
The Privatization Review

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**PUBLIC-PRIVATE PARTNERSHIPS
IN HEALTH CARE**



Birch & Davis
International, Inc.



AGENCY FOR
INTERNATIONAL DEVELOPMENT

**Conference Report
Kuala Lumpur, Malaysia
28 February 1989 to 1 March 1989**

SPECIAL CONFERENCE PROCEEDINGS

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INTRODUCTION

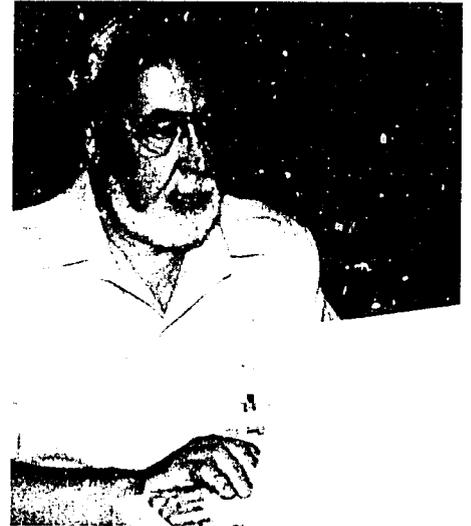
Intense interest in public-private partnerships throughout Asia was evident as a remarkable conference on Public-Private Partnerships In Health Care convened in Kuala Lumpur, Malaysia, on 28 February 1989. Of 16 nations invited to attend, nine Asian countries responded, and the other seven sent sincere notes of regret. Three of the national groups—Pakistan, The Philippines, and Thailand—were headed by their Ministers of Health. The Minister of Health for Malaysia, detained by official business at the last minute, sent his Deputy Minister to represent him. In addition to these nations, participants also were present from Bangladesh, The Peoples' Republic of China, Egypt, Hong Kong, Indonesia, Korea, the United Kingdom, and the United States. (A list of the participants can be found at the end of this report.)

The importance of the conference was underscored also by its sponsorship. Official co-sponsors were the U.S. Agency for International Development, the Privatization Council, and Birch & Davis International, Inc. Additional funding was provided by the United Nations Development Programme. All these sponsors, the World Bank, and the World Health Organization had representatives present.

The two-day conference was planned so that participants would gain much information from formal presentations and panels, but also would have extensive openings to share experiences and establish valuable new acquaintances. Each session was followed by an ample opportunity for questions and discussion, and the two luncheons and one dinner deliberately omitted speakers so that the participants could engage freely in informal conversations. In the pages that follow, highlights of the conference are described.

The participants left with heightened enthusiasm for the potential of public-private partnerships in health care and expressed a genuine interest in reconvening next year for a further exchange of ideas.

Special recognition is due to three people who contributed mightily to the success of the conference. Ms. Veronica Elliott, a Principal of Birch & Davis, served splendidly as overall Conference Coordinator. Dr. Wan Azmin of the Malaysian Ministry of Health was enormously helpful in managing local arrangements. Mr. Hari Krishnan and his staff provided logistical support in Malaysia throughout the conference. They all performed brilliantly.



Mr. Richard J. Steele



Ms. Veronica Elliott

Richard J. Steele, CMC
Editor

WELCOMING REMARKS

The conference moved off in a fast start with four opening speeches. In contrast to most welcoming remarks, these had genuine substance—substance that laid an excellent groundwork for the entire conference.



The Honorable Dato' K. Pathmanaban

From The Government Of Malaysia

The first speaker was **The Honorable Dato' K. Pathmanaban, Deputy Minister of Health for Malaysia**, who read the address originally scheduled to be delivered by the Minister of Health, His Excellency Dato' Chan Siang Sun. (The Minister was detained at the last minute by official state business.)

In these remarks, the Minister said, "Shorn of the clatter of all the high tech gadgetry, high sounding diagnosis and prognosis, and rising above the cry of dissatisfied patients from poor medicine and facilities, that is what health care is: a management issue, but with deep political overtones." Health care "must be anchored on the strong cornerstones of good organization, adequate and trained manpower and reasonable budgets, however financed, if the objective of 'Health for All by the Year 2000' (or any year) is to be realized."

Recognizing the great potential of harnessing the resources of the private sector, the Minister cautioned that much of the newer thinking in this area has been too narrow. "Discussions of private sector participation and privatization in the past have been too much oriented towards solving the budgetary and manpower problems of health care," he said. "Not enough emphasis was placed in these discussions on the issues of equity, access to health care by those who probably need it most, and the gross distortions in resource use in the health sector. . ."

Mr. Prescott S. Bush



Carrying this theme forward, the Minister called for greater attention in public-private partnerships to meeting the needs of the rural poor and to preventing disease whenever possible. "The approach must be more systemwide and comprehensive." Building on an extensive primary health care system, the Government of Malaysia is now "actively discussing alternative methods and approaches to private-public sector partnerships in health care. . ." He urged the conference participants to share experiences and ideas so that the conference will "represent a lifetime of learning for all of us."

From The Privatization Council

The next speech was by **Mr. Prescott S. Bush, Jr., Co-Chairman of the Privatization Council and President of Prescott Bush & Company, Inc.** In welcoming conference participants on behalf of the Privatization Council, Mr. Bush talked briefly about the genesis of the Council and then described some of the forms that public-private partnerships can take.

Of the three major types of such partnerships, Mr. Bush said, *asset sales* are the best known and most controversial. *Private development of infrastructure* has received much less attention but has tremendous potential. Using an example from the United States, he noted that governments at Federal, State, and local levels will underspend by a quarter to a half trillion dollars for infrastructure between now and the Year 2000; only public-private partnerships can close this gap. In the third type, *contracting out*, the primary motivator is the private sector's ability to provide services less expensively than the public sector, partly because of inherent efficiencies in labor deployment and the beneficial effect of competition.

He noted that there has been less public-private partnership activity in the health care sector than in many other sectors. He attributed this to the fact that changing the structure of any health care agency affects profoundly the relationships between doctors and their patients, so change agents must proceed cautiously. Nevertheless, there are great opportunities for such partnerships in the health care sector. He urged conference participants to "chart new directions for strengthening the health care systems of our countries."

From The United Nations Development Programme

Mr. Michael Van Hulten, Regional Representative of UNDP, welcomed participants on behalf of his organization. He commented that some nations are experiencing growth in Gross National Product, but that this makes choices concerning health care more difficult, not simpler. Not only does the health sector have to compete even harder with other sectors for available funds, but planners must decide on such complex questions as how much to invest in high technology. Mr. Van Hulten observed that as personal incomes rise, people can pay for health care and thus have greater choices. A conference to examine how to balance growth along these lines is most appropriate, he said.

From The Health Care Task Force

The third speaker was **Mr. Herbert M. Birch, Jr., Chairman of the Birch & Davis Family of Companies and also Chairman of the Privatization Council's Health Care Task Force**, which had principal responsibility for conceiving and planning the conference. In providing an overview of the design of the conference, he started by suggesting that none of the nations present, including the United States, can afford to make unnecessary mistakes. Although the U.S. has led the world in many aspects of health care, it also has led the world in making mistakes. Out of this, however, comes knowledge that it can share with other nations. Every other nation has a similar experience, and thus has much to share, too.

