



Universal health care adoption in Asia:

Are Life Sciences companies late to the game?

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The United Nations (UN) has set a goal to achieve “Health for All” by 2030 and while 193 countries have signed up to it, more than one billion people still lack access to basic healthcare. If every country without universal health coverage (UHC) is to increase their health spending per capita to the average OECD levels by 2030, it would mean total global health spending will have to increase by 400% or an additional US\$27 trillion over today’s budgets. Such investment is clearly beyond the means of low- and middle-income countries but, according to Dr. Mark Britnell, KPMG Global Head of Infrastructure, Government and Healthcare, “we can’t go back on the aspirations of UHC. It’s too difficult for governments to say they don’t believe in UHC”.

The low- and middle-income countries will need to find new ways to deliver affordable healthcare to all and the answer may lie in how private and public sector players can effectively collaborate across the value chain. These players can help move countries towards UHC 2030 ambitions through:



establishing a global network of private sector players dedicated to developing “UHC-ready” approaches



installing a neutral mediation service to improve the quality of dialogue between public and private sector organizations involved in UHC initiatives



documenting a UHC readiness checklist assessment

These actions, new ideas and real-world lessons are discussed in a study, [The role of private providers in delivering universal health coverage](#),

released by the World Innovation Summit for Health (WISH) in November 2018.

As Asia’s health systems prepare for unprecedented expansion in access to care, the time is right for Life Sciences companies to join the conversation to define a sustainable UHC model for Asia.

FOCUS ON COLLABORATION AND HEALTH ECONOMICS

Globally, the private sector already represents half or more of care capacity in health systems aspiring to achieve UHC. The private sector is considered a leader in the development of future care models that can expand access to care through technology, standardization, skills mix and economies of scale. That said, public payers are increasingly taking a dominant position in low and middle-income countries implementing UHC and this could lead to a reduction in out-of-pocket and private insurance revenue sources for the private sector.

Of the private providers surveyed globally as part of the WISH study, only 25% expressed clear intention to shift their business and service delivery models toward publicly-financed UHC, and a further 25% expressed clear intention not to do so. This mixed picture raises the question of who may be willing to take up the opportunities created by countries looking to fund large-scale UHC programs.

According to drug and device companies at a Life Sciences Asia Pacific executive forum hosted by KPMG in Singapore, their experience with UHC programs has been positive and proactive, and they are looking to move into other parts of the value chain in order to better support UHC. “The goal is not to replace healthcare provision but to work together, such as augmenting operations at clinics, inventory control and even smart chips”, commented Dr. Hsien-Hsien Lei, Asia Pacific Vice President of Medical and Scientific Affairs at Medtronic. But she noted that at the moment, health economics can sometimes still be subjective.

Lalit Mistry, a member of KPMG’s Healthcare team involved in the Ayushman Bharat UHC program in India, believes the private sector can play an indispensable role in achieving health for all. “The sector can do so by demonstrating consistent grit to refine healthcare systems with better and more efficient business models.”

In the journey toward health for all, UHC countries will be seeking balance between control and risk, affordability and innovation, and competition and consistency. Health system governance and stewardship are likely to remain public sector-driven activities with financing, service provision and health products and supply chain open for debate depending on the country and private sector offering (Figure 1). The area of least consensus is possibly around free or low cost service provision which could be exactly the sort of activity a Life Sciences company needs to consider in order to move up the value chain.

According to Frank Buescher, Chief Executive Officer of Sysmex Asia-Pacific, “forward integration is not simple. In many cases, it would mean taking market share away from customers and for us, it’s the labs.” Lei concurred and also shared that Medtronic has been trying to help in other areas of the value chain but not all their efforts have been properly recognized.

While the benefits of alignment between public and private sectors for UHC purposes can be quite compelling, the scale of technical and resource challenges is enormous. Take for example annual health spending. An analysis by Stenberg and colleagues showed that the annual health spending gap across 67 low- and middle- income countries is around US\$300bn. And according to the World Health Organization, there is a shortfall of some 17 million people in the global health workforce, mostly in Asia, Africa and the Middle East.

The scale of private health services is also too large for any government to ignore. In a separate study of 77 low- and middle-income countries, more than 50% of the population use a private provider as their first choice for

basic care. Additionally, in countries where a National Health Insurance (NHI) scheme has been implemented, the governments have signaled an intent to purchase publicly-funded health services from the private sector.

“Many PPPs are still not designed to help the masses, only niche segments,” said Buescher. “Policymakers need to differentiate between cost savings and cost efficiencies, or true health economics.” However, there are challenges, for instance data transparency between public and private sectors, which make the realization of health economics much more difficult to both predict and achieve.

RIDE THE RISING POLITICAL MOMENTUM

Political momentum behind UHC is now at an all-time high. Governments around the world are making major financial commitments toward UHC and many national leaders are also grasping its political value at the ballot box.

