HP+ POLICY *Brief*

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Integrating the Private Sector into Government Health Insurance: Common Bottlenecks and Potential Solutions

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Introduction

With the global movement to achieve universal health coverage by 2030, countries are aligning their national health financing strategies to achieve this goal. In many low- and middle-income countries (LMICs), the private sector is already providing a significant portion of overall healthcare. The U.S. Agency for International Development's (USAID's) *Private-Sector Engagement Policy*, along with other global development initiatives—for example, the Sustainable Development Goals—recognize that the private sector is contributing to the development agenda, including its vital role in strengthening health systems for achieving universal health coverage.

Despite a natural bias toward public sector facilities, some LMICs are integrating private for-profit and nonprofit facilities in government-supported health insurance schemes for primary and secondary care. Examples include Ghana, India, Indonesia, Kenya, Nigeria, the Philippines, and Vietnam (Cotlear et al., 2015). This integration demonstrates an important evolution in stewardship of health systems; recognition of the potential role of the private sector; and willingness to increase capacity, choice, and coverage in these countries. However, national insurance agencies must have sufficient management processes and resources to adequately achieve integration. Each of the critical steps in this process—ranging from accreditation to contracting, reimbursement, quality assurance, and verification and audit—represent potential operational roadblocks that may create challenges and impede scheme expansion.

Helping government anticipate and address these challenges in contracting private providers will be critical to supporting countries to develop sustainable, equitable health systems. Private sector integration within government-supported health insurance schemes can expand the range of options for affordable access to and use of quality family planning, reproductive, maternal, and newborn services; serve as market-shaping opportunities for accredited private provider networks; and leverage the scale and sustainability of private sector integration.

This brief presents results from a study by the USAID-funded Health Policy Plus (HP+) project to develop an operational systems framework focused on understanding key functions and business processes and identifying critical challenges and potential solutions, including identifying specific constraints relevant to the provision of family planning services. These efforts will help governments understand where there is a need for: greater capacity in government-related supervisory and regulatory agencies, systems to assess service availability and readiness, and payment mechanisms—all of which will help governments plan for unforeseen bottlenecks.

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Methodology

Phase 1: The first phase of the study consisted of a structured literature review focused on private sector engagement in government-supported health insurance schemes. The goal was to understand overarching regulatory structures and implementation roadblocks related to accreditation, empanelment, claims verification, and quality assurance.

Phase 2: The second phase was a process to identify potential countries for in-depth interviews and to conduct those interviews. Candidate countries were assessed based on various factors, including status of the national health insurance scheme, the degree to which the scheme already integrated private providers, and whether family planning benefits were included. In collaboration with USAID and country missions, two countries (Indonesia and Nigeria) were chosen for in-depth stakeholder interviews to gain understanding of stakeholder perceptions of current systems, constraints, and possible solutions.

HP+ then conducted 19 in-depth interviews with provider associations, payers, regulators, and health programs in Indonesia and Nigeria. The interview guide was based on the literature review and implementing partner consultations. These interviews were translated, transcribed, and analyzed according to a custom thematic framework using NVIVO software and ensuring inter-coder reliability. The thematic framework centered on existing systems of contracting with the private sector, operational barriers to contracting, and interviewees' proposed solutions to the cited barriers. Findings were organized and presented by themes.

Phase 3: In this phase, the HP+ team developed an operational systems framework and identified common barriers and potential solutions for each key component. The findings were validated during virtual presentations and meetings with stakeholders in Indonesia and Nigeria.

Role of Private Health Providers in National Health Insurance Systems

Many LMICs continue to struggle with how and how much to integrate private providers into formal government-regulated and government-funded health systems. There is limited publicly available information on the experiences of LMICs in integrating the private sector into government-supported health insurance operations. The size and scope of the private sector's role also varies among countries—for example, in India and Nigeria, the private sector is estimated to cover more than 50 percent of all services provided but, in Ethiopia and Vietnam, the private sector accounts for less than 25 percent. Further, countries differ when considering policy decisions about whether or not integration of private sector healthcare providers would improve or accelerate investments in coverage and care availability (Montagu, 2021).