Mr. Birch cautioned that experiences must be tailored to local conditions before they can be applied in any other country. He emphasized that there is no one perfect model.



Mr. Van Hulten, Bush, Pathmanaban and Birch

Mr. Michael Van Hulten



Mr. Herbert M. Birch

With health care expenditures growing rapidly in nearly every country, Mr. Birch foresees a dramatic change in the public-private mix in the health sector over the next 10 to 15 years. This is, in itself, remarkable; as little as five years ago, the public and private sectors were rarely interested in talking to each other, and now the press in many countries is filled with reports of new discussions around the topic of public-private partnerships.

Examining public-private partnerships more closely, Mr. Birch characterized them as combining management issues, incentive issues, and data issues. He concluded by saying that these are the types of issues the conference will explore during its two-day session.



Speakers: Mr. Herbert Birch, Mr. Michael Van Hulst, Mr. Prescott Bush, The Honorable Dato' K. Pathmanaban, Dr. Abdul Kalid bin Saham, and Dr. James Jeffers.

PRIVATIZATION HAS MANY FACES

The first major presentation of the day was delivered by **Dr. James R. Jeffers, Senior Vice President of Birch & Davis International, Inc. (BDI)**. He described a highly systematic methodology for the analysis of health financing alternatives, including public-private partnerships. This approach has been developed during BDI's work to design a National Health Security Fund for Malaysia.

Dr. Jeffers noted that privatization can be of two types. In one, government shifts the burden of *financing* the production of goods or services to the consumers of these goods or services. In the other, government can shift the burden of *producing* goods and services to the private sector. In some instances, the two types are combined.

The greatest advantage of privatization is seen, Dr. Jeffers said, when government has been providing goods or services below cost. When provision of these goods or services is assumed by the private sector, the government no longer has to subsidize them, so budget commitments can be reduced significantly. But even when government produces goods and services at full cost, privatization may yield budget reductions resulting from a slow-down in the growth of the number of civil servants on "pensionable establishment."

Despite these advantages, Dr. Jeffers counseled caution in privatizing. Privatization should be undertaken only after measuring its anticipated benefits against well-defined criteria.

One obvious criterion is *operational efficiency*: will goods or services be delivered to consumers at lower cost than when delivered by the government? But, as suggested in one of the opening addresses, careful attention should be paid also to the issue of *equity*: will privatization result in an increase or a reduction of the quality and quantity of services available to low income earners and to people living in rural areas? Dr. Jeffers suggested other criteria later in his speech.

Furthermore, he warned, "contracts must be written with clear understanding of both the technical specifications of the product or service and of the cost at which it is being produced by government." Most governments find these conditions hard to meet, but they are essential to ensure that the private sector actually will produce goods or services of equal or better quality at equal or lower cost than those now produced by the government.

Finally, Dr. Jeffers pointed out that "government is at the mercy of the marketplace once it has given up the capacity to produce a good or service directly." Because this is true, government has a large role to ensure that true competition and reasonable prices are maintained and to monitor quality standards.



Dr. James R. Jeffers

If these precautions are observed, however, privatization can be a highly useful policy option for governments, and it can take many specific forms. In his work on evaluating health financing alternatives in Malaysia, for example, Dr. Jeffers identified 17 discrete privatization options. These ranged from transferring responsibility for all curative services to the private sector (the most sweeping alternative) to contracting out selected services (the least ambitious). The list of alternatives was not exhaustive, nor were the alternatives mutually exclusive.

He then evaluated each alternative against seven criteria: equity, operational efficiency, allocative efficiency, administrative feasibility, consumer acceptability, provider acceptability, and political acceptability. Alternatives rated negatively on four or more of the criteria were dropped from further consideration. In the Malaysian context, this evaluation pared the list from 17 to seven alternatives. A similar evaluation in other countries would have, of course, yielded different results.

Further analysis of the surviving seven options focused the Government of Malaysia's attention principally on the possibility of establishing a National Health Security Fund (NHSF). Since that tentative decision was made, the Malaysian project team collaborated with the consultant team led by Dr. Jeffers in completing a detailed analysis of the feasibility of an NHSF and developing a comprehensive implementation plan.

Although this methodology is applicable in any country, Dr. Jeffers noted that the information needed to apply it thoroughly is lacking more often than not. He urged each country to carry out experiments and demonstrations that would yield the needed information.

*Dr. James R. Jeffers,
Dr. Abdul Khalid bin Saham,
and Mr. Herbert Birch*



MAKING PUBLIC-PRIVATE PARTNERSHIPS WORK

Clearly one of the highlights of the conference was the next address, delivered by **Tan Sri Datuk Dr. Abdul Khalid bin Saham, Director-General of Health for Malaysia.**¹ In his address, which he titled "Bringing Public and Private Providers Together: Issues, Problems, Solutions," the Tan Sri began by stating that inequality in health status is "something repugnant, and socially and politically unacceptable."

He pointed to the Alma Alta Declaration, followed by adoption of the Health For All goal by the World Health Assembly and its reconfirmation at the Riga Mid-Point Conference in 1988, as "significant global recognition of the current deficiencies in health care and an expression of universal commitment to the reduction of those deficiencies." To achieve this, the Tan Sri identified the challenge before many nations as better planning and management of their health care systems.

Health Care Is An Unusual Commodity

The Tan Sri rejected the concept of health care as an ordinary commodity, implicit in many market-oriented proposals, because of uncertainties on both the demand and supply sides. On the demand side, it is difficult to predict when one will fall sick, and "when or whether such ill health creates demand for health care." As to supply, about 60 percent of the cost of health care can be attributed to the decision of doctors, and there is uncertainty in the way in which demand for health care is met by a doctor for clinical, professional, and economic reasons. The Tan Sri concluded that "Health care is thus a heterogeneous commodity, the demand for and the supply of which cannot be predicted or projected based purely on a market-oriented approach."

Several Factors Are Key In Program Development

Noting that there are a variety of health care systems among different countries, the Tan Sri nevertheless highlighted several key factors that affect health program development everywhere and that are pertinent to the subject of this conference: funding of health care, who provides health care, regulations governing the provision of care, and the public-private mix in the health care delivery system.

As to funding, he proposed that the source of funding is, in many ways, as important as the level of funding. If health care is funded from general government revenue, it is engaged in a perpetual competition with other sectors for these funds, with resulting uncertainties of economic performance. If health care is funded from an earmarked fund or from other forms of social security saving, the health sector may face fewer uncertainties.



Dr. Abdul Khalid bin Saham

¹ Tan Sri is a high title in the Malaysian nobility. *Datuk* (often spelled *Datú*) is also a title of nobility, of somewhat lower rank.

Another important issue in health care funding is the extent to which there is cost sharing. Largely because both users and providers tend to overutilize free or practically free services, many governments have implemented or are seriously considering various forms of user fees. Attention also must be given to budget allocations to geographic regions, programs, and program activities. A well balanced allocation is difficult to achieve, again because of the heterogeneity of health care as a commodity.

