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IMPROVING EMERGING MARKETS HEALTHCARE THROUGH PRIVATE PROVISION

The role of private enterprise in healthcare is to complement and support improvements to public healthcare, not to supplant it. Private providers are the primary source of care for the world's poorest people and their record is often as good as or better than that of public providers. As low and middle-income economies grow and resources become more widely available, competition and consumer choice offer substantial potential to improve the reach, quality, and efficiency of both private and public provision.

Private provision of healthcare exists in all countries and is the dominant source of care for the world's poor, accounting for 40 percent of total health spending globally and about 60 percent in low-income countries.[1] Private participation in emerging market countries is especially extensive in service delivery, ranging from formal providers (both not-for-profit and for-profit) to a multitude of informal providers, including traditional healers, midwives, and itinerant drug sellers. In recent years the number of private providers has been increasing in these countries due to rising incomes and expectations of higher levels of care, as well as the failure of governments to meet those expectations.[2]

Private provision spans the entirety of the health value chain, from financing and manufacturing (diagnostic equipment, hospital beds, etc.) to distribution and retail. And there is growing pressure in many countries to adopt an integrated approach to the organization and provision of care, taking account of the role that private enterprises can play.

The private sector plays a critical role in other important areas of sustainable health systems. Affordable medicine is one, with many low-income countries facing supply and distribution challenges for drugs, a major driver of out-of-pocket expenses. Medical equipment also has potential for private provision, as technology is changing the way that health services are organized and delivered.

In Sub-Saharan Africa, where more than half the population lives on less than $2 a day, the vast majority of people rely on private healthcare. Some two-thirds of that care is informal and without the benefit of either public or private insurance.[3] Private providers are often the preferred choice of consumers in low-income countries because of the perceived higher quality of care and the availability of medicines.[4] And they often can deliver services at the same quality level as the public sector, particularly for routine care.[5]

Yet there are numerous market failures associated with private healthcare delivery. Information asymmetries and coordination of care often make it difficult for consumers to comprehend and evaluate providers' advice on healthcare utilization and the costs of care. This can lead to both underprovision of some services and overprovision of others.[6] And healthcare service providers—from technicians, nurses, and doctors, to producers and sellers of equipment and facilities—tend to be located in urban areas where hospitals and other large health facilities are found, with a lack of facilities and services in remote regions.

But healthcare is more than a market good. It has characteristics of a public good with substantial positive externalities—a healthy workforce for economic growth and vaccinations to prevent epidemics, among many others—that cannot be realized by private provision alone. Equity is also a concern, with widespread agreement that governments should promote policies "that ensure everyone, everywhere, can access quality health services without being forced into poverty."[7]

For all of these reasons, government intervention in healthcare markets is warranted. It must develop sustainable health systems with policy frameworks that define and support the role of the private sector.

Challenges

An estimated 400 million of the world's poorest people lack access to essential health services, a situation that creates catastrophic costs and plunges many into extreme poverty, premature death, or disability.[8] This dearth of care in emerging

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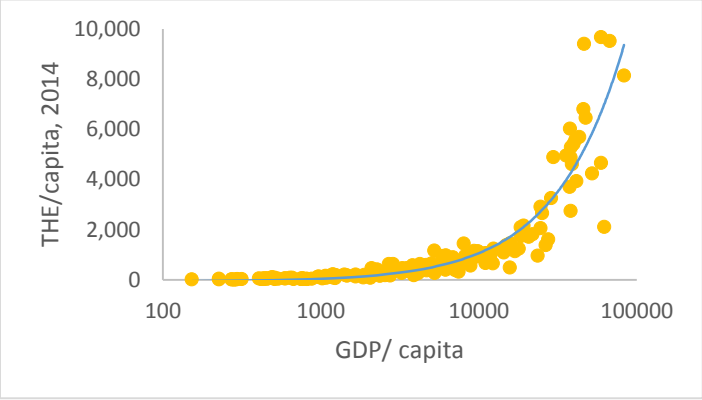
markets is largely the result of inadequate financial resources. For example, Sub-Saharan Africa has three percent of the world's health professionals serving 11 percent of the world's population. The region carries 24 percent of the world's disease burden with healthcare expenditures averaging around $100 per person per year, about half of which represents government expenditures.[9]