Many healthcare systems use a mix of public and private providers for family planning, with the private sector playing a major role in providing products and services. In Indonesia, for example, 66 percent of all family planning services are covered by private sector providers (BKKBN et al., 2018). However, even where government-supported health insurance may include family planning products and services as part of benefits packages, this does not automatically correlate to increased use of family planning. For example, in Indonesia since the national health insurance scheme was launched in 2014, the modern contraceptive prevalence rate has been higher among the uninsured than among the insured.

In addition to possibly increasing access to services and leveraging any existing preferences for private providers, another reason to increase the private sector's integration into government-supported health insurance schemes is to reduce out-of-pocket expenditure for clients. In 2019, estimated out-of-pocket expenditures for family planning commodities from private providers was US$2.73

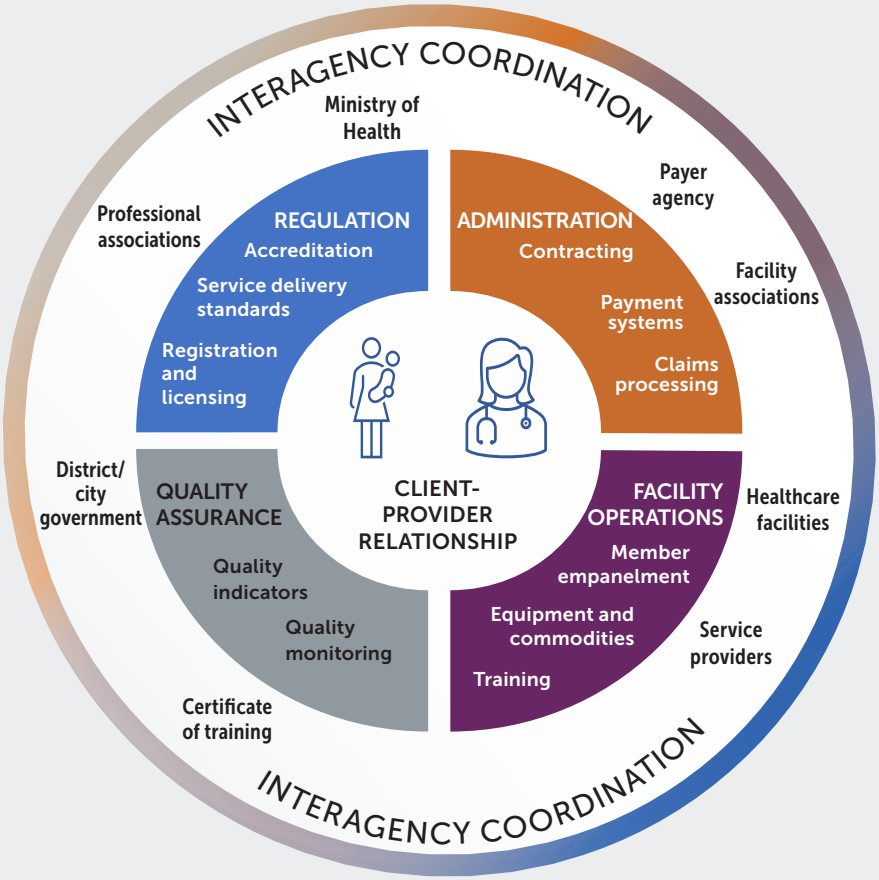
billion across 132 LMICs, with spending on oral contraceptive pills accounting for 80 percent of this total (Weinberger et al., 2021). Effective and efficient insurance systems to ensure clients can access family planning services and commodities from their preferred providers are critical to decreasing out-of-pocket expenditures and increasing use of family planning.

Operational Systems Framework

Based on the literature review and in-depth interviews, HP+ created an operational systems framework for government-supported health insurance schemes. As shown in Figure 1, it incorporates four key functions: (1) regulatory, (2) scheme administration and management, (3) quality assurance, and (4) facility operations.