With respect to who provides health care, both public and private sectors are involved in most countries. The private sector typically concentrates on curative services only, while the public sector tries to provide comprehensive services that include preventive and promotive services. This leads to some problems in public-private partnerships, the Tan Sri pointed out, because the Health For All strategy recommends that basic health care, including preventive and promotive care, should be provided at all first points of contact between the people and the health care system.

The approach to legislation and regulation of health care varies considerably among countries. Countries have attempted to improve the equity, effectiveness, and efficiency of their health care systems through laws and regulations governing "funding, development of the system itself, distribution or location of health facilities, physical standards, and performance criteria or quality control."

The Tan Sri singled out the last of these areas for special comment. He remarked that most countries have legislative provisions on minimum physical standards, staffing, and safety, but quality control has always been regarded as a subject best left to the medical profession to determine and review.

As a result, quality control has been approached mainly from a clinical perspective, e.g., outcomes and side effects of medical interventions. But, the Tan Sri observed, "There is an increasing body of opinion . . . which says that quality should also include such factors as social and personal acceptability of medical interventions, appropriate technologies, waiting time, cost, comfort, welfare of and support for the family, and many other non-medical considerations" of importance to the users of health care.

Two Systems Run In Parallel

The Tan Sri commented that the public and private health care systems operate side by side in many countries, but with different objectives. The public system is motivated by the public good, while the private sector is motivated by profit (not intrinsically bad, unless excessive). Because of these different objectives, the two systems have developed or are developing in different ways:

- The private health care sector is concentrated in high income urban areas.
- The private sector concentrates on curative services, while the public sector necessarily provides more comprehensive coverage.
- The private sector charges full cost plus profit, but public sector health services are heavily subsidized; one result is long waiting lines and high bed occupancy rates in government facilities.
- The private sector often is said to be more efficient than the public sector, but this assertion is questionable when output is compared to cost.

“It is obvious,” the Tan Sri concluded, “that the existence of two parallel systems of health care, one government and the other private, does not promote optimal utilization of resources, equity, or cost containment. It is generally agreed that there should be greater cooperation and coordination between the two sectors within a unitary national health care system. There are obvious, compelling reasons for public-private partnerships in health.”

At the same time, the Tan Sri asserted, “public-private sector partnership in health care . . . can be justified only if it leads to greater equity, efficiency, or cost containment.” After reviewing the significance of each of these objectives, he said, “In my view a discussion on such an important subject as public-private partnership in health would be meaningful only if it is done within the context of these objectives.”

Public-Private Partnerships Can Exist In Four Areas

Although the Tan Sri admitted that an analogy to conventional business partnerships cannot be carried too far, such partnerships provide useful clues that can be used in forming public-private partnerships in health care. First, there has to be a basic common purpose. Then there has to be general agreement on how much should be invested in what. Most important is to agree on appropriate structural and operational arrangements. “The current dichotomy between the public sector and private sector will have to be bridged . . .”

Public-private partnerships can be useful in any of the four major components of a health care system: development of facilities, actual delivery of services, manpower development, and research.

Greater participation of the private sector in health infrastructure development would be welcomed. Unless there is agreement or control over the location of facilities, however, the tendency of the private sector to maximize return on investment may exacerbate existing inequities.

A closely related possibility is to allow private practice in government institutions. This must be planned carefully from the start; “the private practice must be an integral part of the government institution practice, not just an appendage.” To have two sets of patients in one institution could be interpreted as “allowing private doctors to have a second bite at the cake.”



*Dr. Abdul Khalid bin Saham and
Mr. Herbert Birch*

Public-private partnerships in actual delivery of health care already exist in many countries. Greater use of private clinics can improve accessibility, but only if better health care financing programs are provided at the same time. One promising approach in this area is to allow a definite budget to private physicians to treat patients for whom the government is responsible. User fees are becoming more popular, but they tend to be counterproductive because poor people, the very people who are most in need of services, may delay consulting doctors because they cannot afford even nominal user fees.

In inpatient care, the public sector may have to continue to serve rural areas because the private sector has no financial incentive to do so, according to the Tan Sri. Even in the urban areas of Malaysia, there is a barrier to use of private inpatient facilities by those not covered by third party payments. The question is how to bring these facilities into the mainstream of national health care delivery.



Dr. Abdul Khalid bin Saham

A national health insurance scheme can address many of these questions, said the Tan Sri. Such a scheme can allow people who otherwise could not afford care to use private sector facilities, but only if the scheme does not pay far less than private patients or privately insured patients. Government will still have to subsidize the care of the poor and of people living in areas where there are no private sector providers. On the other hand, he said, "to cater for the still uneven health facility coverage, different premiums may be charged for different regions until a more equitable distribution is achieved."

With respect to manpower development, both public and private sector policy makers almost always see this as a responsibility of the government. At the same time, there is no doubt that this approach results in a significant subsidy of the private sector because the private sector gets its staff from "the movement of pre-trained and experienced personnel from the public to the more paying private sector." The Tan Sri went on to say, "Whether the private sector should contribute towards the cost of training, and if so to what extent and how, are issues that need to be discussed. I am not aware of any model which addresses these issues adequately."

The private sector dominates technological research and development in its search for marketable products. There already is significant collaboration, however, particularly in clinical trials. "What may be lacking," said the Tan Sri, "is a full understanding of the technology needs of different health care systems, particularly regarding the role of technology in relation to equity in health care, efficiency, and cost containment." This is especially true with respect to developing countries, which must import most of the technologies they need.

MEDICAL EDUCATION: A NEW AREA FOR PUBLIC-PRIVATE PARTNERSHIPS

A paper on public-private sharing of the cost of medical education was prepared by **Dr. Megat Burhainuddin b. Megat Abd. Rahman, Director, Training and Manpower Development Division, Ministry of Health, Malaysia.** Because Dr. Megat was unable to deliver the paper personally, it was read to the audience by Tan Sri Dr. Khalid.

Dr. Megat began by observing that, although there are many models—none entirely satisfactory in projecting the need for doctors, there is nevertheless “. . . continuous pressure to train more doctors, particularly at the primary care level.”

A classical approach to medical education visualizes it as a tripod, the three legs being teaching, service to the community, and research. Rapid cultural and economic changes in most nations are having profound impact in each of these areas, making it difficult to keep the tripod balanced. One direct result is correspondingly rapid changes in medical school curricula. Planning of these changes is being supported in some cases by private foundations and agencies, notably in the United States and the United Kingdom.

In planning public-private partnerships in the medical education area, it is useful to recognize clearly some of the current issues in this area. One is the substantial exodus of doctors—both general practitioners and specialists—from the public sector to the private sector, with a resulting strain on the ability of government facilities to provide adequate care. Measures to stem this flow typically only postpone it. A second issue is inequitable geographic distribution of doctors in most countries, with rural areas being persistently underserved. A similar problem is imbalance of the distribution of doctors between specialties.

The solution to some of these problems, Dr. Megat contends, is “through involvement and coordination of the public and private sectors whereby resources in both sectors could be optimally used to fulfil national health plans and objectives. The crux of the problem is how much persuasion can be used effectively through good will, and how, and ways to apply ‘carrots and sticks.’”