As incomes grow, countries are better able to address healthcare market failures through subsidies, regulation, and outright provision of services, and per capita GDP is correlated with health expenditures and outcomes (*Figure 1*).[10] Yet public health budgets in emerging economies are not increasing at the same pace as health expenditures. While spending as a share of GDP has increased from 6 percent to 12 percent in advanced economies since 1970, spending in emerging economies has risen to just 5 percent of GDP, from less than 3 percent.[11]

Figure 1: GDP/Capita v Total Health Expenditure/Capita Worldwide, Constant US$, 2014



Source: World Development Index, World Bank, 06/07/2016.

An additional challenge involves non-communicable diseases, or NCDs, such as cancer, cardiovascular disease, and diabetes, which caused more than eight million deaths in low and middle-income countries in 2013.[12] The increase of NCDs in emerging countries has been driven in part by the success they have had in increasing incomes and combatting infectious diseases such as HIV/AIDS. Dramatic changes in urbanization, global trade, consumption, and longevity have drastically altered lifestyles in emerging countries. With life-expectancies projected to rise and higher incomes enabling the adoption of unhealthy lifestyle choices (sedentary occupations, overeating, etc.), the toll of NCDs is expected to rise.

At the level of the family, these diseases may lead to reduced incomes, higher health expenditures, and even impoverishment. At the state level, the challenge of NCDs translates into lower productivity and competitiveness, accompanied by rising health and welfare expenditures. According to the World Economic Forum, NCDs will inflict $21.3 trillion in losses on the developing world over the next two decades.[13]

The growth of NCDs presents an opportunity for private sector participation, however, as cheap and effective prevention, management, and treatment tools and policies are not widely implemented in emerging economies. Competition and consumer choice, along with the necessary financial resources, can change that, delivering more efficient and affordable healthcare outcomes.

Consumer Choice in the Health Insurance Market

Risk pooling, achieved either through private insurance or through community nonprofit insurance associations and government provided social insurance, is critical to the equitable and efficient provision of healthcare services. Out-of-pocket payments, or user fees, render many essential services unaffordable and expose individuals, and especially the poor, to catastrophic expenses. In the absence of universal coverage there is no opportunity for cross-subsidization between rich and poor individuals or between the healthy and the unhealthy.

An ongoing policy debate in many countries concerns universal healthcare coverage and whether it should be approached via a single payer or through multiple private payers in a competitive insurance market. There is no systematic evidence that one approach is appropriate for every economy and situation.

It is clear, however, that risk-pooling arrangements increase access and improve healthcare outcomes.[14] On average, out-of-pocket payments constitute nearly half of healthcare financing in low-income countries, compared with 30 percent in middle-income countries and 14 percent in high-income countries.

Private insurers, both non-profit and for-profit, cover less than 10 percent of health expenditures in all but five low and middle-income countries, as most residents of those countries cannot afford insurance.[15] However, private insurance has benefited middle and higher income people in emerging economies such as Turkey, India, Brazil, and China, either through individual or corporate subscriptions.

Public and private insurance markets often grow in parallel. Indonesia, for example, has set ambitious targets for social insurance, and by 2019 it will be compulsory for all residents to contribute to the social health program.

Wherever public or private insurance is in place, consumer choice can play a positive role in promoting quality care at affordable prices. For example, Singapore's healthcare system relies heavily on consumer choice, and with expenditures at 4.9 percent of GDP in 2014, it is among the highest quality and least

expensive systems in the world (compared with 11.5 percent of GDP in France and nearly 18 percent in the United States).[16]

There are alternative ways to use consumer choice to address the overprovision of medically unnecessary services, including diagnostic review mechanisms in which physicians and hospitals receive a set amount for each condition they treat without regard to the number or types of services utilized for treatment. With the revenue per condition fixed, hospitals and healthcare providers are incentivized to cut costs and improve effectiveness in order to maximize profits, rather than maximize revenue by increasing the services they provide, as is often the case with fee-for-service payment mechanisms.

