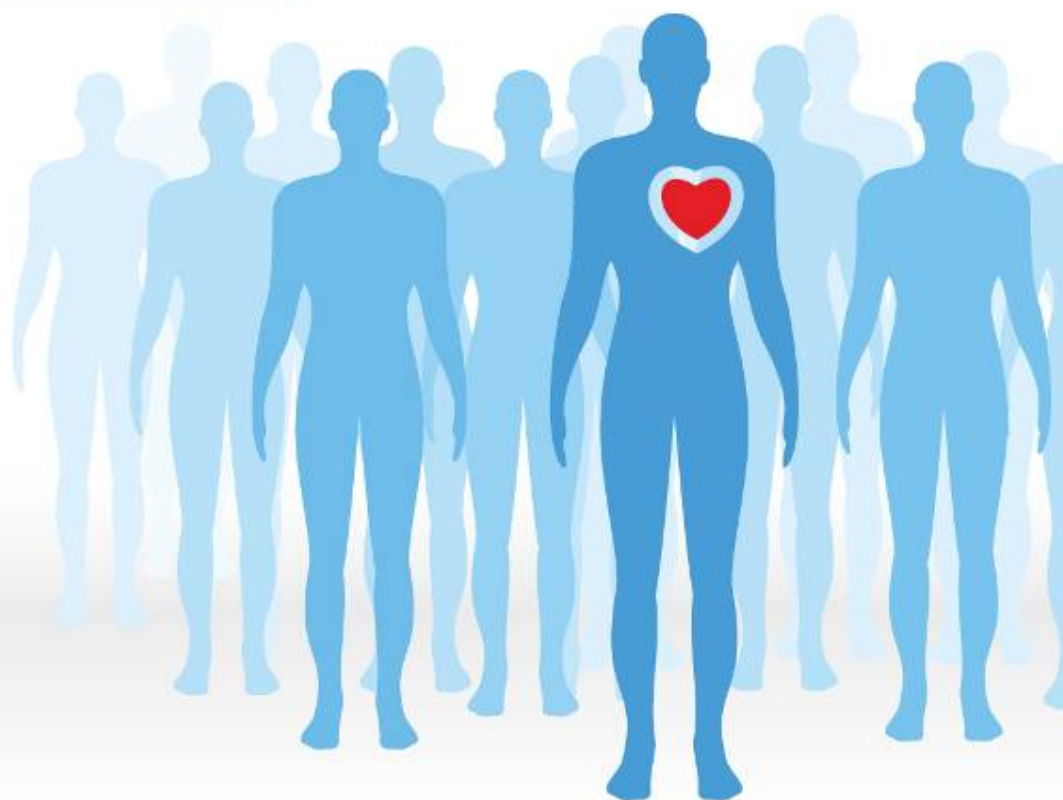


Healthcare in Asia

Priorities for reform

March 30th – 31st, 2010
The Fullerton Hotel, Singapore

Executive summary



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Speakers



- Arthur Higgins, Chairman, Bayer HealthCare
- Huang Erdan, Assistant Professor, China Health Economics Institute, Ministry of Health, China
- Song Ruilin, Executive Director-General, Chinese Pharmaceutical Association Research Center for Medicinal Policy
- Lilibeth David, Director, Bureau of Local Health Development, Department of Health, Philippines
- Cheng Shou-Hsia, Director General, Bureau of National Health Insurance, Taiwan
- Carolyn Buck Luce, Global Life Science Sector Co-leader, Ernst & Young
- York Chow, Secretary for Food and Health, Government of the Hong Kong Special Administrative Region
- Thomas Chan, Deputy Secretary for Food and Health, Government of the Hong Kong Special Administrative Region
- Shane Solomon, Chief Executive, Hong Kong Hospital Authority
- Martin Sepúlveda, IBM Fellow and Vice President, Integrated Health Services, IBM Corporation
- Khaw Boon Wan, Minister of Health, Republic of Singapore
- Yang Chih-Liang, Minister of Health, Taiwan
- Sarah Muttitt, Chief Information Officer, Ministry of Health Holdings
- Endang Rahayu Sedyaningsih, Minister of Health, Republic of Indonesia
- Phua Kai-Hong, Associate Professor of Health Policy and Management, Lee Kuan Yew School of Public Policy, National University of Singapore
- Wong Yue-Sie, Group Chief Operating Officer, Singapore Health Services
- Hasbullah Thabrany, Institution Center for Health Economics and Policy, Universitas Indonesia
- Peter Sheehan, Center for Strategic Economic Studies, Victoria University
- Henk Bekedam, Director of Health Sector Development Division, World Health Organisation



Introduction

“We need to talk”: Public-private cooperation and Asian healthcare systems

Economist Conference’s first “Healthcare in Asia” conference took place in Singapore in March 2010 under the theme of *Priorities for Reform*. The aim was to discuss the pressing health challenges confronting the region’s emerging economies and newly industrialised states.

