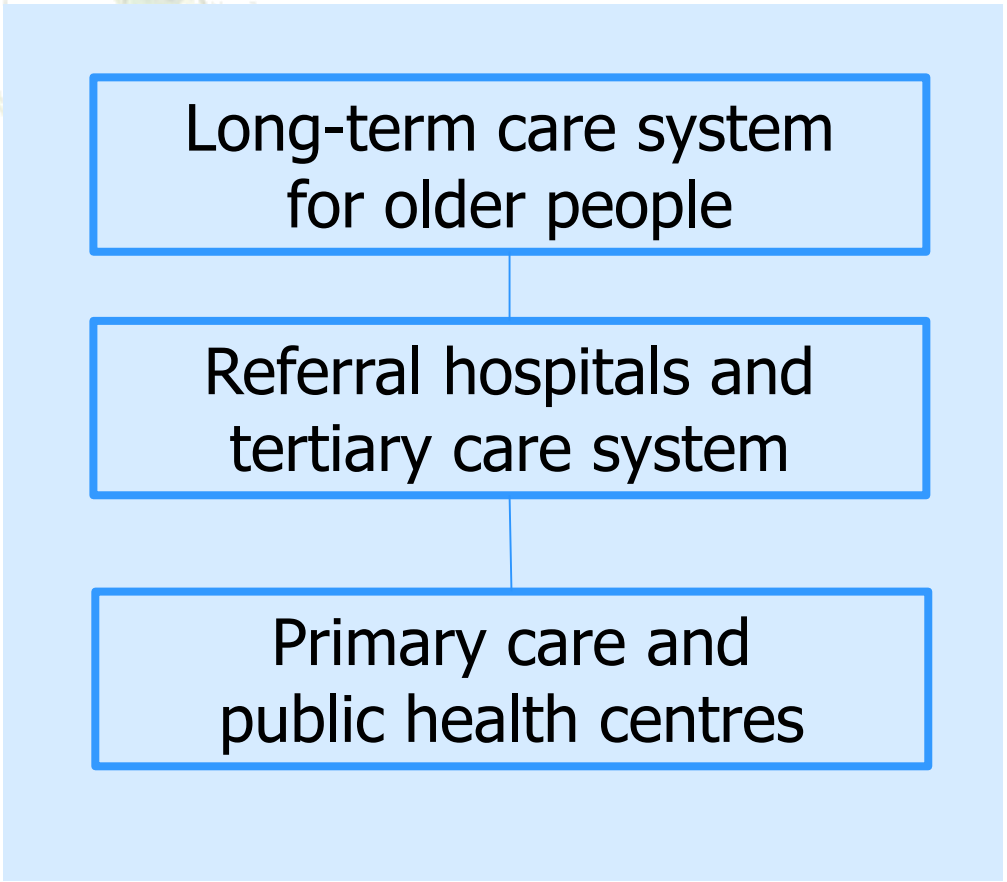
- Increase in public providers
- Increase in private providers (passive privatization): potential for efficiency, potential demand inducement and cost increase?

Effects of the predominance of big private hospitals

- Inefficiency: Over-specialization, Cost escalation
- Potential demand inducement and profit seeking (especially when they are paid by *fee-for-service* system)
- Inequity: despite the extension of benefit coverage, the share of out-of-pocket payment in total health expenditure does not decline (due to the increase in the use of new technology, not in the benefits package)

-> concerns on *financial protection*

Integrated Service Delivery for UHC (Universal Health Coverage)



II. Physicians

Dual function of physicians: Physician provides both information/advice (*diagnosis*) and *treatment*

-> Physician can have financial incentive to distort diagnostic information to provide more care and provide those services that gives higher margins to physicians, especially when physicians' income is directly related to the amount and type of services they provide (e.g., fee-for-service payment)

Demand inducement:

When the physicians provides more care than the patient would want if the patient had the *information and knowledge* that the physician has

Competition among Physicians

Physician-induced demand: The greater the number of physicians, the greater the amount of care provided, and the higher the price

Target income hypothesis: Physicians have a target income that s/he wants to achieve

Optimum amount of fraud: if a physician is involved in demand inducement too excessively, s/he has the risk of getting bad reputation.

- physician should balance the benefits of inducement (short-term income) and the cost of inducement (bad reputation, long-term income loss)

Medical Practice Variation

Large (cross-sectional) variation in the rates at which procedures and medical interventions are used in similar populations (after controlling for other determinants, e.g., age, sex, income, insurance coverage, and disease patterns)

E.g., Variations exist even in countries with health financing mechanism with universal coverage

Substantial disagreement among providers about the marginal productivity (value and efficacy) of various types of medical care

- *Uncertainty* associated with the outcomes of alternative interventions, lack of agreement about appropriate standards of care, e.g., AI (Artificial Intelligence)?