Although there are variations from country to country, Dr. Megat notes, medical education is highly subsidized by government in almost every country. This leads to a situation he describes thus: “Substantial government subsidy and the resultant control is seen as a method of implementing national policies related to economic and social development. In some countries the control is in fact used to settle conflicts

among rival groups in multiracial or multireligious societies. Government control often offers many advantages. A uniform set of policies, rules, and procedure can be applied to the institutions in the country." Where national health insurance systems are in place, these systems often provide both direct and indirect subsidies to medical education.

Before addressing specifically how medical education costs might be shared between the public and private sectors, Dr. Megat focused on government policies that regard educational institutions as national resources as a central issue. These policies can be major barriers, but the issue need not arise if both sectors are considered as one corporate body with one set of goals.

As possibilities for public-private partnerships in medical education, Dr. Megat suggested: private sector allocation of research funds to medical schools; private sector grants to training institutions for equipment, books, and physical development; purchasing of privilege to use facilities in teaching hospitals by private practitioners; subsidy of training costs by national health insurance plans; and scholarships or bursaries for medical students. To make any of these approaches effective, however, there must be a clearer definition of the cost-sharing concept and a determination of the rights of each of the involved parties.

CURRENT EXPERIENCES AND ISSUES

After a convivial luncheon, the participants returned to an afternoon session in which representatives of five nations each spoke briefly about current developments, trends, and issues of prime interest in his country.

IN EGYPT

Dr. Mohamed Ibrahim Shehata, Chairman of the Health Insurance Organization in the Arab Republic of Egypt began the session by describing the evolving health care structure in Egypt. The country's health care system now consists of four segments: the Government's free health care systems, consisting chiefly of the Ministry of Health and the universities, which provide "free" services; the independent public "cost recovery" systems, consisting of the Health Insurance Organization and the Curative Care Organization; the private sector; and the voluntary sector.

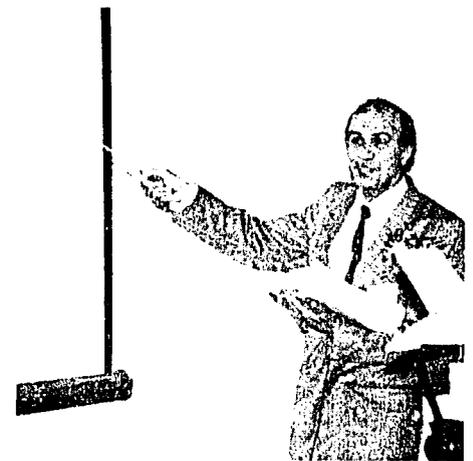
According to Dr. Shehata, the Ministry of Health provides primary and secondary care, both inpatient and outpatient, and also promotive and preventive services. With 63,676 hospital beds, it has 63.4 percent of such beds in the country, but occupancy rate is only about 50 percent. Utilization of the Ministry's 3,632 ambulatory care facilities also is low.

Universities (government operated) and other government-operated agencies provide secondary and tertiary services in hospitals that contain about 22 percent of the hospital beds in the country. Occupancy rate in these facilities is about 85 percent.

The two independent public "cost recovery" systems—the Health Insurance Organization and the Curative Care Organization—provide primary, secondary, and tertiary care in their hospitals and ambulatory care facilities. Each accounts for about four percent of the hospital beds in the country, which are occupied at a 65 percent rate for the HIO and 73 percent for the CCO.

The private sector has 20,845 registered private clinics and 1,172 private hospitals, the latter containing 7.5 percent of the hospital beds in Egypt. There are few data on utilization in these facilities.

As to problems in the Egyptian health care system, Dr. Shehata lists a serious surplus and maldistribution of physicians, medical education that is overly specialist- and hospital-oriented, lack of motivation because of low provider income and benefits, no organized referral systems, lack of active community participation, and excessive dependency on foreign donor support.



Dr. Mohamed Ibrahim Shehata

IN SOUTH KOREA

Discussing the situation in South Korea was **Dr. Chong Kee Park, Professor of Economics and Director, Institute for Business and Economic Research, Inha University, Korea.**

Enactment of the Medical Insurance Law in 1976 is regarded by Dr. Park as one of the earlier efforts in public-private partnerships in health care. Since its implementation a year later, it has played an important role in promoting health care in Korea. One of its great advantages is that it ensures the flow of funds into organized health care services.



Dr. Chong Kee Park

Dr. Park says that Korea is one of the few developing countries in which coverage of the population by health insurance has progressed at a rapid rate. Initially, the National Federation of Medical Insurance extended compulsory coverage to only the employees of companies that employed 500 workers or more, allowing the employees of smaller firms to participate on a voluntary basis. The threshold was dropped to 300 workers in 1979, to 100 in 1981, to 16 workers in 1983, and to five workers in 1988. The self-employed were added in 1982 by occupational groups and in rural areas. A parallel insurance scheme covered all government workers, teachers, and workers in educational institutions starting in 1979; in 1980, military dependents were added, and in 1981 coverage was extended to pension recipients and their dependents.

As a result of these programs, Dr. Park says, the percent of the population covered by health insurance increased from 8.8 percent in 1977 to over 66 percent in 1988.

In 1977, the government also introduced a Medical Assistance program for people unable to pay for medical care. This program now covers more than 10 percent of the population, Dr. Park reports. For people below the poverty line or unable to work, the program pays all charges for both inpatient and outpatient services; for those who can work, the program pays 50 percent of charges and provides interest-free loans for the other 50 percent.

Thus, three out of four people in Korea are covered now by some form of health insurance. Dr. Park says that the government expects to attain universal coverage by the middle of 1989, when self-employed people in urban areas and employees of the smallest companies are added.

Against this background, Dr. Park described the recent reorganization of the health care delivery system into a systematic patient referral system. There will be 142 primary care catchment areas, eight secondary care catchment areas, and 27 hospitals and medical institutions, each of more than 500 beds, designated as referral centers for tertiary services. Private sector providers play a significant role in this system.

IN THE UNITED STATES

Dr. O. David West, Senior Vice President of Birch & Davis International, Inc., spoke from the perspective of 29 years of diversified operating experience in the United States and in several other countries. He said that the best formula to use when trying to change the health care system is to remember that patients is what it is all about—people caring for people.

In approaching privatization efforts in a nation where there have been few such moves, Dr. West recommended starting by identifying as many privatization possibilities as possible—perhaps as many as 50—and then cross off the initial list all that are highly controversial. This may leave 10 that are relatively non-controversial. Look at these 10 to see which are really solid “wins” for the government, and ask “Will the doctors like it? Will patients?” This may narrow the list to three to six that are “win/win” situations for everyone involved. By implementing these possibilities, which everyone wants, a track record of success is established. Then, some of the more controversial can be attempted with a higher probability of success.

He then described some privatization activities in the United States, some of which are working very well and some are not.