Among these challenges, healthcare systems in Asia continue to suffer from the threat of infectious disease (such as tuberculosis, dengue fever, malaria, HIV-AIDS, and pandemics such as SARS). But on top of this, a new burden is emerging in the form of non-communicable, chronic disease (such as diabetes and cancer); driven by factors such as lifestyle changes and environmental degradation brought about by economic growth, the layering of new chronic diseases over the existing burden of infectious diseases leads to what is often termed the double-disease burden. Equally important, populations in Asia are ageing rapidly, with major implications for the nature of care and how it is funded.

And just as these challenges grow greater, so too do the expectations of citizens about the quality of medical care they should receive. As the conference showed, the real questions are not whether to reform but what to do and how to pay for it.

Critical questions

The healthcare systems in Asia that face these issues are highly diverse and of varying sophistication. They do, however, share three things in common. First, all of them face constrained resources. No matter how robust or fragile a particular country’s health system may be, all will struggle to find the money, personnel and equipment needed to meet the demands of people’s growing and shifting health priorities. In some economies, rapid economic growth means that money is available for healthcare, were there a will to give this high priority, but a lack of trained personnel still creates resource shortages.

The second issue is that health systems are not prepared for what is coming. Some provide little more than rudimentary care to large swathes of the population, especially in rural areas. In many, the structure of healthcare delivery is problematic. All too often it is built around hospitals and other secondary facilities rather than primary care (or better, a balanced continuum of primary and secondary care). A simple expansion of current systems through greater spending would be highly ineffective in meeting the health challenges of the next decade. Instead, investment in innovation—in new ways of doing things, big and small—will be essential.

A third common element among the region’s health services is an evolving relationship with the private sector. Even in countries with universal healthcare, such as Thailand or South Korea, private firms play a role, and there is no shortage of experiments in how this might develop. There is widespread agreement in the region that it is not a case of choosing between public or private, but rather of building a partnership between the two. The key issues are how the relative roles are defined and managed, with appropriate incentives and control systems, to allow private resources to contribute to an efficient and equitable health system.



Finding the public-private balance

Of particular importance is working out how best the public and private sectors should work together; their relative contributions will almost certainly vary across the different components of health systems. As a starting point, most people agree that governments have an essential role to play in ensuring a minimum level of health service, and basic health infrastructure in a country.

Funding these services can be done in numerous ways, including voluntary private insurance, compulsory health savings account, mandated company insurance of employees and national insurance schemes with various contribution requirements. It was widely accepted at the conference that there is a strong case for government taking the lead in establishing some form of universal insurance coverage, but that private insurance should also play a role.

In terms of the delivery of health services, practices vary widely across the region. Many countries have private hospitals, clinics and specialists, and several governments are even encouraging medical tourism, frequently by private firms, to increase the funding for medical infrastructure. Rising patient demand alone will insure a growing healthcare market in these countries. Indeed, in India, hospitals have already replaced pharma as the high-growth industry of choice for entrepreneurs.

The conference also noted the powerful role that private firms can play through managing the health of their own employees. A growing number of them are driving health system reform by adopting advanced practices that ensure their employees stay as healthy as possible. In addition, the growing role of private not-for-profit healthcare organisations in Asia was also noted. In India, for example, the Aravind Eye Care System and the Health Cities initiatives both revolve around not-for-profit models.

One perceived danger of an increased role for the private sector is rising inequality in access to services and health outcomes. Not all forms of private engagement carry this risk, but some certainly do. Wealthier individuals able to buy better healthcare, for example, inevitably creates disparities in provision, and may divert resources that could be used to improve healthcare for poorer segments of society. Similarly, where market elements are introduced into public systems—such as charges for prescriptions in Chinese hospitals—the result can often be a decline in access rather than an overall improvement in quality. Governments in the region are generally committed to containing inequality in access to health services while involving the private sector in the funding and provision of those services. The key issue is whether privately funded healthcare is integral and complementary, or even additional to, basic healthcare for all, or whether it crowds out basic healthcare.

Addressing this issue will be critical in the years ahead. Given that the resources needed for a largely public care system are not available in Asia, it is clear that private participation will be ever more necessary. Indeed, ignoring the potential resources available through private sector involvement carries its own ethical threat. In a 2005 case, for example, Canada's Supreme Court ruled that making private health insurance impossible but at the same time providing insufficient care violated human rights to life and security. "Access to a waiting list is not access to healthcare", two of the judges wrote.



Such considerations apply to all cash-strapped systems, and these are certainly present in Asia. Those of certain wealthier locations, notably Taiwan and South Korea, are feeling the pressure of providing universal healthcare. Among less well-off countries, India's government is raising spending but nobody even pretends it will do more than alleviate some of the problems and, at best, provide very basic care to all; the country's deficit leaves little room to manoeuvre. Even China's investment in healthcare, with recent initial steps towards universal insurance coverage, faces financial uncertainty, questions over whether cash-strapped provincial governments—the main funders of health services in China—can meet their share of the costs. Indeed, managing issues of decentralised delivery in large, complex societies is a key issue for many countries.

The innovation imperative

Whatever the precise role of the public and private sectors, and the appropriate balance between the two, both will face a number of key issues in the coming years in Asia. These are the need for comprehensive and continuing innovation; the centrality of providing (and, in some cases, initiating and establishing) primary care; the need for effective integration of all components of the health system; and the role of incentives, metrics and measurement.

