Botswana Private Health Sector Assessment

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Overview of the Presentation Today

- PSA Purpose
- Landscape of Private Sector Provision
- Supply-Side Considerations
- Health Financing in the Private Sector
- Sustaining PEPFAR Investments in Priority HIV Services

Purpose of the PSA

- Provide evidence and guidance to key stakeholders to leverage private health sector resources for both service delivery and financing, in light of decreasing donor funding in Botswana

- Commissioned by USAID and approved by MoH

PSA Methodology

- Extensive literature review
- Secondary data analysis
- Refine SOW based on stakeholder input
- Key informant interviews in Gabarone, Francistown and Maun
- SWOT analysis
- Consultation workshop to discuss and vet preliminary findings and recommendations
- Produce draft report for stakeholder comment
- Finalize PSA report

Landscape of Private Health Sector Provision

Botswana: A Unique Country in SSA

- Large land mass, small population with concentrated pockets of habitation
- Middle-income status with relatively high GDP
- Enormous public sector success in essential health services, particularly in MCH
- Very wide ART coverage (95%) but persistently high HIV prevalence (23.4%)
- Since GoB finances the majority of HIV services, PEPFAR focuses on TA to strengthen MoH systems, in anticipation of further declining donor funding

Overall, Conducive Environment for Private Sector Provision

- Strong commitment and longstanding experience with PPPs in service delivery for ART
- Registration and licensure process supports private sector growth
- Recent MoH forays into contracting for facilities management and PHC service delivery
- CPD system newly instituted and piloted; includes private sector friendly modalities
- GoB training includes private sector in priority health services (e.g., ART, TB and SMC)

Botswana's Small Size Influences Private Sector Growth

- Heavy concentration of population in a few urban centres
- Limited private health sector reach in rural areas
- Urban market has limited ability to absorb new public and private facilities
- The expansion of private health financing sources is limited by the size of the population

Insufficient Dialogue on Broad Private Health Sector Issues

- Medical Practitioners Association historically focused on medical aid issues

- Gap in direct dialogue by private clinicians with the MoH on service provision issues, including:
  - Feedback on registration, licensure and enforcement
  - Feedback on clinical aspects of PPP service delivery models
  - Discussion on clinical nuances and implications for contracting in (e.g., standards of care for patients treated by private doctors in public facilities)

Effective Enforcement Supports Private Sector Quality

- Recent discussion about shifting licensure and enforcement functions from MoH to Health Professions Council (BHPC)→ requires capacity-building for BHPC
- Potential duplication in inspection role between medical aid schemes and MoH
  - Prospects for a uniform inspection system
- Private provider openness to effective enforcement as a tool to improve quality and build market share
  - *"If I am guided and enforced in best practices of care each year, more patients will want to come to me and I can offer them better quality services."*

Strong Private Sector Role in HIV Services from Prevention to Treatment

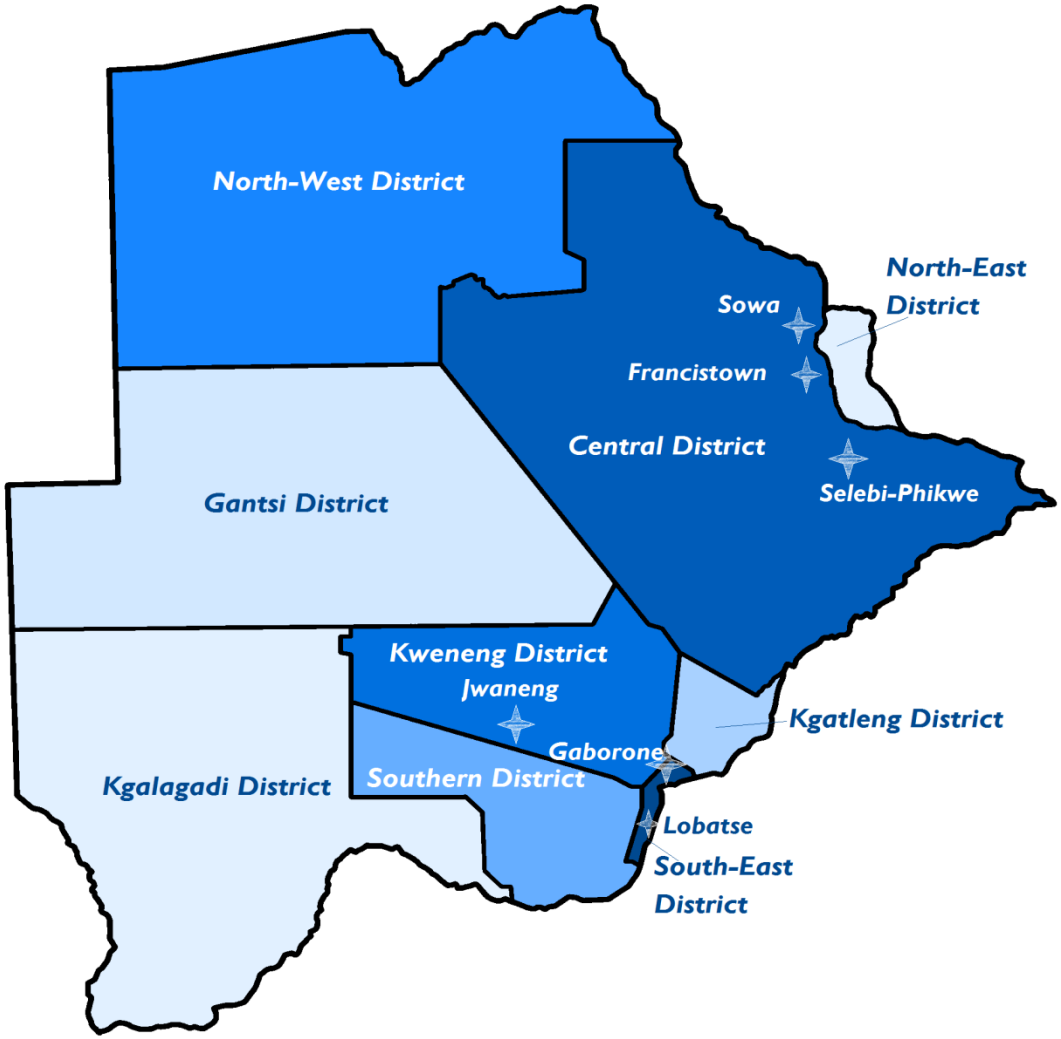
- Private sector clinicians offer ART, both to public sector patients through a PPP and to private patients covered by MASs
- MASs cover full spectrum of HIV services
- NGOs mainly focus on HIV care and prevention services