One area of activity has been the armed forces approach to paying for care of military dependents and retirees by private providers, which occurs when military treatment facilities do not have the capacity to care for these patients. Until recently, the CHAMPUS program—which is responsible for paying for the care of dependents and retirees—routinely paid the private doctors whatever they billed for services to these patients. This has been changed; CHAMPUS now pays only at the 90th percentile of what all the doctors are billing; by refusing to pay the most expensive 10 percent of charges, Dr. West said, a great deal of money is saved. In the future, allowed charges probably will be reduced to the 80th percentile.

The armed forces also are building free-standing ambulatory care facilities and leasing them to private doctors, who then charge the military a discounted rate for treating military dependents and retirees. Dr. West set up preferred provider organizations (PPOs) in Florida and Georgia, in which the private doctors agreed to discount their usual fees 31 percent for military dependents and retirees, saving the military more than \$30 million in the first year.

One of the most successful forms of public-private partnerships, according to Dr. West, is one in which private companies build hospitals and clinics for the government on a turnkey basis, saving great amounts of time and money. Government agencies also have little experience in implementing managed care programs, so some are now contracting out for this service. Some government hospitals also are contracting out the

Dr. O. David West



process of billing private insurance companies for services to insured beneficiaries, in an arrangement in which the private contractor is paid a percentage of the amounts collected.

The common denominator of all these examples, Dr. West notes, is that everyone involved in each case, including the patients, wins.



Dr. Zan Shuliang and Dr. Wang Minging

IN THE PEOPLES REPUBLIC OF CHINA

The presentation concerning the Peoples' Republic of China was presented by two physicians, **Dr. Wang Minging, Director of the Bureau of Health Care in the Ministry of Health**, and **Dr. Zan Shuliang of China Medical University**. Because Dr. Wang Minging speaks little English, he first made some brief remarks in Chinese. Dr. Zan Shuliang then translated these remarks and read a paper concerning medical care for the aged, prepared earlier in English.

The Peoples' Republic of China, Dr. Wang Minging pointed out, is the most populous country with the largest elderly population in the world. With a tradition of respecting the elderly, China has paid much attention to their medical care, as well as to recreation and study opportunities. This is reflected in the fact that average life expectancy in China in 1949 was 35 years, but by 1985 it had reached 69 years. In the two major cities, it had reached 72 to 73 years.

The beginnings of geriatrics in China occurred in 1959 with establishment of both a geriatric laboratory at the Chinese Scientific Academy and of a geriatric institute at Beijing Hospital to study diseases of the elderly. National academic conferences on geriatrics and gerontology were held in Beijing in 1964 and in Guilin in 1981. The Chinese Journal of Gerontology started publication in 1982. The system has grown to include 47 gerontology institutes at provincial and municipal levels, and 86 geriatric hospitals.

Dr. Widodo Sutopo



Regular physical checkups are provided free of charge to veteran carriers, intellectuals, and staffs every one or two years.

Dr. Wang Minging concluded by reminding the audience that China is still a developing country in which there is still much room for improvement in the health care system.

IN INDONESIA

Dr. Widodo Sutopo, Special Assistant for Health Finance to the Minister of Health for Indonesia, described the current situation in Indonesia. He began by introducing seven principles on which the Indonesian health development strategy is based, including one that states, "The national health efforts are organized by the government, but its activities are to be carried out harmoniously by the public sector, private sector, as well as the community themselves."

A series of charts portrayed the current health system of Indonesia. The total population is expected to grow from 165 million in 1985 to 231 million in 2005. The population is aging, as these figures show:

<u>Age</u>	<u>1985</u>	<u>2005</u>
< 15	38.8	29.2
15-64	57.8	65.5
65 +	3.4	5.3

Life expectancy has increased rapidly, from 56.0 years in 1983 to 65.0 years in 1988. A major factor in this increase is a sharp decline in infant mortality rate over these five years, from 99.3 to 49.8, and in child mortality (1 to 4 years old) from 17.8 to 6.5.

The health infrastructure is growing apace. Although the number of hospitals will increase only from 1,436 in 1988/89 to 1,472 in 1993/94, the number of hospital beds will increase from 122,998 to 132,158 over the same period. During this period, the number of general practitioners will increase from 23,084 to 35,584, and the number of specialists will nearly double, from 1,825 to 3,575.

The proportion of all types of health manpower in the private sector is projected to remain stable at 40 percent. Of the doctors in Indonesia in 1987, 33 percent worked in Ministry of Health (MOH) health centers, 49 percent in MOH hospitals, 3 percent in other government and quasigovernment hospitals, and 15 percent in private hospitals.

Health expenditures increased 43 percent from 1982/83 to 1986/87. As a percentage of Gross Domestic Product, however, this represented a decline from 2.93 percent to 2.71 percent over the four years.

Two-thirds of all health expenditures are from commercial and private sources, mostly out of pocket expenditures, which increased 36 percent over the four-year period. MOH expenditures increased only 13 percent during this period. The largest increases were in non-MOH government expenditures, which nearly doubled.

About 10 percent of the population is covered by some form of health insurance. Of this coverage, 94 percent is in direct government programs, five percent in government-related programs, and only one percent in private insurance.

ELSEWHERE

An active period of questions and discussion followed these formal presentations. One participant commented on the fact that working with averages hides what is happening to the lowest 30 percent of the population; unless we get better data on this lowest segment, we cannot really tell whether we are making progress with respect to equity.



Dr. Wang Minging and Dr. Widodo Sutopo

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During this period, **His Excellency Alfredo Bengzon, Secretary of Health for The Philippines**, also shared an overview of his philosophy of managing a national health care system. He identified the three major roles of his department as a policy maker, a provider, and an enforcer. In the latter role, the current administration has made a special effort to have all sectors participate in setting ground rules.

Secretary Bengzon then referred to Tan Sri Dr. Khalid's earlier characterization of health care as a unique commodity. Another reason why health care is unique as a commodity, he said, is the complexity of the health care market. It is comprised of four components:

- Providers, who are not just doctors; it is important to recognize other health workers as part of the equation.
- Beneficiaries; Secretary Bengzon deliberately avoided the use of the term "patients," because the purpose of the system is to keep people from becoming patients.
- Facilities
- Funders

Center stage is held by the party that can develop a proper balance of these four components; this is the job of government, in Secretary Bengzon's view. The task is complicated by the fact that a significant part of demand is not rational. For example, an enormous amount is spent on drugs, much of which is irrational and inappropriate.

Government should lead, but also respond. Really meaningful changes are controversial. Government must lead by making the people want these changes. But government also must be careful not to get too far ahead of the people, the Secretary said.

The population can be divided into four groups, according to Secretary Bengzon: the well, the worried well, the early sick, and the sick. Few resources are needed to care for the first three groups, but many are required for the truly sick.

Beneficiaries must become active participants in their own health care, he said. To make sure that this happens, his department has drawn in new staff people with experience in communications and advertising. A foundation has been established in Manila to identify highly skilled people in both the public and private sectors and rotate them between the sectors.

Informal discussions continued on well into the evening, as the participants talked over dinner.