Well-established and well-funded healthcare systems usually cope well with medical innovation. In such a context, it is relatively straightforward to replace existing surgical procedures or drugs with more effective ones. But developing countries in Asia face a more complex set of innovation challenges, ranging from increased emphasis on detection, prevention and early intervention, to the difficulties of delivering health services in vast rural areas.

One issue that even mature health systems have difficulty with is changing delivery systems, or business model innovation, to use the private-sector phrase. Professor Clayton Christensen of Harvard University and his co-authors, in *The Innovator's Prescription*, argue that the general hospital—as a relic of the past—is highly inefficient for modern healthcare. Of course, some change within existing systems is possible, especially where it involves the provision of new services—such as the successful introduction of half a billion Accredited Social Health Activists in rural India. But where innovation requires changing the way that healthcare is provided, then a combination of complexity, bureaucracy, tight regulation (often based on legitimate concerns for safety), and entrenched interests tend to stymie progress.

China is discovering some of these difficulties on a grand scale with its reform programme, but it is not alone. The biggest barrier for Indonesia hiring foreign doctors or India creating streamlined programmes for rural physicians are the complaints of existing medical personnel. On the other hand, business model innovation—either within organisations or through the arrival of new competitors—is a strength of the private sector, and public health systems can learn from this experience.

One innovation that many are calling for in the region is greater emphasis on primary care, both to achieve better health outcomes and to achieve them more cost-effectively. In many countries the central point of provision is the hospital, perhaps supplemented by specialist doctors. There is a need to train more primary healthcare personnel, not just doctors, to make better use of existing resources, and to provide individuals with clear incentives to use primary healthcare services.



A call for interaction

Greater interaction between all the actors in health is vital. Simply letting business fill in the gaps in state provision will limit the possible impact of the resources they bring. First, market dynamics mean that the private sector, on its own, is unlikely to be of help with certain issues. Private hospitals in most of these countries, like state ones, are predominantly urban. Consumer demand, though, will not be great enough to entice companies to address the rural gap.

Moreover, depending on the existing structure of the market, the benefits of bringing in private money can be wasted. As the conference heard, for example, health systems based predominantly on private insurance have tended to see even more rapid cost escalation than state ones. Finally, effective health systems need to integrate a wide range of offerings of which some are public goods. Matters such as the promotion of public parks and better urban planning to make environments more conducive to healthier lifestyles, however important to a population's health, do not have a compelling business model.

Central to success will be how the interaction is organised. In particular the alignment of incentives is crucial. As one conference participant from a Singaporean hospital group pointed out, such misalignment is partly responsible for the large divide between public and private hospitals in his country, and the failure of both to establish better links with primary care. In India, the types of medical provision that get funded and how the money is provided help explain why private hospital companies are attracting investors but private chains of GP surgeries are not. Indeed, badly designed payment systems are more than capable on their own of stifling innovation in any country: the Chinese fully realised that using pharmaceutical sales to fund hospitals had to end if they wanted hospital doctors to prescribe in a more effective manner.

No country has squared the circle of how to harness both public and private elements of healthcare provision with complete success. What is clear is that the provision of appropriate incentives must be backed by well-developed metrics and strong measurement systems. And some elements of best practice are starting to emerge. As discussed, aligning payments systems with the kind of healthcare delivery that is desired is the most effective way to direct the private sector, or even a government health system's own employees.

Fee-for-service payments are just the biggest example of how perverse incentives can lead to too much of some activity and not enough of another. Relying on patient outcomes where possible is a far better approach. It certainly rewards innovative improvements in care much more quickly than fee-for-service. The gathering of data on outcomes also greatly enhances transparency within healthcare provision, one of the great barriers to efficient markets in the sector. Although measurement is sometimes difficult, that is in part a function of its novelty: the practice has only started within the last decade or so.



11 key takeaways

Peter Sheehan, professor at Victoria University, summarised 11 key takeaways from the Healthcare in Asia conference as follows:

1. Key health challenges facing developing countries in Asia
 - Ageing, the growth of 'developed country' chronic diseases in developing countries and overlapping transition (countries being forced to address both infectious and chronic diseases)
2. Need for a comprehensive approach to reform
 - Involves many disciplines
 - Specific to the needs of the context
 - Data-based
3. Emphasis on innovation, rather than just scaling up
 - Broadly defined, context specific
 - Disruptive and/or evolutionary
4. Finance—the roles of government and the market
 - Potentially different roles in financing and delivery (example: Taiwan)
 - Strong case for universal provision
 - Continued role for private insurance
5. Need for the government to assure basic provision of services
 - Needs focus on infrastructure and service provision, not the level of spending
6. Managing issues of decentralisation
 - Key issues in countries such as China and India
7. Role of the private sector in financing, managing and delivering healthcare
 - Competition and incentives—need to manage equity distortions
 - Potentially a big role for large companies, including management of their employee's health
8. Importance of governance, competition, metrics and adequate resources in ensuring the efficiency of hospitals
9. Greater emphasis on primary care, for both efficiency and outcomes
 - The need to develop better primary care resources (not just physicians) where these are not available
 - Make better use of existing resources
 - Incentives for using primary care services
10. Need for greater, more systematic attention to detection, prevention and early intervention
11. Data-based management and monitoring—the role of IT systems
 - Desirability of interoperability within and across national systems
 - Provision of information for evidence-based policy
 - Developing effective health IT systems will be a long road for many countries



2011 and beyond—it's good to talk

The ability of Asian countries to meet the health challenges they face will depend on many things. Countries will need to understand what private organisations can best provide, and where the state is the most effective actor. They will need to develop structures, incentives, and regulations to encourage and reward innovation. And they must design a coherent, integrated system that is geared around health outcomes rather than just resource inputs. These are mammoth tasks and will never be fully complete.