For the private sector, this rise represents both a threat and an opportunity. The threat is in the form of a decline in the proportion of self-paying and privately-insured patients as a result of well-designed and funded public UHC programs. The share of spending from out-of-pocket and pre-paid private sources is also projected to fall or at best remain flat over the next two decades.

On the positive side, the comparably stronger growth in public spending represents an unprecedented opportunity. A World Bank study of 24 UHC reforms in developing countries found that the annual spend on national programs can be as high as 6.8% of gross domestic product (GDP) in some countries. In Indonesia, for example, some 60% of the US\$6 billion budget is earmarked to cover the provision of services by private hospitals enlisted in the nation’s NHI scheme.

Figure 1: A typical public-private mix in many health systems



ALIGNING PUBLIC-PRIVATE SECTOR GOALS AND EXPECTATIONS

KPMG’s interviews with large public payer organizations across the globe has thrown light on a disconnect between governments’ expectation of private sector players enlisted in UHC programs and what they actually offer. In the coming years, governments are likely to focus more on integrated pathways of care (in and out of hospital), primary care in rural and underserved areas, and innovations in digital healthcare (Figure 2).

Sharing an observation, Buescher pointed out that “(some) governments are still short-term minded and don’t fully understand value-based contracting” and Lei cautioned that “it will be hard to make value-based contracting work if governments don’t have interoperability”.

To achieve real alignment, Life Sciences companies will need to establish an understanding of the psychology of governments and care providers, and help drive conversation around value-based contracting which is gaining traction.









The utmost priority remains to secure and build the capacity to treat very large numbers of patients at a high level of consistency in the quality of care through standardization. “We cannot buy the services we want because they are not there,” said Atikah Adyas, Senior Researcher for the Indonesia’s Ministry of Health. “Ours is a large and diverse country across many islands, but private investment remains only in the large cities.”

Public payers interviewed accepted that private sector failure to address needs was due in equal part to unclear market signals from the national governments. Going forward, these governments intend to introduce the following into their UHC program:

-  offer more standardized service packages across socioeconomic levels (incentivizing evidence-based care)
-  provide assurance around scale and volume of patients
-  impose quality standards that would reward the high-value services delivered by the private sector

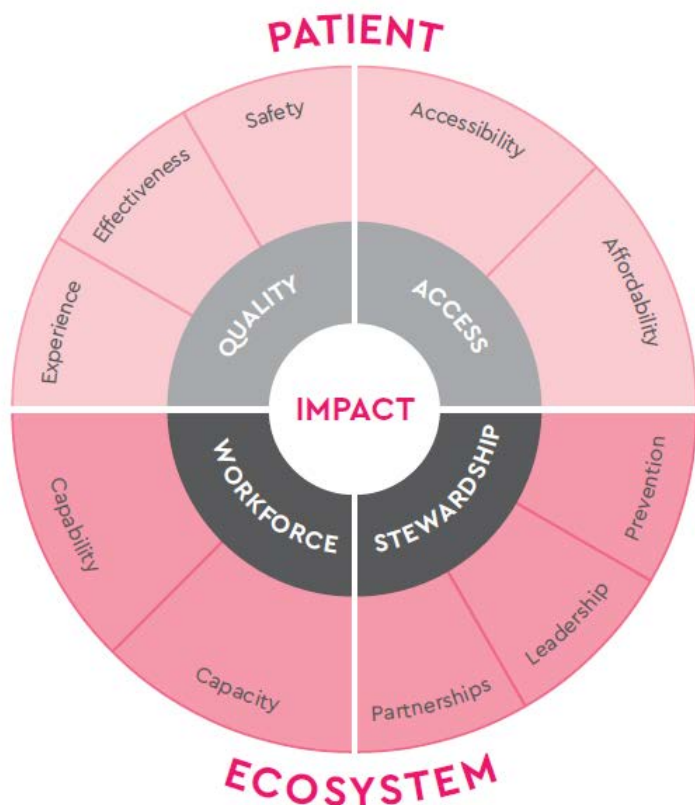
Still, the analyzed picture suggests that the private sector has not geared up for the potential opportunities of publicly-financed UHC. Further, private sector players are also challenged by the fragmented and varied government programs and differing objectives within the private sector, for example the role of pharmaceutical players versus that of private care providers.

Figure 2: Misalignments between public payers and private providers in UHC

What payers say they want from private providers	What payers say they are offered by the existing private sector
 Highly standardized, large-scale health services	 Overpriced specialist care from 'islands of excellence' or unreliable independent operators
 Innovative models for delivering integrated preventative, primary and secondary care.	 Episodic, fee-for-service treatment in hospitals
 Universal, last mile access	 City-based care located where additional capacity is less needed
 Skills to design and run high-quality, low-cost health services	 Skills to design and build world-class facilities

To claim any level of alignment or contribution to UHC, the private sector will need to think more deeply about their role along the lines of a health impact framework (Figure 3).

