The Market Economy and Regulating the Private Health Sector

Professor Michele Forzley

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MoPH PHD Kabul

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Some Questions:

Why should the MoPH regulate and how can MoPH regulate the private health sector?

What are the objectives of regulation?

What are the options?

What is the evidence of what works?

What is MoPH already doing?

What more might it do?

12 Key Messages

KM1: ID Objectives of regulation

- Regulate the quantity of care - includes geographic distribution and types of care
  - market entry
- Regulate quality of care – see slide 11
- Regulate the efficiency of care
  - cost effectiveness, performance based financing, insurance
- Ensure equity or access to care
  - Provisions for the poor
  - Avoid catastrophic health expenses for all
- Other objectives: mandated, whole system view, advance the health of the population

KM2: Recognize regulatory capacity can be improved

- Regulatory capacity in LMICs: weak and inefficient
- Substantial evidence that when regulatory options implemented well – good results
- Main reasons
  - Lack information and understanding about private sector
  - Lack administrative/managerial capacity
  - Insufficient resources: computer know-how, skills
  - Insufficient data to plan and regulate
- All of the reasons for weakness can be addressed without high administrative costs and need not be resource intensive.

KM3: Main Regulatory Options:
Instruments can fit into more than one category

- Mandates/Control and Command
  - Legal mandates
  - Policy Mandates
- Self Regulation
- Incentives
- Non-mandated policy options
- Options from the patient perspective
- Non-MoPH options

KM4: Regulation is a complex process

- Strengthening existing systems is essential
- Build system in phases
  - Add low cost options such as self regulation
- Combine options
  - C&C with other instruments such as purchasing
  - Accreditation with health insurance or vouchers
- Systematically review, evaluate and adjust

KM5: Most countries have legal mandates

- Afghanistan is like other countries
  - Basic laws: legislation, mukararah, standards, guidelines
  - Establishing standards/checklists, monitor and enforce
  - Control entry – licensing/sanctions
  - Enforced by government – future self regulatory bodies

Instrument	India	Indonesia	Vietnam	Philippines	Thailand
Law on Private Sector	In process, Subsidies for tertiary care	√ Requires hospital governing board and its roles, specifies # of specialists by category	√ Tax exemption +	√ Bench book of performance indicators, accreditation is based on these	√

KM 6: Price Setting is not best practice.

- Price setting as per the PHCR is not use by other countries with market economies.
- Where there is national or private social insurance
  - Contracted providers
  - Benefit schedules or annual amounts per patient
- Tied to effectiveness
  - Comparative effectiveness approach CER – UK
  - Results based financing RBF = P4P– no proof of effectiveness
    - Can have distorting effect
- Alternatives:
  - Social insurance to protect against catastrophic risk
  - Consumer information –schedule of fees posted and facility report cards – evidence plastic surgery charges declining

KM 7: Command and control is instrument to ensure quality

- Licensing facilities and personnel
- Rational standards/checklists/type of facility
- Monitor/sanction
- Report mortality and morbidity data (PHCR 37)
- Also self regulatory/ int'l best practices
  - Remediation System – Advice
  - National Treatment protocols/clinical guidelines
  - Continuing education
- No evidence that accreditation works in LMICs - must have other regulatory tools in place: C/C among others.

KM 8: Afghanistan legal and policy mandates authorize all options

- Art. 6 of Afghanistan Public Health Law (APHL): MoPH shall

  "be responsible to manage, guide, control, evaluate, the provision of comprehensive and quality health services to all citizens…"

- Art 8 APHL: " fixing geographic location…

- Art. 3 APHL: facilitate and monitor private sector

- Private Health Center Regulation (PHCR): MoPH shall:

  license, set standards, monitor, enforce and sanction, collect information M&M

KM 10: Many non-mandated policy options

Self Regulation

Strengthen ethics and self accountability

- Foster ethical behavior and create standards
- Accreditation
- Training and continuous provider education
- Franchises, Networks, HMO model
- Professional Assoc.
- Technology
  - EHR and databases
  - Telemedicine

Incentives

Align incentives with quality, affordability and access

- Purchasing and contracting
- Pay for performance
- Demand side financing insurance or vouchers coupled w/ interventions known to succeed.
- Right to operate
- Cooperation and collaboration with private sector

KM 11: Many options from the patient perspective

- Increase demand for quality: insurance and vouchers
  - Subsides for targeted populations for high impact interventions to increase supply by private sector and therefore demand
  - Social marketing programs
- Educate and incentivize patients to demand the most beneficial services
  - Citizen report cards/quality comparisons and complaint lines – Educate consumers, regulate advertising, labels,
  - Quality report cards
  - BCC/Information on healthy behavior- immunization, no smoke, ORT
- Build civil society as advocate and watch dog for health

KM 12: Many non-MoPH tools

- Legal mechanisms
  - Medical malpractice laws
  - Anti trust laws
  - Define and protect consumer and patient rights
  - Legal framework for health insurance and banking
- Investment incentives
  - Respect for rule of law
  - Tax holidays
  - Waivers of import duties
  - Land grants
  - Banking system
  - Power and telecommunications grid
  - PPP
  - Subsidies

Conclusion: The regulatory system in Afghanistan is under construction.

- PHCR – planning book implementation
- Licensing
  - Index standards, canon mukararah – what is correct behavior?
  - Restructure license process forms – comply with law
- M&E joint monitoring, coordination of inspections
  - Reports and records of inspection and referral to LIED
- LIED – sanctions and review draft tarsal amal
  - Sanctions guidelines,
  - DRSC
- Self regulation- APHA, acknowledgment for standards compliance,
- Finalize, approve, implement. Keep adding and getting stronger.

Best wishes and tashakar, merci, shukran, and thank you.
Prof. Michele Forzley

Supplemental Slides

Focus: Commercial sector

Regulation is cost of doing business.

How an owner calculates the cost of regulation.

- Owner's Investment = initial capital investment
  - Start up expenses include:
    - MoPH License and AISA fees
    - Construction, Equipment, Salaries
    - Operating Costs until revenue exceeds expenses

- Expenses include:
  - Operating expenses: salary, electricity, water, supplies
  - *The cost of complying with regulations*

- Gross revenue- expenses = net revenue
- Net revenue - revenue taxes = net profit

- Net profit can be spent by
  - Re-investment in the business – new equipment, expansion
  - Repay initial capital investment – return of capital
  - Paid as dividend to owner

Suggestions on making Afghan regulatory system more effective

- Strengthen regulatory capacity
  - Build the system required by PHCR with adequate resources
  - Improve skills and attitude MoPH managers
  - Delegate managerial authority to department heads/Reduce bureaucracy
- Build empirical information base
  - Description Data form at licensing/ map PHCs
  - Mortality and Morbidity data
  - Information feed back loops – monitor the monitors
- Build institutional capacity of private sector – associations - long term goal- more self regulation
  - Plan to delegate some authority

Resources and References

- Business Handbook for Private Providers
  - Suma Foundation
- Understanding Private Sector Involvement in Health Systems - Global Health Council www.globalhealth.org
- Starting a Medical Practice, AMA
- Public Stewardship of Private Provides in Mixed Health Systems
  - Results for Development/Rockefeller Foundation
- Working with Non-State Actors to Achieve Public Health Goals –
  - Montreux Challenge: making Health Systems Work April 2005 WHO
- The Regulation of Private Hospitals in Asia
  - University of Leeds Nuffield Center for International health and Development