What will help, however, is for the private and public sectors to keep engaging with each other and trying to understand the interplay of policy, regulation and market forces. In the coming years, Economist Conferences' Asia Healthcare Summit intends to promote and be a part of this dialogue.



Executive summary



An audience of just over 200 senior healthcare stakeholders gathered for Economist Conferences' first Healthcare in Asia event, held in Singapore at the Fullerton Hotel on March 30th-31st 2010.

Asia is at a critical juncture in the development of its healthcare systems. Economic growth is providing policymakers with an opportunity to fast-track the modernisation of their systems. But the path to reform is uncertain, and the financial and demographic challenges to modernisation are considerable. Some countries must simply grapple with the short-term struggle of meeting current demand. Others are thinking strategically about what kind of structures and means of financing are best-placed to meet the needs of their future populations.

Given these overarching concerns, the theme of the conference this year was 'Priorities for reform'. Many of the discussions focused on how countries can improve the efficiency of their healthcare markets, strike the right balance between the public and private sectors, and maintain equitable healthcare provision.

Keynote:

Khaw Boon Wan, the minister for health from Singapore, said that in the developed world, healthcare reform has become a key policy priority because of five factors:

- Healthcare costs continue to rise faster than general inflation.
- More doctors have not necessarily led to price reductions.
- Greater healthcare spending has not always led to better health.
- Patients' expectations continue to rise.
- Employers and taxpayers are increasingly reluctant to pick up the bill.

For most of the 20th century, medical advances brought about dramatic improvements in health outcomes, like lower infant mortality rates. However, according to Mr Khaw, though the 21st century continues to see medical advances, many are costly with no clear victory over the diseases they try to combat. As a result, medical advances today are seen as a source of cost escalation and are sometimes even accused of spurring demand for services of questionable value.

Ageing populations and slower economic growth in developed countries have also placed pressure on existing healthcare models. In places like Germany and the US, many employers, faced with ballooning healthcare bills, are keen to shift the burden to the employees.

According to Mr Khaw, while it is still unclear what an appropriate healthcare funding model should look like, some of the dynamics of the healthcare market are now fairly well understood:



- The fee-for-service remuneration system perversely incentivises over-servicing by providers.
- The provision of free healthcare at point of consumption wrongly incentivises over-consumption by patients.
- Over sub-specialisation has fragmented healthcare delivery and if poorly coordinated does not lead to better care but only higher cost.
- Health outcomes are not easy to measure, making comparison of providers' performance difficult.
- The resultant lack of transparency causes market failure.
- The widespread use of defensive medicine in some countries adds significantly to healthcare cost.

Importantly, says Mr Khaw, in many countries politics has caused major distortions, resulting in further market failure.

Mr Khaw believes the key to a sustainable health care system is to depoliticise healthcare, minimise market distortions and allow healthcare to function as normally as other economic activities. Singapore tries to achieve this through the following tenets:

- Health outcome is a personal matter. Hence, Singapore inculcates amongst its citizens a strong sense of personal responsibility over their own health.
- There is no free healthcare. Every healthcare service is eventually paid for by the patient, either through taxes, or reduced wages. The government's job is to make sure that the cost of delivery is as low as possible by, for example, cutting out abuses and other moral hazards
- Specialisation and subspecialisation have brought about medical advances, benefiting many acute patients. But over-specialisation can be inefficient, and possibly end up as fragmented care without necessarily better outcomes.
- Citizens must accept that we are still mortals and thus medical science has its limits.

In terms of funding, Singapore inherited the British taxation-based system, and combined it with the US insurance-based system, to create a hybrid which tries to combine the best of both worlds. It achieves universal coverage for all its citizens through multiple levels of heavy government subsidy, compulsory health savings account and a low-cost national insurance scheme with deductibles and co-payment. According to Mr Khaw, three of Singapore's sub-sectors are particularly competitive—the GP, the obstetrics and the LASIK markets, with multiple players, good market information and active consumers shopping around.

In addition, from an urban design standpoint, Mr Khaw stressed the importance of creating a living environment that promotes good health, including having many parks in the city. He is particularly optimistic that medical advances, such as in genomics, stem cell research and biomedical science, will be able to solve many future healthcare problems. He concluded that economists and academics must continue to support policy reform with robust analysis, unbiased by political or ideological inclinations.