Competition in the Market for Healthcare Delivery

Private provision of healthcare delivery consists of both for-profit and non-profit enterprises. In practice, there often is no easy way to separate private from public provision of medical services, as public funding is often used to support private provision and private funding is used to support public provision. The private sector consists of for-profit enterprises, community-based nonprofits, and charities.

Private providers adopt a variety of business models, principles, and objectives. Informal providers operate in the slums of major cities, while sophisticated clinics serve wealthier areas. Nongovernmental organizations often run nonprofit services in rural villages where no public services exist. Public-private partnerships include both government and privately funded insurance and voucher programs for the purchase of both private and public health services as well as government contracting for the private provision of various kinds of medical services and facilities. The private sector also plays a vital role in educating and training healthcare professionals.

As noted above, many of the 400 million people lacking access to minimally essential healthcare services live in the poorest areas of the lowest-income countries, where physical infrastructure and skilled personnel are in short supply. Even where available, medical services in these countries are often substandard. The need for skilled personnel drives significant private sector investment in medical training.

Private provision works better in some areas of healthcare than others due to the prevalence of market failures in some sectors. There is a strong case for private sector involvement in outpatient services because it is easier to establish criteria for licensing and regulating service provision, making them more contractible and open to competition. Pharmacies and laboratory services are also easy regulate, so they also see high levels of private provision. And private provision type is aligned to the maturity of a specific market. Historically, specific investments were generally directed to pharmaceutical and medical products and to outpatient services for lifestyle diseases that offer the highest margins at reduced costs. However there is now a clear push in many markets for greater use of so-called multi-service integrated care models. For governments to benefit from private participation in these models they must own and manage the health systems' agenda and implementing framework.

From an economic perspective, the greater the ability to monitor, license, and regulate a good or service, the easier it is to structure a functioning market that is relatively free of unnecessary and fraudulent goods and services. Similarly, there is substantial potential for competition and private provision where government regulation is effective.

Health supply chains in low and middle-income countries involve multiple public, private, and faith-based actors ranging from policymakers, procurement agents, and program managers to regulators, suppliers, and distributors. In developed countries the government regulates the quality of the product and relies on the private sector for its supply and

Overcoming Regulatory Barriers in China's Healthcare Market

Over the past 12 years Aier Eyecare Hospital Group, a for-profit enterprise, has surmounted regulatory, legal, and tax barriers to become the largest private hospital group in China and the leader in treating eye ailments, with 100 hospitals and over three million patients each year.

When Aier entered the market it was clear it would be difficult for a private company to earn the necessary public trust and attract customers. Private care in China was widely considered to be of poor quality, leaving Aier to counter stereotypes and create a trusted brand.

To gain market share, Aier modernized delivery of ophthalmology care. The company maximizes service utilization of talent, equipment, and infrastructure through its multi-tier network by allocating doctors and equipment to locations where they are needed most. It controls infrastructure costs by leasing buildings and retrofitting interior spaces to create a hospital environment. Aier also purchases in volume and negotiates discounts directly from suppliers, enabling economies of scale.

Recently, China initiated efforts to remove regulatory barriers in order to facilitate the entry of other private competitors and to further improve the quality and efficiency of the country's healthcare providers. Today there are more than ten thousand private hospitals in China, twice the number operating in 2008

distribution.[17] In emerging economies, however, the public sector also owns and manages the supply chain, a situation that often results in higher prices and allocation inefficiencies. It is estimated that in low and middle-income countries the average availability of drugs at public facilities is less than 25 percent (only in 1 out of 4 cases is the customer is able to find the desired drug), compared to around 65 percent in private facilities.[18] In addition to the public-private divide, there is an urban-rural divide of health facility availability.