OPEN DISCUSSION OF THE PRESENTATIONS

Rather than a panel on health care financing that had been scheduled for the second morning, an open discussion of the presentations to this point was held. The discussion was led by **Mr. Clyde Fritz, Vice President of Johnson & Higgins and President of the Privatization Council,** and **Dr. Jeffers.**

Dr. West clarified his earlier recommendation that privatization efforts start with non-controversial opportunities. He believes this is a good strategy so a good track record can be established early, but he also agrees that the most significant privatization opportunities are likely to be controversial. They should not be avoided.

Mr. Fritz described the Federal cooperative program, which was first proposed by the U.S. Office of Personnel Management. In this privatization approach, former employees of a government activity that has been privatized retain an ownership interest in the activity. The private sector group that takes over the privatized activity must operate it at a savings of at least 10 percent compared to government operation.

Dr. Jeffers discussed in greater detail some of the thinking that has gone into planning the National Health Security Fund for Malaysia. Government studies typically focus on health care delivery, he said, but health care financing must be looked at, too. Much is done piecemeal now. We should think as systemically about financing as we do about health care delivery.

Dr. Jeffers said that planners of the Fund had to consider three population segments: the employed (including civil servants), the self-employed, and the unemployed. The self-employed sometimes are financially better off than is recognized.

The idea of the Fund is to pool financial resources from all segments, then distribute them to meet real needs. The private sector should become involved in the social responsibility for providing care to all the people. The two systems, public and private, are operating in parallel now; the Fund will integrate them.

One of the advantages of this approach is that it allows planners to look at all privatization options at the same time, and to evaluate them according to a consistent set of priorities. Primary responsibility for collecting funds should be put on the government. It may be possible to piggyback on existing collection activities of other government agencies; many of these agencies are deeply enmeshed in the country's banking system and are already quite efficient.



Dr. James R. Jeffers and Dr. Clyde Fritz

If a separate National Health Security Fund is established in this way, it isolates health financing from the competition of other sectors and also, to a large extent, from the business cycle.

Dr. Jeffers described the Dutch approach, in which the government provides comprehensive health insurance for people below a specified income level. When people rise above this level, they are no longer eligible for government health insurance and must buy insurance from the private sector. The private health insurance sector is organized and regulated by the government.



Dr. James R. Jeffers

In response to a question from the floor, Mr. Birch commented that the largest current problem in the United States is financing health care for the 37 million people who have no health insurance whatever—people who earn too much to be eligible for Medicaid but too little to be able to pay for their own care or to buy private health insurance. These people are getting care; the issue is who pays for it. One approach is to impose a dedicated tax on employers who already pay for health insurance.

Dr. Tariq Sohail, Advisor to the Prime Minister on Health and Population, Pakistan, differentiated between health care and illness care. Pakistan is trying to move away from a doctor-dominated system, and is thinking seriously about how the private sector can get more heavily involved in health care.

In Pakistan, he noted, the private sector has been composed almost entirely of general practitioners (GPs). There are very few specialists—Pakistan has 3,000 specialists now but needs 9,000; the need will grow to 20,000 in 2000. Training of specialists is thus an immediate priority.

The government has been attempting also to involve GPs more heavily in primary health care, Dr. Sohail said, in part by giving them incentives to work in semirural areas. Many of the government clinics in these areas are now unused because they have no staff.

Third, the government is involving non-governmental organizations (NGOs) in low-cost diagnostic work in urban areas. The NGOs are paid cost plus a small profit, he explained, resulting in a significant reduction in expenditures.

Other current initiatives of the Pakistan government reported by Dr. Sohail were charging commercial rates for improved services in private rooms in government hospitals and simultaneously abolishing all user fees in wards and poor patients' facilities. This averts the usual problem that user fees are the greatest burden on those least able to pay.

Pakistan is experimenting with national health insurance for catastrophic illnesses (not including automobile accidents). The nation is trying also to get people to take greater responsibility for their own

health. This is difficult, Dr. Sohail noted, because health has been considered a state responsibility for the entire 20th century.

In Pakistan, the government intends to make teaching hospitals and centers of excellence autonomous. They thus will become eligible for private funding, and they will allow specialists from outside government to admit patients to these facilities.

Dr. Sohail closed his remarks by commenting that there is a large area of health care not discussed yet in the conference, even though it exists in all countries. This is the area of traditional healers of all types—the whole area of non-allopathic medicine.

Tan Sri Dr. Khalid welcomed this last point, saying that it raised again the question of focus—Are we talking about curative services only or about the total health care system? Traditional healers provide a variety of preventive health care services, such as antenatal care. For certain types of sicknesses, he said, traditional healers are very important. In Malaysia, the Ministry of Health thought that providing fully trained midwives would reduce the demand for traditional birth attendants (TBAs), but this turned out not to be true; TBAs often are preferred because they provide services that midwives do not, such as cooking for the family.

The Tan Sri cautioned that ministries of health must concentrate on cost. “Sometimes when we develop a very complex system,” he said, “we impose a very great overhead cost. Therefore, look for simplicity.” At the same time, ministries must always fear that the poor and disadvantaged will be denied services. He asked how ministries should reassure the public that the government is not just interested in cutting cost, or that the private sector is not just interested in making great profits? Also, is the national health insurance scheme going to impose the same level of premiums everywhere, even though facilities in some areas are not equally good? Government has a responsibility to ensure quality of care in both public and private sectors, he stated.

Mr. John W. Chambers, Secretary-General, Provisional Health Authority, Hong Kong, told the conference that Hong Kong currently is moving in a direction different from most of the participating countries. The colony has a system much like the UK's National Health Service. Inpatients are charged only \$3 a day.

He said that his Provisional Health Authority is proposing to remove the health care system from direct governmental authority, but it still will be financed mostly by government. User fees will be raised gradually. Under the umbrella of new authority, both government and non-government hospitals will be moving more toward autonomy. Hong

Kong has not gone to an insurance scheme, he said, because of the complexity of collecting premiums.

The colony is planning to contract out some services from the hospitals—initially engineering, but eventually some clinical services.

THE MANAGED CARE CONCEPT

Mr. Herbert Birch returned to the platform to moderate a panel that examined the managed care concept.

Mr. Stuart W. Friedman, President, Birch & Davis Health Management Corporation, opened the first presentation of this panel by paraphrasing a recent editorial in the *New England Journal of Medicine*. The editorial said that we are currently in the third revolution in health care. The first was the era of expansion, which has occurred in most countries. The second is the era of cost containment, touched off in many places by taxpayer revolts. The third is the era of information, touched off by the fact that neither payors nor consumers know what they have gotten for what they have paid.

Later in his presentation, Mr. Friedman listed some of the most important techniques that characterize managed care. Perhaps most fundamental is a change in the reimbursement system so that doctors are motivated to provide all the care that is appropriate and necessary for each patient, but only such care. The doctors, and often the hospitals, in a managed care system share in the financial rewards of good performance and also the risks of poor performance.

Management of such a system requires quantitative assessment of performance, Mr. Friedman remarked. This, in turn, requires a lot of data. There must be effective utilization control, based on written protocols that standardize care.

Managed care systems emphasize use of ambulatory care in preference to inpatient care whenever possible, he noted, and use of allied health professionals rather than more expensive doctors. Primary care physicians act as gatekeepers. There is a special emphasis on health education.