Priorities for reform:

According to Peter Sheehan, professor at Victoria University, Asia's rapid economic growth and shifting demographics has led to the conjunction of three healthcare trends: ageing, the onset of 'diseases of development' (like obesity and smoking-related disease) and the persistent threat of infectious disease. While these trends have been experienced elsewhere before, their coming together is unprecedented.

Furthermore, the phenomenal rates of change in Asia's social, economic, political, cultural, and technological spheres has hampered the efficiency of healthcare delivery, according to Phua Kai-Hong, professor at the Lee Kuan Yew School of Public Policy. Asia is witnessing, amongst other things, rapid travel and migration (international, rural-urban) of both humans and animal populations; tremendous mutation of species; and glaring income disparities, leading to underdevelopment and poverty living alongside 'affluenza'.

One of the main challenges for healthcare reform, according to Professor Sheehan, is balancing the role of the community with that of the market. Asians have a strong tradition of looking after their family and pursuing opportunities in the marketplace—any reform must take into consideration these potentially conflicting desires. Countries must strive to achieve a suitable public-private mix.

Professors Sheehan and Phua agreed that private insurance can do a good job if it complements a public system, ideally where there is a minimum package of services. Private insurance can perhaps be used to pay for higher-end treatments.

Second, Asian governments must be made aware of the importance of healthcare to their economies. During the rapid economic growth of the past 30 years, healthcare has often been taken for granted. Now this needs to change—health must be at the centre of economic development and thought of more strategically. After crystallising the objectives of health reform in their individual countries, governments will then be able to better strike a balance between equity, efficiency and quality.

Importantly, governments must be careful to align incentives correctly. For example, they should ensure that healthcare providers are well rewarded, but do not try to exploit the information asymmetry by raising prices for consumers. These sorts of challenges will be especially acute for countries transitioning from a socialised/centralised system into a market economy.

Mr Sheehan and Mr Phua agreed that innovation is extremely important for healthcare reform. Governments need to consider changing old processes, embracing new technologies, and thinking of new ways to use old technologies.

In this regard, Mr Phua argued that it is important that any innovation is followed through on, and outcomes measured. According to him, medical compliance and adherence is poor across Asia. As a result, the effectiveness of treatments is low.

Another key challenge, says Mr Phua, is capacity—government must decide how to allocate scarce medical resources. Their decisions will be influenced by their level of development and demographic profile.

Finally, although much attention is focused on dealing with market failure, Mr Phua suggested that countries should also be aware of how to deal with government failure. Ultimately, be it the government, private sector, or civil society, it is important to prioritise good governance.



Case Studies:

Indonesia

Dr Endang Rahayu Sedyaningsih, minister of health for Indonesia, said that Indonesia's tremendous geographic spread and economic diversity exacerbate the challenge of devising a sustainable healthcare system. According to her, the government is focused on seven key areas.

First is the need to provide good basic care. This includes wellness centres, healthcare education, and primary care facilities. The operating funding for these comes from local governments.

Second is the need to increase the number of doctors in the country, and improve their distribution—at the moment, they tend to be concentrated in Java, the main island where most Indonesians live.

Third is improvement of the health insurance system. Fourth is ensuring better provision and distribution of drugs. Fifth is to give greater emphasis to municipalities with problems. Sixth is ensuring good governance, in part by eradicating corruption. Seventh is the need to build world class hospitals—so Indonesians seeking treatment “do not need to come to Singapore,” says Dr Sedyaningsih.

Dr Sedyaningsih also stressed that the Indonesian government is eager to engage with the private sector towards reforming its healthcare system. In addition, it is keen to allow foreign doctors to practice in the country. There is much demand for them, particularly because of their experience with infectious disease. However, here it faces protectionism from the local doctor's lobby. A compromise may be for foreign doctors to be allowed to work in public hospitals but not their own private practice.

Indonesia has also taken several steps in its fight against infectious disease. This includes empowering the community to take care of itself; efforts to develop high-tech laboratories; influencing universities to increase their research capacities; and strategic stockpiling of vaccines. Although Indonesia has enjoyed some successful collaborations with other countries in understanding and fighting infectious disease, Dr Sedyaningsih said that she would like to see more progress. According to her, one sticking point in the past has been around intellectual attribution—the feeling that Indonesian academics were not fairly recognised for their contributions in collaborative research.

Hong Kong

Dr York Chow, secretary for food and health with the government of Hong Kong, said that healthcare must be a high responsibility of any government because many threats are related to variables beyond an individual's control (like food and the environment) and because of information asymmetry in the market.



Hong Kong spends the equivalent of around 5.5% of GDP on healthcare. Half comes from the taxpayer, and half from private insurance or out-of-pocket payments. The second half is increasing faster. According to Dr Chow, its challenges include how to

- Manage the private sector, otherwise costs will grow.
- Manage ageing—younger generation cannot afford to support elderly.
- Focus not just on financing, but on service and distribution of service.
- Encourage activity/exercise in an urban area.

In terms of encouraging exercise, Hong Kong has tried to provide facilities and infrastructure throughout the city, as well as implementing harsh rules against smoking—"Not even at the Hong Kong Sevens," says Dr Chow. According to him, tobacco is easy to clamp down on, as taxes can be increased, and wrongdoers easily fined. (Dr Sedyaningsih said that in Indonesia, it is not as easy, as there is much opposition from tobacco farmers. Nevertheless, it is in the process of preparing regulations around advertising and against selling in small packs.)