The regulatory component relates to the processes by which private providers are officially licensed, registered, and certified to be suitable for participation in health insurance schemes. The scheme administration component includes scheme management, administration, and business functions (contracting, payment systems, etc.) that are often led by the payer agency. The quality assurance component relates to the ongoing monitoring and supervision of private facilities and providers to ensure that clients are receiving proper quality of care. The facility operations component encompasses the overall functions and operations of the healthcare facility, including provider and facility capacity, profitability, and access to commodities. Finally, the framework recognizes that these systems are complex, involve many different types of stakeholders, and require

Figure 1. Operational Systems Framework for Government-Supported Health Insurance Schemes



strong interagency coordination to ensure that systems work efficiently and effectively.

Literature Review and Interview Findings

The sections that follow describe the key findings from the structured literature review and from in-depth interviews in Indonesia and Nigeria as they relate to the operational systems framework and its key functions, barriers identified, and possible solutions.

Regulatory Systems

Most LMIC health systems have already established the regulatory and governance structures required for licensing and registration of health professionals and facilities to ensure quality and safety for public and private healthcare. Licensing functions for healthcare professionals are often led by national professional associations with mandatory memberships for respective healthcare cadres and also include continuous professional development requirements for relicensing.

Registration systems for private healthcare facilities are also an established and accepted norm in most mixed healthcare systems. The registration and licensing function for facilities is usually managed by a unit within the Ministry of Health or an independent government agency.

The accreditation requirements for incorporation into government-supported health insurance schemes are developed and led by an autonomous government agency designated to manage the scheme (often referred to as the payer agency).[1] These accreditation requirements generally apply to all public and private healthcare facilities and function as a basic requirement for participation in a government-supported health insurance scheme. The payer agency establishes additional accreditation criteria that both public and private stakeholders may consider to be more stringent than registration/licensing processes. In Nigeria, both public and private stakeholders said stringency was a characteristic of payer agency accreditation requirements (see Box 1).

BOX 1.

"The Lagos State Health Management Agency requirement for accreditation is even more stringent than the state regulatory agency. For example, if you are a small clinic located on the second floor of a building, if you don't have a ramp and two exits, you won't qualify for the scheme."

—Lagos state regulatory agency representative

Common Regulatory Barriers

Both public and private stakeholders said many barriers inherent in regulatory systems relate to human and financial resource constraints. In Indonesia and Nigeria, the registration functions for individual private facilities are decentralized and managed at district and state levels where capacity and resources vary significantly. Stakeholders report that these systems are still very much reliant on paper-based processes and, even when electronic platforms were introduced to streamline processes, private providers do not necessarily embrace them immediately.

Most stakeholders recognize that data systems are weak and that there is limited information-sharing across agencies, which translates to additional verification processes required for professional licensing. State and district agencies responsible for private facilities suggest that their ability to proactively monitor the registration and licensing status of private facilities is limited by human resources and financial constraints.

Private sector providers suggest that accreditation requirements are often not aligned to market realities. In Indonesia, for example, private midwives mention that accreditation requirements are the same for midwives who assist deliveries and

[1] The payer agency is responsible for the empanelment process of assigning beneficiaries to a provider, who then provides comprehensive services to the beneficiary.

BOX 2.

"For the midwife who provides labor service, it is possible to survive since there are delivery services and increased income. However, the accreditation requirements are the same for the midwives who do not assist labor, which includes having a full-time assistant, a [memorandum of understanding] with a third-party clinic, and a waste management system. As a result of this requirement, many private midwives have closed down."

—Indonesia Midwives Association member, Serang district

for those who do not. Private midwives who do not assist deliveries (and who have less income as a result) find it difficult to meet the same requirements and many are closing their practices (see Box 2).

Stakeholders suggest that changes in service delivery regulations are not well disseminated and therefore there is confusion among providers. For example, in Indonesia, new regulations increased the number of antenatal care visits from four to six along with the requirement to visit a doctor in the first trimester for reimbursement under the national scheme. Midwives, however, are for many women the first point of contact during early pregnancy. The requirement for a doctor's visit complicates compliance with service delivery protocols for women who choose to visit a midwife rather than a doctor. Service delivery regulations related to family planning are also perceived by some stakeholders as creating barriers to access. These are discussed in more detail in the section on family planning considerations.