In contrast to most other types of providers (until recently), Mr. Friedman said, managed care organizations must be particularly skilled in marketing and contracting.

Mr. Friedman then explained that managed care actually is a continuum of organizational types, ranging from conventional indemnity insurance with some form of utilization control, such as second surgical opinions, through preferred provider organizations and open-ended HMOs (the latter allow members to obtain care outside the HMO, but at a higher out of pocket expense), to pure HMOs (which represent the ultimate in managed care, at least for now). To organize any of these managed care types is a complex undertaking, he emphasized.

By combining financing and delivery under one umbrella, and by providing incentives to keep people well, Mr. Friedman concluded, we intro-

Mr. Stuart W. Friedman



duce rationality and the potential for improved care. Continuity of care is much better in a managed care plan. Despite 40 years of managed care experience in the United States and elsewhere, the concept is still in its infancy. Managed care has been used quite successfully in mixed private-governmental models. The US government is moving very rapidly in this direction.

Mr. Birch then described the just announced changes in the United Kingdom's National Health Service, which Birch & Davis International, Inc., has been following closely.

Like most countries, the UK was experiencing a rapid and continuous rise in health care costs, to the point where they were generally acknowledged to be out of control. Several quite sophisticated evaluations of the situation led to the recent publication of a White Paper, which announced the intention of implementing several fundamental changes in the National Health Service (NHS). The title of the paper—*Working For Patients*—is very important. The paper puts the needs of patients first. Patients will have greater choices of where to obtain their health care. Nothing in the paper talks directly about privatization.

Among the modest things already done in the spirit of the paper are several instances in which the NHS and private sector have jointly financed a new day surgery. Also, there is at least one instance in which a private sector group has bought land from a NHS hospital, on which it has constructed a new private hospital; the private hospital will share certain support services with the adjacent NHS hospital. The paper anticipates also that the private sector will buy underutilized capacity in NHS hospitals.

A more profound change, Mr. Birch explained, is that hospitals will be allowed to opt out of the NHS and to operate more like private hospitals. NHS hospitals will no longer have the monopolies they have now; for the first time, they will have to compete among themselves and with private hospitals and hospitals that opt out of the NHS.

Although there are few ambulatory surgical centers in the UK now, Mr. Birch foresaw that hospitals that opt out of the NHS will establish several hundred of them within the next year or two to enhance their own competitiveness.

An equally profound change, he went on, is that GPs will be allowed to set up group practices that are paid on a capitation basis. The capitation amount will be expected to cover each patient's entire care: not only the GPs' services, but also drugs, specialist services, and hospitalization. The GPs will be allowed to keep any money not expended from these capitation amounts.

Although this will force the GPs to become more cost-conscious in treating patients, Mr. Birch commented, the GPs also will be motivated



Mr. Herbert Birch

to treat their patients well because the patients will be free to change to another doctor if their treatment is not satisfactory. Thus, the group practices will be motivated to invest at least part of the excess of the capitation payments over cost in improved patient benefits.

This presentation was followed by one by **Mr. Andrew Wilk, Business Development Director, BUPA International, United Kingdom.** BUPA is the largest private health insurance company in the UK. Mr. Wilk explored the role of private health insurance in an environment like the UK.

The overall theme of his presentation was summarized in these words: "Private insurance is not the solution to chronic underfunding in the public sector, but it gives assistance, by permitting public funds to focus on those areas of greatest need, by encouraging those who can afford it to voluntarily meet their own health care costs."

Although the NHS provides high quality of care, he said, the NHS also allows long hospital waiting lists as a buffer against unlimited demand in a cash-limited system. Individuals and companies are prepared to pay for additional advantages to themselves: more personal service, more experienced specialists, better surroundings, being seen without delay.

Consequently, about 10 percent of the UK population—over five million people—have purchased private health insurance; about half of this insurance is paid for by employers, and the other half by individuals. Ninety percent of this insurance is sold by companies that, like BUPA, are not-for-profit. Only about 20 percent of private acute health care is paid out of pocket.

The greatest use of private insurance in the UK, Mr. Wilk reported, is for elective surgery. There is relatively little demand for preventive and primary health care.

Mr. Wilk continued, "The growth in private health insurance membership experienced in the UK has led to further private investment in additional facilities and services, bringing into being new private hospitals and equipment . . ." The number of private hospitals in the UK has increased by 30 percent, to more than 200. Private health insurance also permits the best doctors to be retained within the community by affording them opportunities for additional income.

He contrasted private health insurance with national health insurance schemes by saying, "National health insurance funding does nothing to bring extra resources into the health system. Indeed it creates financial limits for development." It was largely for this reason that the recent White Paper rejected a national health insurance approach.

Mr. Andrew Wilk

SPONS



Growth of private health insurance requires a supportive environment. Tax relief and fiscal incentives are important. Although the wisdom of tax relief for the cost of private health insurance has been debated hotly in the UK, there is general agreement that it should be extended to retired people.

One of the most exciting provisions of the White Paper, in Mr. Wilk's view, is the potential for provision of clinical services by the private sector to state-funded patients. This already has allowed significant reductions in hospital admission waiting lists.

Mr. Wilk's concluding words were, "I have argued that private health insurance is a valuable source of additional finance for the nation's health care needs. No country will have sufficient money to rely on the public sector alone, whether financed from a national health insurance scheme or general taxation, even if it can be made more efficient through the application of internal market forces or modern management principles. We believe that the establishment of conditions favorable to the growth of private health insurance offers an important complementary route toward the goal of greater national total resources for health care, for the benefit of all."

MANAGING HEALTH CARE RESOURCES

The second panel of the day, on managing health care resources, was moderated by **Mr. Roy A. Scholvinck, Director, Management Advisory Services, Touche Ross International.**

Mr. Richard J. Steele, Senior Vice President of the Birch & Davis Family of Companies, led off the panel with a presentation on the indispensability of good data. He repeated remarks of earlier speakers about the urgency of controlling health care costs.

He added that managing a modern health care system also involves making difficult decisions, such as whether we are obligated to prolong every life as long as possible, regardless of cost, or whether the aged in our societies are as fully entitled to all the benefits of modern medicine as the youngest citizens, or how to choose between using high technology to save a few lives and using the same amount of funds to achieve small improvements in the health of perhaps thousands. There are no right answers to these dilemmas, Mr. Steele said, but the choices must be made nonetheless.

Making these choices invariably starts by describing an existing condition and then defining the desired condition at some future time. Then the decision maker must recognize that there usually is more than one way to get from one to the other. The central task of resources management, Mr. Steele stated, is to choose the combination of methods that will move us most surely from the existing condition to the desired condition at the lowest cost. In real life, many such decisions must be made concurrently.

All of this requires an enormous amount of data: data to describe existing health status, data to describe the desired future condition, and, most important, data that tell us about the relative efficacy and costs of the health care approaches we might take.

Mr. Steele asserted that there is a severe shortage of the needed data in virtually every nation. The problem is particularly severe in countries in which most or all health care has been provided by the government, where the value of collecting more than the most rudimentary data has not been recognized. In these countries, for example, little typically is known about the cost of inpatient treatment of various illnesses.