In the absence of authorized drug retailers in rural areas, the population often relies on unregulated and unlicensed providers, with vast differences in price and quality. A recent survey found that 30 percent of all malaria drugs were counterfeit or substandard.[19] Emerging market countries also lack price and mark-up regulation, which means that prices for comparable products can vary significantly along the supply chain and among different suppliers. In order to avoid counterfeit drugs, customers are often willing to pay a premium for trademark drugs. Increasing demand for those products drives prices higher, while cheaper generic options struggle with low acceptance and market penetration.

By handing over some of the responsibilities of manufacturing, logistics, and distribution to private firms, governments can focus more on regulation and quality control. Cooperation between governments and businesses is crucial to making drugs available and affordable.

Competition and Consumer Choice

Most countries do not offer statutory healthcare coverage for informal workers and their families. Even in countries where informal workers and poor people do receive basic healthcare services, medications and treatment often require out-of-pocket payments.[20] A number of private initiatives that do not depend on government funding and social insurance, such as franchise distribution, vouchers, and various public-private outsourcing arrangements, fill the vacuum.

Franchise distribution offers specialized services that are not otherwise available, including medical imaging procedures, kidney dialysis, and cataract and cardiac surgery. Vouchers, both privately and publically funded, enable the purchase of healthcare from both private and public venders. Governments outsource the provision of myriad services, including non-clinical support (housekeeping, maintenance, catering, laundry, security, etc.), ancillary clinical services (laboratory, radiology), and core clinical services such as surgery and reproductive healthcare. They can also outsource the management of public facilities.

Regulation and Regulatory Barriers

For either private or public healthcare provision to be effective, there must be sound, enforceable regulations. That requires:

- Licensing of medical practitioners
- Stringent approval procedures for new drugs and technologies
- Vigilant inspection and monitoring of the manufacturing and delivery of pharmaceuticals
- Sound legal procedures that patients and families can use to obtain redress for harms done to them.

In emerging economies, laws and regulations that govern the health sector are often outdated. Many were developed decades ago and now impose unnecessary burdens on the health sector. For example, nearly 35 percent of the approximately 108 million rural population of Bangladesh have limited access to public healthcare facilities and face high out-of-pocket payments in a rapidly growing private market. Yet a recent study found that while regulatory reform in the country is essential to remedying that situation, the nation's licensing and accreditation system is outdated and ineffective.[21]

No matter how well-crafted, regulations can have unintended and often counterproductive consequences. In many countries there are myriad regulatory barriers to market entrants that decrease the potential of innovations to lower costs, increase efficiencies, and introduce new products and services. These barriers commonly include:

- Restrictions on private sector access to qualified professionals who practice in the public sector
- More stringent contracting standards and payment principles for private providers
- Bureaucratic procedures that entangle prospective entrants in red tape
- Government reimbursement rates and tax treatments that discriminate against private providers.

By the same token, governments can be a powerful source of information, apprising consumers of the nature and treatment of specific illnesses to enable better decisions, alerting pharmacies and consumers about the nature and extent of counterfeiting, and rating physicians and hospitals with regard to quality and affordability. Such information strengthens consumer choice and creates more efficient providers.

Competition and Destructive Innovation

Going forward, a significant contribution of the private sector will be innovation that can render traditional approaches to healthcare delivery obsolete and accelerate the advance of affordable quality healthcare. One of the most encouraging

innovations is telemedicine, the use of information and communications technology to deliver healthcare.

Telemedicine—also known as "e-health" and "telehealth"—employs modern technologies to transmit information via text, audio, video, or still images to a range of healthcare specialists. It is relevant to a variety of disciplines including dermatology, radiology, and cardiology.[22] A simple Internet connection can allow doctors and other professionals to remotely diagnose and treat a wide range of medical conditions.