Proposed Solutions to Regulatory Barriers

Stakeholders suggested potential solutions to address some of the operational barriers to regulatory processes:

- **Strengthen data systems that link national and state registration and licensing mechanisms.** There should be better coordination between national and state agencies and organizations. Poor data systems can create licensing delays. In Indonesia, for example, licensing delays for private providers meant that some healthcare facilities could be expelled from the national health insurance scheme.
- **Acknowledge that accreditation requirements should reflect market realities for the private sector.** Private sector providers and facility owners suggested that private sector facilities are often more streamlined in their workforce needs. Private facilities have fewer employees and employ higher-level medical cadres. In Nigeria, for example, private hospitals may employ community health extension workers (instead of nurses), who are allowed to conduct more procedures than nurses, and therefore are more functional. This is also due to the overall shortage of nurses in the health workforce.
- **Strengthen interagency coordination to increase awareness of new regulations and address regulatory barriers.** Private providers suggested that new regulations and policies are not well disseminated. Any changes to service delivery regulations and protocols should be properly disseminated to public and private facilities.

Scheme Management

The payer agencies responsible for scheme management support multiple business functions, including beneficiary and provider management (empanelment and accreditation), claims management, and financial management of the system, which encompasses payments to providers (Asian Development Bank, 2021). Many health insurance systems involve both national-level governance and decentralized key functions and operations, which creates additional strain on state and district governments in low-resource settings. Stakeholders suggest that payer agencies are primarily focused on ensuring that relevant healthcare services are available to the covered

BOX 3.

"NHIS is a purchasing/regulatory agency. What we do is ensure that our enrollees get the services they paid for. It does not matter what market we get them from; we just need to ensure that they are good quality and efficient (so that we're not wasting the enrollee's funds). Whether it's public or private, it should be the same service."

–National Health Insurance Scheme, Standards for Quality Assurance representative

population with no explicit strategy to recruit private facilities. For example, in Nigeria, the National Health Insurance Scheme (NHIS) states that its role is to ensure that quality services are made available to beneficiaries, regardless of whether they are public or private (see Box 3). Stakeholders recognize that private facilities often represent a large segment of participating facilities and also recognize that, in certain health markets, it is not feasible for the public sector to meet all service delivery needs.

Common Barriers in Scheme Management

The most common issues in scheme management for private providers relate to the limited number of beneficiaries empaneled to their facility (see Box 4) and the perception that capitation rates are too low and not adjusted in a timely fashion. There is a lack of understanding of the terms of the contract between private facilities and the payer agency. Both public and private stakeholders recognize that the empanelment of beneficiaries to a specific facility will take time, but this is particularly problematic for a private facility that doesn't have a sufficient volume of beneficiaries for financial viability. Some stakeholders also mentioned that there is a lack of transparency or possible collusion in facility contracting and a perception of unfair competition between public and private facilities. Capitation rates are often perceived as too low, stakeholders said, and tariff adjustments are not managed efficiently. In Indonesia, for example, both public and private stakeholders said that the scheme had not adjusted its tariffs since its introduction in 2014 (see Box 5).

BOX 4.

"The major challenge is that [private facilities] don't have enough enrollees and they complain that capitation is too small and they want higher tariffs. Private providers are more sensitive to profitability."

—Lagos State Health Management Agency representative

BOX 5.

"We cannot deny that there is a challenge with tariffs. Whenever we have a discussion with colleagues from the health facility association, the issue of the national health coverage tariff is always raised. It is a very fundamental thing to be improved."

–Badan Penyelenggara Jaminan Sosial Kesehatan-Ketenagakerjaan (BPJS-K)

Solutions to Barriers in Scheme Management and Administration

- **Support business planning through transparency on plans and timing for increasing beneficiary empanelment.** Private facilities said that empanelment numbers were often not sufficient to allow scheme participation to be financially viable, suggesting that payer agencies should be more transparent regarding how they plan for increasing empanelment numbers. Private providers also need to understand complex payer contracts to ensure timely, correct reimbursements and to avoid claim denials.
- **Ensure that introduction of digital systems is accompanied with appropriate capacity building and dissemination systems to support use in the private sector.** Many stakeholders said that electronic/digital systems were not immediately embraced by the private sector and that adequate support and capacity

building is required to ensure these systems increase efficiency. In Nigeria, the Lagos State Health Management Agency is building the capacity of private providers to support the use of its digital platform, including facility visits to provide on-the-job support.