Mr. Steele then quoted from a recent lecture by Dr. Paul Ellwood, a prominent US physician-researcher. Dr. Ellwood is convinced that it is now technically feasible and economically imperative that we examine much more closely the efficacy of medical procedures by measuring their



Mr. Roy A. Scholvinck, Mr. Dennis J. Duffy, and Mr. Richard J. Steele

results scientifically—a process he terms “outcome measurement.” Dr. Ellwood goes so far as to say, “If physicians want to remain in control of their profession, they must have the motivation to track and evaluate health outcomes routinely.”

Mr. Steele endorsed Dr. Ellwood’s thoughts completely, but added that this type of analysis must be done at the level of national health policy as well as at the level of individual medical procedures. Both efforts will require development of databases much more extensive than any now in existence—development that is now technically and economically feasible.

He concluded by saying that if such databases are not developed on a priority basis in every country, “. . . it is inevitable that our management of health care resources will decline and health care will be even more, not less, of a drain on our national treasuries.”

Mr. Robert Clinkscale, President, LaJolla Management Corporation, United States, next discussed some approaches to public-private partnerships in health care data sharing, using the new US hospital payment system called diagnostic-related groupings, or DRGs, as an example. This system is now used by the Medicare program (covering health care of people over 65 years of age and certain severely and chronically disabled people), by many State Medicaid programs (health care for the poor), and some of the largest private health insurance companies.

The DRG system was developed, Mr. Clinkscale explained, in response to the rapid escalation in the costs of hospitalization. It classifies patients being admitted to hospitals into 468 groups, defined principally in terms of admitting diagnoses, age, and sex. Payment to the admitting hospital for any DRG is a fixed amount, regardless of the length of stay and the actual cost of providing treatment.

Although there is some evidence that the system has been effective in reducing hospital cost inflation and patient lengths of stay, Mr. Clinkscale believes that hospitals may be merely shifting costs to other care settings, such as outpatient departments, laboratories, physicians offices, and nursing homes.

Even though the DRG system may be of limited value as a cost-containment device, Mr. Clinkscale continued, it still has enormous potential value if all public and private buyers of hospital services would pool their own databases into one comprehensive national database. This database would eliminate many of the data gaps, imprecisions, incompatibilities, and internal inconsistencies that limit the usefulness of existing databases.

A number of exciting research and management opportunities would become available through use of this DRG-type of large scale database,



Mr. Robert Clinkscale

Mr. Clinkscale contended. Both government and private sector contributors could benefit. Mr. Clinkscale foresaw these applications:

- **Clinical Research**—A database of this type would be valuable, even essential, to the outcome measurement approach advocated by Dr. Paul Ellwood, as described earlier in the panel presentation by Mr. Steele.
- **Cost-Effectiveness Research**—Clinical management involves continual tradeoffs of treatment outcomes with cost. The database would support the essential underlying research. Marginally cost-effective procedures detected by this research could be subjected to rigid peer review or eliminated from insurance coverage altogether.
- **Surveillance And Utilization Review**—The database could be used to pinpoint unusual utilization patterns by either patients or providers. Those who show such patterns could be subjected to closer observation and possibly counseling.

Each of these applications is of sufficient value by itself, Mr. Clinkscale concluded, to justify the effort of building the comprehensive database.

The final panel presentation was made by **Mr. Dennis J. Duffy, President, The Axiom Group, United States**, who reviewed the history of utilization review efforts in the United States. He began by agreeing with Mr. Clinkscale that the DRG system is better as a recording system than as a reimbursement device.

In the early days of the Medicare program—the early 1960s—every hospital was required to have a utilization review committee. These committees reviewed medical records, but Mr. Duffy said that they were not effective because the doctors were reluctant to question the judgment of peers in their own hospitals. Also, reviews were done so much after the fact that they had little effect on correcting clinical misjudgments.

Subsequently, Mr. Duffy continued, the Congress passed a law which established over 200 Professional Standards Review Organizations (PSROs)—organizations composed of and controlled by doctors that reviewed medical records for Medicare patients in all hospitals in a geographically defined area. The PSROs also were charged with doing medical care evaluations—scientifically designed studies of specific clinical problems in hospitals under their jurisdiction.

The PSROs suffered essentially the same weakness as the utilization review committees, according to Mr. Duffy, stemming from reluctance of local doctors to pass judgment on their peers. They did result in some reduction in average length of stay of Medicare patients, but hospitals and doctors compensated by admitting more patients. When President Reagan took office in 1981, he eliminated the PSROs from the Federal budget.

The Congress then established 50 Professional Review Organizations (PROs), one in each State. These rather recently established organizations, which have Statewide jurisdiction for preadmission certification and retrospective medical record review, have been modestly effective in containing costs of the public insurance programs but much less so for the private insurance programs. Private insurance programs were initially rather uninterested in the PRO program, Mr. Duffy commented, but were forced by employers to become involved.

Mr. Duffy concluded that policy makers and researchers in the United States have tried for a long time to fix something, and have yet to find a very good answer. He does believe, however, that some progress now is being made.



Front row, L to R: Dr. James Jeffers, Mr. Prescott Bush, Secretary Alfredo Bengzon
Rear row, L to R: Dr. Zan Shuliang, Mr. Stuart Friedman, Dr. Wang Minging

QUO VADIS?

In looking back over the two days, **Tan Sri Dr. Khalid** said that it was clear that the participants shared a concern about escalating health care cost and the need to introduce measures to overcome this escalation. The public and private sectors operate side by side, he said, and there was a general consensus in the conference that there should be more public-private partnerships. Also, the participants agreed that such partnerships could and should ensure equity, efficiency, and cost containment in the delivery of health care.

He recalled his statement in his opening address that health care consists of four components: facility development, service delivery, training, and research. The conference had touched only lightly on the last two, but they are worthy of public-private partnerships, too.

“How do we tackle the next steps?” he asked. “What do we do nationally to achieve partnerships? Do we know enough about our own health care systems?” The Government of Malaysia did not, he said, until it embarked on its recent national health care financing study. He suggested that another possibility at the national level would be sensitization forums like this conference. Still another possibility would be training for health care managers. Most such managers are doctors, he noted, but doctors have been trained to manage biological systems (patients), not economic systems.

Or the participants could work internationally toward the objective of public-private partnerships, he added, through international agencies and forums. “Do we need sensitization forums?” he asked, “and who should be responsible?”

He is favorably impressed by the fact that the World Health Organization has become much more pragmatic, less focused on technologies. Donor agencies should take the lead in promoting public-private partnerships, he added. He suggested that some cross-national studies are needed, from which national policy makers can learn from each other. There are not enough publications in this field. There should be international forums for reporting research and exchange of experiences.

He concluded by asking rhetorically, “How do we sell this important subject to government, to providers, to users? How do we implement these ideas?”

In a final comment, **Mr. Birch** noted that most of the donor agencies have shifted rapidly in just the last year toward management issues and toward acknowledgement that there is a private sector—a highly favorable sign.

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