III. Degree of Vertical Integration

IDEAL system: division/differentiation of roles among different types of health care or different levels of health institutions

- With close coordination of care for cost-effective continuum of care for patients

E.g., Primary care by general practitioners (GPs) as a **gatekeeper**, who refers to

-> specialized care provided by specialists

-> inpatient care in hospitals

-> long-term care institutions or home-based (community-based) care

Should Revitalize **Primary Care**

- Gatekeeping for efficiency
- Front-line providers in health security issues
  e.g., infectious disease
- Focal point for the continuum of care for older people:
  even more important in an era of population ageing
- Prevention and promotion for NCDs:
  e.g., physical exercise, health education,
  community-based interventions

In the private sector-dominated health care delivery system, roles of different types of care/institutions is not well differentiated, potentially leading to

-> Duplication of equipment, facilities, or personnel among primary, secondary and tertiary care institutions, and wasteful competition among them

-> resulting in health care cost inflation

Examples of inefficiency and cost inflation

a. Physician offices adopt very costly medical equipment, often resulting in induced demand (patients with minor cases may be induced to use costly services)
b. Specialists treat simple/minor cases
c. Acute hospital's beds are occupied by long-term care patients, who need social care rather than medical care

IV. Legal Ownership of H Institutions

1. Public

E.g., UK, Scandinavian countries

- Tax and budget, public/citizen as the owner
- Goal of public welfare: e.g., access to care by the poor
- Difficult to define and measure the goals and performance of public organizations

  -> difficult to use financial incentive mechanism for (public-sector) management
- Potential inefficiency in operation, bureaucracy, managerial inflexibility due to excessive control, lack of competition and market disciplines

2. Not-for-Profit (NFP) Private

E.g., US, Netherlands

- No residual claimants (owners) in NFP organizations
- For-profit private entities are flexible and efficient operation, but neglects social goals (people do not trust for-profit entities to actively engaged in philanthropic activities because of profit seeking)
- Public entities provide public benefits, but can be inefficient in operation because there is no actual owners, who have a financial interest associated with the efficiency and profitability of the organization

2. Not-for-Profit (NFP) Private (continued)

- Rationales of NFP hospitals: use the merits of public entities and for-profit entities (i.e., public/social goal + operational efficiency/flexibility)

- Because of the absence of owners in not-for-profit organizations, membership and role of the *governing board* is important

- Tax is usually exempted for not-for-profit organizations (in return for community benefits)

- Role of not-for-profit or non-governmental organization (NGO) in health care (e.g., NFP hospitals, participation of civic groups in health policy) is different in different countries depending on history (e.g., church) and government policy toward NGO

3. For-Profit (FP) Private

- Existence of 'owners' who have claims on the profit (net income or residual from the operation):
  managerial efficiency, but strong orientation to profits can result in higher prices and limited access to (especially poor) patients

- Type of (private-sector) owners as residual claimants:
  physician-owned hospitals (e.g., Japan, Korea, Taiwan) or for-profit *corporatized* hospitals with investors/stockholders as owners (e.g., US)

- Individually-owned for-profit hospitals can have a problem in the transparency in management

- Most pharmacies, many specialize clinics and diagnostic centers are for-profit entities

Proportion of private hospitals, Asian countries, 2014 or the latest year

Country	Private hospitals (%)
Australia	30
Cambodia	3
China	42
Indonesia	60
Japan	80
Korea	90
Lao PDR	0
Malaysia	30
Mongolia	14
New Zealand	40
Philippines	60
Thailand	24
Viet Nam	30

Source: The author's compilation from various sources.

4. Functions versus Ownership

Functions (behavior), rather than legal ownership, matter

E.g., Private providers with public function

- Contract to provide basic essential (publicly subsidized) health care (and get reimbursement by government)
- NHI contracts with private providers

E.g., Public providers with private function

- Provide non-basic health care, for which patients pay

When government has a strong role in *financing* (by tax or social insurance, with minimum out-of-pocket pay by patients), health care can be *delivered* by public or private providers -> with good regulation of private providers

V. HRH (Human Resource for Health)

HRH: Education/training, retention/distribution, motivation/performance, regulation/policy

1. Capacity

Education system, Licensing and registration, continuing education

Skill mix affects the quality and cost

- Physicians, nurses, community health workers: cost-effective substitutions?
- General practitioners and specialists: politics?
- Key role of primary care providers: gate-keeping, continuum of care, quality, cost effectiveness

2. Retention and Distribution

Urban/rural distribution

- Need higher compensation/benefits for workers in rural areas: e.g., training opportunities, better career path
- Admission of rural students to medical schools with a condition of mandatory practice in rural areas after graduation

Public/private distribution

- Low pay in public facilities and dual practice
  -> issues of quality, productivity, brain drain, informal pay, etc.