In order to control costs, doctors at the Hospital Authority (HA), which serves 90% of patients in Hong Kong, have to decide which drugs are most cost-effective. Extremely expensive medications are removed from the standard list. In that way, doctors have liberties to control costs. On average, the government pays 97% of the cost at the HA, while the patient pays 3%—the fixed charge of HK\$100.

China: Lessons from the most ambitious healthcare reform programme ever implemented

In order to implement reform, a country needs political support, solid evidence to guide policy, and comprehensive consultations, said one panelist from a multi-lateral organisation.

According to him, healthcare in China was not a high priority in 2002. The onset of SARS was an example of an opportunity coming out of a crisis—it created the necessary political support in the country and, amongst other things, led to improved surveillance on AIDS and tuberculosis.

Concurrently, reporters from the China Youth Daily presented sound evidence for greater healthcare spending—although China spent the equivalent of 4.5% of GDP on healthcare, only 20% of the total came from the government. Subsequently, in 2006, China's president declared that everybody must have access to healthcare services, which initiated an effort between 14 ministries.

Finally, before embarking on its reforms in 2009, the government carried out wide and comprehensive consultations.

According to another panelist—a Chinese academic—he proposed that China's main objective is to have a system which is more equitable and efficient. To this end, it conceived of a 5-point system:

- 1) Universal coverage (most important).
- 2) List of standard drugs.
- 3) Build a more efficient primary healthcare system.
- 4) More equitable public system.
- 5) Restructure public hospitals.



He thought that the implementation of points 2-5 is still in its preliminary stages. Restructuring public hospitals is particularly challenging because of equitable compensation issues. According to one panelist, as providers only get 5-20% of their salary from the government, doctors are always thinking of ways to make more money. He feels that perhaps insurance should pay the salaries of doctors, which will allow the insurer to bargain on behalf of the patient. However, it will not be easy—he cited the example of South Korea, where doctors went on strike to protest against similar payment changes.

It was raised that it will not be easy to implement the 5 points because of China's size and diversity. For instance, it was said, that achieving universal coverage by 2020 is difficult. There is a big gap between the government's capacity and people's expectations which will have to be bridged. Nevertheless, the government deserves credit for agreeing to be the main contributor to the healthcare system. It is determined to provide subsidies and grants to the needy.

One of China's big challenges is narrowing the gap between the best and the worst hospitals. For instance, Beijing has 60 big hospitals, many of which are of a "similar standard to those in Hong Kong and Singapore". However, if one drives just 150km outside the city, service can be much worse.

The main obstacle to reform that was mentioned is the gap in mindset between China's Ministry of Health (MOH) and Ministry of Finance (MOF). It was noted that the MOF does not like to consider the demand side implications of healthcare reform. Therefore, with reforms initiated by the MOH, what is said is different from what can actually be done. One panelist suggested that one way to win the MOF over is through the argument that better healthcare will eventually boost consumption, by reducing the need for precautionary savings.

China has also had difficulties coming up with a standardised drug list. For instance, one problem had to do with drug insurance coverage, which initially relied on a list from Singapore. China quickly found that what worked for Singapore did not necessarily work for it—the list was relevant only to urban employees. There are also differing standards for local and foreign drugs. Finally, enforcement of any standardised list is also difficult.

According to a representative of the pharma industry in China, any reform in China is done step-by-step, through the use of pilot schemes. In the same way that Shenzhen was a pilot for economic reform, other small locales will pilot healthcare reform. The government still needs to carry out many experiments before it can fully understand what a sustainable healthcare system might look like. In particular, it needs more experiments where it goes wrong—so far, all the healthcare pilot lessons have been successful. Thus, the government does not yet know where the pitfalls may be.

Interview with an industry leader: Arthur Higgins

Arthur Higgins, chairman of Bayer HealthCare, said that Asia has great potential as a healthcare market because of the clear correlation between economic growth and higher healthcare expenditure; and because Asia's highly qualified researchers and large patient pool make it an ideal site for R&D. In his opinion, two main challenges it faces are the increased pressure on public health budgets which has been exacerbated by rise in chronic and lifestyle diseases; and the complex regulatory hurdles which delay access to new drugs.



He described five lessons which Asia could learn from Europe and the US. First, investing in healthcare is crucial to a healthy population and strong economy. The sustainability of these healthcare systems is dependent on more diversified sources of funding, including private health insurance and co-payments. It is important for countries in Asia to find the right balance between social and private healthcare.

Second, the right framework conditions are needed to support innovation and patient access. This includes establishing a solid intellectual property rights regime as well as streamlined, transparent regulatory and reimbursement processes. In this vein, Mr Higgins would like to see a pan-Asian regulatory body set up to ensure the harmonisation of regulatory standards, leading to faster approvals.

Third, Mr Higgins believes that Asia should capitalise on best practices and set up new partnership models to speed up drug discovery and development. According to him, individual pharmaceutical companies can more effectively tackle all the R&D challenges by partnering with stakeholders—the Innovative Medicines Initiative in Europe is proof that such public private partnerships can be successful.