Figure 3: Health impact framework



“Digitalization in healthcare can have a huge impact on medical outcomes albeit with lower costs; governments from developing economies like Bangladesh are awakening to this possibility and initiating action,” said Dr. Keren Priyadarshini, Regional Business Lead, Healthcare, APAC at Microsoft. “Governments’ main focus for moving ahead with digitalization is to lower costs and improve support for patients.” Lei added that “medtech needs to link to the overall government digital transformation program, for instance the interoperability of databases.”

UHC SUCCESSES IN ASIA

Telenor Health, an in-house start-up by Telenor, is one such example of a private sector initiative where the business and service delivery model is being reoriented to meet the scale of health for all. Telenor, one of the world’s largest mobile telecommunications networks, pivoted to a healthcare offering with Telenor Health in 2015. Its first product, a digital health platform, was launched in 2016 and has five million members across Bangladesh today. Telenor offers a variety of services for free to its SIM card holders in Bangladesh – 24/7 chat line using artificial intelligence (AI), discounts up to 30% across more than 2,000 clinical facilities, cash payouts in the event of a hospital inpatient stay, fully-portable personal health record, care provider navigation tools

(including online reviews of user experiences), and personalized health content associated with individual interests and trends.

This platform is Bangladesh’s largest voluntary health insurer by lives covered as well as the largest telemedicine supplier. Ultimately, Telenor aims to be a digital front door to government UHC programs.

The track record of many low and middle-income countries shows that an enabling environment has not always been in place. Suspicion, division and lack of dialogue were noted in interviews from both sides of the table and this has done little to galvanize private sector confidence in future partnerships. Consequently, many countries have seen two-tier private sector efforts evolve – high quality, high-cost services for the top of the wealthy pyramid, and under-regulated, often unsafe services for the bottom. Lessons learnt thus far include providing certainty and commitment of UHC purchasing, clarity of direction of UHC reforms and improving trust amongst the stakeholders.

Critically, driving out poor private sector performers is just as important as rewarding the good ones. “Stick” approaches include licensing, anti-trust, sanctions and price regulations, as seen by India’s recent price controls. “Carrot” tools can include accreditation and public information campaigns. Similar governance should be introduced for governments especially around payment for services.

In Asia, Thailand is a trailblazer for UHC success. To tackle its sizeable informal sector, the country has implemented a series of incremental reforms to health financing over the last 15 years. Under the UHC scheme introduced in 2002, the government consolidated welfare revenue streams to cover nearly 48 million people, automated the enrollment process to avoid the pitfalls of means testing, and introduced a 2% levy on tobacco and alcohol sales to strengthen preventative and primary care. These funding shifts have enabled Thailand to fund more than 700 new healthcare initiatives to date.

In India, Delhi’s Mohalla clinics are an example of government forging practical ties with the private sector to provide care for the underserved population.

Since 2015, 164 Mohalla clinics have been set up across the state with plans for a total of 1,000 such community facilities by the end of 2018. The clinics can be made from used shipping containers, see up to 100 patients per day with costs fully borne by the government, and serve as supplemental income sources for private doctors. The model is now being rolled out to other states in India with plans for 200 clinics in Hyderabad. “The advent of Ayushman Bharat, India’s National Health Protection Scheme, marks the dawn of UHC in India across primary, wellness, secondary and tertiary care,” said Mistry. “The program relies on a collaborative effort by both public and private sectors to achieve the vision for holistic care.”

ACHIEVING HEALTH FOR ALL BY 2030

Every country pursuing UHC will face its own unique set of challenges to achieve the full scale of health for all by 2030. The current pace of progress is not sufficient and support from the private sector could be the catalyst. The KPMG-WISH study proposed three solutions:

1 Establish a global network of private sector players dedicated to developing “UHC-ready” approaches – to share lessons, work collaboratively on themes of mutual interest, scale up sustainable models of health promotion, cross-train the workforce, and measure impact.

2 Install a neutral mediation service to improve the quality of dialogue between public and private sector organizations involved in UHC initiatives – for early-stage relationship and trust building, joint visioning, drafting legal frameworks, commercial alignment, and grievance management.

3 Document a UHC readiness checklist assessment – including timely payment mechanisms (e.g. escrow accounts or partial upfront), independent quality accreditation, price determination, fragmentation/standardization, workforce.

Information in this article is drawn from the World Innovation Summit for Health (2018) report, The Role of Private Providers in Delivering Universal Health Coverage. Retrieved from: <http://www.wish.org.qa/role-of-private-sector-in-healthcare/>

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