3. Motivation/Performance

Payment system

- Fee-for-service: over-provision, increase in volume and intensity, incentive for specific areas that need an increase in productivity
- Capitation: prevention and promotion,
  potential under-provision and referrals
- Case-based payment: H system context of introduction
  e.g., DRG (Diagnosis Related Group) or variants
- Pay for performance: primary care-based or
  facility-based

Setting payment *level* for providers

4. Regulation and Government Policy

Government role is crucial due to information asymmetry between patients and providers

Quality assurance:
- mandate or minimum standard (in terms of structure)
- financial incentive, penalty
- disclosure of provider performance to consumers

Flexibility in civil service system for health care:
e.g., pay scale

Self regulation by professional associations?

VI. Policy to Improve Efficiency in Health Care Delivery

1. Outsourcing

Outsourcing and contract management in public hospitals: *supporting/non-medical* services such as dining and cleaning, etc. can be provided by external firms through contracts

- Contract management should be based on price and quality of services
- Providers of those contracted services can use expertise (better quality) and economies of scale (lower cost by dealing with large volumes)
- Hospitals need performance evaluation and monitoring to make decisions on whether to continue or terminate contracts

2. Separation of Purchasing and Provision

SHI (Social Health Insurance)

- One of the rationales of Social Health Insurance with independent insurance agency
- When the majority of hospitals are public, ministry other than MoH often governs SHI purchasing

Tax-based financing with public delivery

- Purchasing and provision are separated in British NHS (primary care providers as the purchaser)
- Little experience (of separation of purchasing from provision) in Asia, exception in Thailand

Potential Issues in the Separation of Purchasing and Service Provision

Separation of purchasing from service provision can contribute to efficiency and responsiveness to consumers/patients

Challenges to effective purchasing:

- In many rural areas of low-income countries, there is little competition among providers (i.e., little choice of providers)
- If public providers are not competent (not providing high quality), is it because of the lack of incentives or the lack of resources?

3. Purchasing/Contracting

1) Purchasing in the Public System

Government purchases (contract-out) primary care (or essential service) from NGOs in Bangladesh, Pakistan

Public hospital can purchase/contract for specialized services (e.g., dialysis), laboratory, etc.

- Various types of contracts : how to share initial investment cost, operating cost, net income, etc.

Vouchers for targeted population to use targeted services (e.g., MCH) provided by both public and private providers

2) Purchasing in the context of SHI

a. Contracting with Providers

In the beginning of SHI, it can contract with public providers only and extend it to qualified private providers

- Due to technical capacity issues (e.g., benefit/payment design, performance monitoring and evaluation)

Purchasing specific services or all types of services (benefit package)?

Many NHI under UHC contracts with public and private providers with *same terms*, e.g., price, benefits package

b. Payment System for Providers

- FFS (Fee-for-Service)
- Case-based payment, Activity-based funding:
  requires technical capacity for implementation

Balance Billing

- SHI has a limited impact on reducing the financial burden on the insured (e.g., Philippines)

Extra Billing

-When providers are allowed to provide both insured and insured services, providers (paid by FFS) induce demand for uninsured services (e.g., new and expensive technology) (e.g., Vietnam)

c. Pricing

Same or different prices to public and private providers?

- When public hospitals still get big budget from government: H Ins can pay lower price to public providers

-> low cost, fair ground for competition

- Budgets to public hospitals in LICs is insufficient

-> generous reimbursement by HI (or same amount with private providers) to public providers to enhance their capacity and quality?

- Differential pricing: considering costing and other *policy goals* (e.g., serving disadvantaged areas)

d. Quality of Care

Difficult to measure patient outcomes
- quality measured in terms of structure and process

Quality improvement and monitoring
- ex ante by guidelines or
  ex post by claim review and assessment
- public disclosure of provider performance:
  e.g., prescription rate, number of medicines per prescription, and expense of medicines prescribed

Pay for performance (P4P)
- Performance in terms of expense, process, outcomes

VII. Autonomy of Public Hospitals

1. Rationales

Efficiency, purchasing (e.g., SHI)

Additional motivation

- Ideology of market system, competition, efficiency
- Reduce government budget
- Vested interests

Context of former planned economy

- Inefficiency of public system
- Push for privatization: privatization of hospitals has smaller political-economic stake than other public enterprises?

2. Key Issues of Autonomy

Managerial decision-making autonomy:

Capacity, Flexibility (different degrees)

- Human resource: hire and fire,
  permanent staff vs. short-term staff based on contracts
- Price setting, service mix
- Procurement: centralized, decentralized
- Budgeting, capital investment, debt financing

Benefit package and payment

- Include services in the benefit package?: Integration
- At which price? Allow balance billing or extra billing?

3. Role of Government

Government capacity and willingness for more
sophisticated/nuanced regulation
(rather than command-and-control regulation)
-> Prerequisite for autonomy or PPP

NEED Monitoring and Evaluation
- Who uses, why, how much payment?
- Quality of care: staff capacity, government regulation
- Profit-maximizing behavior:
  service denial for poor patients,
  demand inducement (over supply),
  low quality (lack of regulation)