- **Plan for regular and appropriate adjustments to tariffs and reimbursement rates.** Given that private facilities do not receive additional subsidies from the government, it is critical for their financial viability to ensure that tariffs/reimbursement rates are adjusted in a timely fashion to keep pace with inflation and other rising costs.

Quality Assurance

The importance of establishing appropriate quality assurance in healthcare systems is well documented, yet this function is dependent on interagency coordination and sufficient governance structures. In practice, there are multiple institutions or mechanisms for assuring quality of care (such as ministries of health, medical professional councils, and national and state agencies). In many countries, including Indonesia and Nigeria, decentralization of these functions and varying capacity and resources at state and district levels present additional challenges. The payer agency is ultimately responsible for ensuring quality; but quality assurance relies on interagency coordination at national, state, and district levels. Some stakeholders suggest that accountability structures are weak or nonexistent for monitoring a pivotal issue such as the quality of care.

Common Barriers

Common quality assurance operational barriers cited by stakeholders in Indonesia and Nigeria include capacity and resource constraints, such as lack of human resources or limited budget for conducting ongoing supervision visits—meaning that these activities are not conducted regularly. In Indonesia, district-level stakeholders suggest that quality assurance systems are still limited by resource constraints, and within the national health insurance agency, BPJS-K, there is more of an emphasis on cost containment than on quality assurance (see Box 6). In Nigeria, stakeholders recognize that quality assurance for the private sector will require additional resources and will depend largely on support and capacity building being provided (see Box 7).

BOX 6.

"Since the focus of BPJS-K is quality for money, they always communicate about cost and quality control, but in reality they are always focused on cost control, but not yet on quality control."

—District Health Office representative, Serang district

BOX 7.

"The only way you can adequately regulate the quality of care of the private sector is to bring some form of support for them and ensure that they keep to standards."

—National Health Insurance Scheme, Standards and Quality Assurance representative

Solutions to Barriers in Quality Assurance

- **Allocate resources for supervisory monitoring among payer agencies.** Most stakeholders recognized that resource constraints are a major barrier for overseeing private sector quality assurance initiatives. Many oversight functions are conducted by other state agencies but stakeholders suggested that payer agencies also need to dedicate resources for supervisory monitoring. In Nigeria, the Lagos State Health Management Agency and the state regulatory agency are working with PharmAccess to develop quality improvement plans and provide implementation guidance for all facilities involved in the scheme.
- **Integrate digital monitoring tools to monitor facility issues prior to field**

visits. Stakeholders suggest that digital monitoring tools (e.g., data warehouses) may help to increase efficiency and cost-effectiveness of field monitoring visits.

Facility Operations and Financial Viability

Private healthcare facilities and providers independently manage their operations and financial viability. Unlike public sector facilities that receive additional budgetary support for personnel or other operational costs (rent, utilities, etc.), private facilities must cover all operating expenses through their revenue. Private stakeholders suggest that some human resource and equipment requirements that the government stipulates for accreditation in national health insurance schemes are not financially feasible for the private sector.

Common Barriers

The specific barriers stakeholders mentioned include lack of affordable capital for equipment and other infrastructure improvements, limited access to government-supported training and capacity building programs, and, in some cases, poor data systems and recordkeeping. Despite these barriers, most private facilities recognize the potential benefit of participation in social health insurance schemes.