Fourth, Mr Higgins feels it is important for Asia to develop a holistic approach to disease prevention and control as a top priority. As chronic and lifestyle diseases are on the rise in Asia, effective prevention would significantly reduce the burden these diseases have on healthcare, as they are often caused by known and avoidable risk factors.

Finally, as empowered patients make healthier patients, Mr Higgins thinks Asia should shift towards more patient-centred healthcare, with patients having access to high quality health information.

Mr Higgins also said that it is important for Asia to clamp down on counterfeit medicines, perhaps by implementing a common track and trace system to address counterfeits.

In his opinion, the research-based pharmaceutical industry can be a crucial cog in Asia's healthcare system by manufacturing medicines; demonstrating the added value of new medicines with high quality data and transparent health technology assessments; partnering with academia and other stakeholders to accelerate the development of lifesaving medicines; providing timely responses to major and emerging health threats; and developing a new coding and identification system to fight counterfeit medicines.

Financing options:

A health minister joining this session said that there are three funding options for a country. Group 1 is where general taxation pays for more than 50% of costs. Group 2 is where social insurance pays for more than 50%. Group 3 is where out-of-pocket payments cover more than 50%.

Each model is imperfect. Group 1, as with the UK's NHS model, suffers from long waiting lists and market failure. Group 2, as with Taiwan, is prone to civic failure. Group 3 does not result in universal coverage.



According to the minister, an OECD study in 2007 showed that a Group 2-type funding model will result in lower overall healthcare expenditure. However, as Taiwan is experiencing now, it can lead to escalating government expenditure and therefore tricky political compromises.

According to another panelist from an international advisory firm, a society has to ascertain its healthcare objectives and find ways of measuring the relevant outcomes before it can decide what sort of funding model to adopt.

A leading professor at Universitas Indonesia, defines society's healthcare objectives as a tension between libertarian equity and egalitarian equity. For libertarian equity, a private insurance model works best—the more you pay, the more you get. For egalitarian equity, social insurance works best—you get what you need regardless of how much you pay.

The minister also believes that any model reliant on private insurance will inevitably lead to cost escalation. (In the case of Taiwan, private insurance is allowed only for supplementary care.) Vijay Vaitheeswaran, health correspondent for *The Economist*, agreed, saying that much empirical evidence supported this. Private insurance is good in so far as it encourages innovation and delivery system reforms that might not otherwise happen.

Costs also escalate when third-party payment is involved, mentioned one participant. This divorces the patient from the true cost of service, leading to over-demand. Essentially, there is double information asymmetry—between insurers, providers and patients.

It was also noted that one way to control costs is by empowering consumers, knowledgeable patients can drive efficiencies in delivery. Therefore, the overall reform conversation must be moved from being product centric to being about outcomes. This involves giving the right information to consumers, and dealing with demand management.

All three panelists agreed that it is difficult to decide which procedures and services to pay for. Essentially, what is important for a society is often quite different from what is important to an individual or his/her family (e.g. end-of-life treatment). One mentioned that it is important for each society to prioritise different treatments based on its own objectives and preferences.

Breakout sessions:

What are the options for funding better healthcare?

- Individual countries first need to decide what 'better healthcare' means. Beyond common indicators like infant mortality, it is not clear what constitutes better healthcare. For instance, if drug expenditure as a percentage of total is very low, does it necessarily mean that costs are contained, or simply that everything else is so expensive?
- Alternative ideas include credits for good health in a social insurance system; private insurance only for catastrophic events; sin taxes to fund healthcare; and drawing lessons from education sector funding, where there are parallels.



Public versus free market mechanism—what is the right balance of healthcare financing?

- Private hospitals can be used to deliver healthcare that is public-funded; this mixed approach has been used effectively in some Asian countries.
- In Asia, use of community-based models has not had a successful track record.
- Use of shared public financing models including both federal and regional government levels can help to provide more equitable public financed solutions across regions.

How applicable are Western funding models to Asia?

- Different levels of development among countries in the region. Within the countries itself there are great diversities in development which has impact on accessibility and efficiency of health care delivery system.
- Growth of consumer demand for better healthcare resulting from improvement in access to information especially through ICT.
- Healthcare funding mostly tax-based in many countries. Social insurance schemes still at low level of coverage in especially in middle and low income countries in the region. Growth of private health insurance providers to fill in the gap.
- Privatisation of health care services without capacity of the government to regulate leads to unintended consequences.

Top-down reform—organisational change and governance:

One panelist—a hospital group chief executive—spoke about his experience with medical service aggregation. Critics of aggregation frequently point to two problems associated with monopolies. First, they end to become bureaucratic, unresponsive, and out of touch with the community. Second, they become non-innovative.

On the flipside, he presented the benefits of aggregation. First, an aggregated system, for example Hong Kong, can respond swiftly to crises, like swine flu. Second, it is easier to introduce systems, like clinical management, across the whole network. Third, decision-making systems are better, as big groups can afford to buy the best administrators. Fourth, there is extensive sharing of expertise and best practise across the group. Fifth, a large group can exert pricing power on suppliers, amounting to 10-30% discounts in pharmaceuticals, systems and devices purchases. Sixth, it is easier to find budgets to use for innovation.