For example, in Tanzania, Airtel Tanzania, the second largest telecommunications company, provides a free service that facilitates text messages about infant care to mothers and pregnant women. Over a two-year period some 500,000 parents received 40 million text messages about safer motherhood practices and behavior, helping to reduce infant mortality by 64 percent and maternal mortality by 55 percent.[23]

Telehealth has become embedded in Brazil's delivery of healthcare.[24] While the country's initiatives are public and utilize public hospitals and medical personnel, they depend on an advanced information and communications infrastructure that was largely the result of the privatization of its telecommunications system that began in 1998.

The potential for these and other telehealth initiatives needs to be kept in context, however. Most are nascent projects with little published, systematic evidence regarding their performance. And while telemedicine offers exciting prospects for widespread expansion of low-cost quality care, many emerging countries—particularly those in Sub-Saharan Africa—will require costly upgrades to electricity and telecommunications networks before the technology can be used effectively.[25] Telemedicine also entails substantial outlays for Internet training of health practitioners—and for consumers, many of whom are impoverished and undereducated.[26]

Other initiatives pushing the boundaries of healthcare provision include:

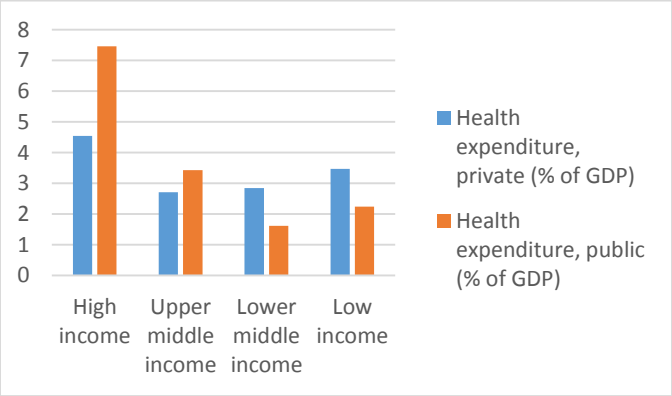
- Tiered fee strategies, in which services differ only in amenities and waiting time but not clinical quality, allowing providers to use wealthier patients' choices to subsidize the cost of care for lower income individuals
- Task-shifting, in which simple medical services are performed by lower and mid-level professionals in order to reduce operating costs
- Specialization and high-volume, low-unit cost delivery that maximizes the use of infrastructure
- Outreach that increases the availability of services in underserved areas.

Macroeconomic Benefits

Healthcare provision, both private and public, constitutes a significant industry and provider of high-value output and productive employment. As a percentage of GDP, total health expenditures range from an average of about 6 percent in low and middle-income countries to an average of just over 11 percent in high-income countries (*Figure 2*).

Total health expenditure is the sum of public and private health spending. On average, countries around the world spend about 4.0 percent of GDP on private healthcare and 6.0 percent on public. For OECD countries the figures are 4.7 percent of GDP on private, 7.7 percent on public; for low and middle-income countries it is 2.8 percent on private and 3 percent on public; and for the least developed countries it is 3.1 percent on private, 1.8 percent on public.[27]

Figure 2: Private vs Public Expenditure on Healthcare, % of GDP, 2014



Source: Source: World Development Index, World Bank.

According to the World Bank, healthcare workers account for a significant share of the labor force in virtually all countries—up to 13 percent of the total workforce.[28]

Conclusion

There are many examples in which consumer choice and competition have improved the affordability and access of healthcare in the emerging world.

Robust regulatory standards and enforcement are necessary for consumer choice and competition to reach their full potential. However, many regulations and tax policies impose barriers that discriminate against private providers and reduce the benefits of competition.

Private investors are spurring innovations in telemedicine, delivery, operating room procedures, workforce training, and the generation of new revenue streams. Many of these innovations originate in emerging market countries and all of

them are helping providers—both private and public—improve access to better and more affordable healthcare to their citizens.

Governments have multiple ways of unleashing the potential of private businesses in contributing to quality healthcare for the broad population. Regular updates of relevant regulation, public-private partnerships in insurance and healthcare markets, competition in private provision, and access to information will go a long way toward that end.■

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Notes

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