Solutions to Barriers in Facility Operations and Financial Viability

- **Ensure access to single-digit interest rate loans for private healthcare providers to purchase equipment or make infrastructure improvements.** The low-interest rate loans will support private providers in making the additional investments that are needed to meet accreditation requirements and implement patient and financial management systems.
- **Develop platforms for ongoing capacity building for the private sector.** This may include interagency coordination with the Ministry of Health and/or professional associations to support training, for example, on financial management to enable private providers to manage limited resources and understand government contracting.
- **Provide some flexibility for achieving accreditation requirements.** For example, requirements could be amended to allow providers to be accredited if they sign a memorandum of understanding that they will implement service upgrades or other changes during a specified amount of time. In Indonesia, private facilities may sign a memorandum of understanding with BPJS-K that outlines specific improvements to be made in order to maintain accreditation. In Nigeria, the Lagos State Health Management Agency grants provisional accreditation to some facilities and provides a moratorium for meeting remaining criteria.

Interagency Coordination

Efficient and effective health systems require strong governance structures and interagency coordination. Stakeholders mentioned examples where there is good coordination on the development of standard operating procedures and training, but stakeholders suggest that stronger coordination is needed in other key areas. In Indonesia, for example, stakeholders mentioned that interagency commitment is needed to address regulatory barriers (see Box 8). Other stakeholders mentioned that communication is delayed and there is a need for better coordination between agencies on compliance and monitoring—for example between the district health office and professional associations—and a need for a better system to resolve conflicts with BPJS-K, given that no neutral arbitration exists to resolve

BOX 8.

"We made the effort to coordinate with the social security administrative body, BPJS-K, the Ministry of Health, and with the inspectorate, but we hit a dead end…"

—National Population and Family Planning Board representative

such disputes. In Nigeria, opportunities exist for improved networking to coordinate learning exchanges. For example, the Association of General & Private Medical Practitioners of Nigeria is coordinating with government agencies on behalf of private providers.

Family Planning Considerations

The financing of family planning services through government-supported health insurance systems varies significantly between countries, with some benefits packages including coverage of counseling and information services only, others covering only some family planning methods, and still others providing full coverage of all long- and short-acting methods. The other variation is the financing of commodities, which are often covered through other programs. In Nigeria, for example, family planning commodities are financed through a Basket Fund supported by the federal government while some states (Lagos, for example) procure commodities in addition to what the national government provides. However, stakeholders continue to report chronic stockouts of family planning commodities.

In Indonesia, stakeholders suggest that some protocols for the provision of family planning services during and after delivery disincentivize providing that service because of stringent regulations (see Box 9). For example, IUDs and implants are only reimbursed when they are provided in primary care facilities, which means that women who deliver in another type of facility miss the opportunity to receive a postpartum family planning method covered by the health insurance scheme.

BOX 9.

"Providing family planning services during delivery and postnatal is very complex because we have to follow strict regulations. It is a very rigid, insurance-based system—and not easy to follow."

—National Population and Family Planning Board representative

Conclusion

Many health system stakeholders—global development partners, government agencies, and private providers—recognize that efforts to achieve universal health coverage and expand access to priority health services will require a greater role for the private sector in government-supported insurance schemes. While social health insurance schemes may include some family planning products and services as a part of their benefits package, this does not automatically translate to broad access to a wide range of methods and increased use of family planning services. In addition, out-of-pocket expenditures for family planning commodities continues to be high. For countries that are just gearing up for private sector contracting in social health insurance schemes, this study offers important policy findings and recommendations on how to manage and potentially avoid common barriers to private sector contracting.

As the size and purchasing power of insurance schemes increase to reach lower-income households and geographically diverse locations, they will need to expand their provider networks. At the same time, the overall expansion and increased financing of government-supported schemes will make it easier to address some of the key incentives and critical barriers to private sector integration. Many of the barriers mentioned by public and private stakeholders are related to human and financial resource constraints. The most common scheme management issues for private providers are the number of beneficiaries empaneled to their facility, the perception that capitation rates are too low, and that rates are not adjusted in a timely fashion. The governance and accountability structures to monitor quality of care are still nascent in many settings, particularly for the private sector. Other challenges mentioned by the private sector include lack of affordable capital financing for equipment and other infrastructure improvements and limited access to government-supported training and capacity building programs. Addressing these pain

points will allow ministries of health and other stakeholders to develop and test policies that offer a stronger value proposition to private facilities and providers interested in participating in health insurance schemes.

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