Though aggregated, the same panelist mentioned that Hong Kong Hospital Authority decentralises by devolving day-to-day operations to the cluster level, and frequently engaging the community and clinicians. He also emphasised using clinical, evidence-based key performance indicators, and setting up activity targets, in order to keep the aggregated provider efficient.

A senior policy maker from the Department of Health in the Philippines, described some of the challenges her country faced in decentralisation of service delivery and part of the financing to local provinces.



First, she claimed that decentralisation was “too fast, too soon”. It could have prepared local authorities with better capacity. Second, decentralisation led to huge disparities in performance. The same 15 provinces have performed poorly, as their lack of capacity has persisted across the last decade.

She says that what is needed before decentralisation is better education of local governments as well as implementation in stages, rather than at one shot. Another challenge is that the government has very little information about the private sector. It is assumed to be of better quality, but is also responsible for high costs. Part of the reforms is controlling costs by making the public sector more competitive. Interestingly, when local authorities had to remit their incomes to the central government, it made up just 30% of their total budget. When they were later allowed to keep their incomes, it jumped 200%.

Another panelist from the Bureau of National Health Insurance in Taiwan, says that the Taiwanese market is highly competitive because there is a single buyer. Hospitals have to be efficient or they will be driven out of the market. The government does not set too many regulations over public hospitals, which account for 30% of total beds, but instead lets them compete with private or non-profit.

As a result, general satisfaction is above 70%, and there has been significant consolidation, from 800 hospitals in 1995 to 550 now (the total number of beds has remained the same).

Challenges include how to deal with governance of hospitals. One way is to use extensive quality indicators which are available publicly on websites. In particular, the government has started monitoring the performance of public hospitals closely. Still, he contended that he is unsure if a centralised or decentralised system is better.

Breakout sessions:

How can appropriate organisational structures and management systems be identified for individual markets?

- Ensure client accountability and listen to the client's voice—this will spur efficiencies in public sector delivery
- Create proper incentives for serving rural/poor e.g. doctors in India must serve a year in rural areas in order to get their license
- Create proper collaboration between primary care and hospitals, especially in rural areas, e.g. through accreditation; funding of networks of facilities rather than individual delivery points

How can organisational structures and management systems be made more efficient?

- There are two broad models for hospitals, aggregated and disaggregated. Very disaggregated hospital systems can benefit from some aggregations that allows economies through pooling of IT, procurement and management.
- Aggregation has its limits, as larger systems can become unresponsive and bureaucratic, which also becomes a barrier to innovation.
- Need to develop skilled workforces and leadership programmes to help the innovation process.



He mentioned that his company spends US\$2bn on coverage annually for its employees. By dealing directly with primary care physicians, it negotiated an agreement where primary care is completely free for its employees—no cost sharing and no deductibles. Accordingly, the company gets more “bang for its buck” with primary care where there is a high level of trust between the patient and provider. Even though the initial investment is high, he says that this primary care approach will cost 35% less than using a lot of specialists. By placing family primary care at the centre of its healthcare programme, the business succeeded in improving the health of its employees and hence their productivity, as well as making physicians conversant in business, which brings them one step closer to what is expected of them with the so-called Obamacare, the healthcare reform programme in the US.

As part of its comprehensive healthcare approach, the company he works for has introduced innovations in disease management, smoking cessation, as well as obesity in children. By addressing obesity, it ensures that its employees’ families are well taken care of, which ultimately impacts the productivity of its workers—parents with sickly children tend to be more distracted at work.

According to the executive, with proper metrics and data collection, the firm has managed to shift the health risk distribution of its employees towards a lower risk profile. Thus he believes it is important for healthcare systems to create the proper data infrastructure to understand its particular health risk distribution.

In addition, for countries with insufficient physicians, he argued that a lot of primary care can actually take place without physicians. Instead, a massive effort is needed to redirect and retrain health professionals like nurses. According to him, Cuba is an example of phenomenal primary care without too much investment in physicians.

Breakout sessions:

Private sector role in driving innovation

- There is a lack of engagement between governments and the private sector in terms of proactive discussion of policy and reforms. There is a need for creating such regular frameworks for dialogue at a national level across Asia, so that private sector views are taken into account at an early stage in policy development
- Asian governments that have already made progress with establishing private public partnerships need to engage with other Asian governments, to assist in developing PPP across Asia
- The private sector could work together through industry associations to make substantial progress and greater impact on key initiatives, such as distance learning for rural doctors, so that efforts are not piecemeal and of little overall impact



Managing demand—from primary to secondary care

- There is much historical baggage which leads to insufficient primary care—around pricing, incentives, difficulty of imposing standards on GPs, lack of prestige around the GP profession, fact that procedures have been distorted
- Countries must improve training and education of GPs
- It would help to give GPs access to laboratory/ X-rays/other specialised services so that they can care for patients with specialised needs
- In addition, it is important to include GPs in clinical pathways of patients
- The structuring of incentives is important, to provide the subsidy at the right level, perhaps with means testing. In addition, important to incentivise preventive medicine

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