Supply-Side Considerations

Policies and Programs Have Favored Private Sector Growth

- Economic growth and HIV epidemic created opportunity for greater private sector role
  - Greater demand for health services
- Swift licensing of private providers
  - Influx of foreign doctors, pharmacists
- Policies enable greater access to essential medicines
  - Limit mark-ups
  - VAT exempt
- PPPs helped expand access to HIV treatment through various channels

Private Practice is Concentrated in Urban Areas…



…So Are Investments in Health Infrastructure

- SOTA hospitals
  - Private-for-profit
  - Public (4 new)
  - University Teaching Hospital (2014-15)
- Robust private labs, pharmacies

Investments in Health Infrastructure May Outpace Population Growth

- Private sector health market = mostly MASs cover
  - Small proportion of the total urban population
- Perceived quality of public sector is associated with demand for services in the private sector
  - Gaborone vs Francistown
- SOTA public hospitals also able to compete with private sector
  - Contracting-out for health specialists

Significant Number of Private Health Facilities and GPs

	Botswana	
	Public	Private
Hospitals	35	9
Public Clinics	286	
Private Doctors' Surgeries		363
Health Posts	343	-
GPs	683	650
Pharmacies	-	110
Total Number of Facilities	664	482

Source: Public Sector numbers from Central Statistics Office's *Health Statistics Report 2009;* Private sector numbers are from BPOMAS and PULA registry, as of 15 May 2013

From “Emergency” to “Ownership”

A Close Look at the Supply Chain

HIV Epidemic Created Strong Incentive to Partner with the Private Sector

- In 2005 – cost of ARVs drop, influx of donor support
- Limited MOH capacity to respond to high demand
- MOH engaged the private sector
- Innovative PPP to expand ART initiated
- MASs cover ART through the private sector

Success of All 3 Models Contribute to Universal ART Coverage

- Public Sector - Central Medical Stores
  - Uninsured
  - PEPFAR TA through SCMS
  - Free ARVs through GSK-GOB partnership
- Private Sector – wholesalers/distributors, pharmacies, dispensing doctors and labs
  - MAS cover; out-of-pocket
- Unique PPP for HIV/AIDS Services
  - Procured by CMS
  - Warehoused/distributed by MAS
  - Provided to uninsured through private channels
  - Private providers reimbursed through MAS

Public Sector Supply Chain Works Relatively Well…

- But stockouts persist
- Why?
  - Delays in procurement/delivery cycles
    - Leads to rationing
    - Ad hoc purchase from local wholesalers – more costly
  - Distribution challenges
  - Facility reporting does not always reflect consumption
- Plans to contract out warehouse/distribution
- Still reliant on donated drugs – until 2014
- PEPFAR TA shifting to greater ownership

Private Sector Supply Chain Is Reliable and Efficient

- Appears to be “healthy” competition among wholesalers
- Mark-ups from wholesalers to private providers:
  - ARVs range from 2 – 5%
  - Other prescription meds range from 5-10%
- Mark-up from providers to patient
  - ARVs - up to 10%
  - Other meds – branded (~35%), non-branded (~55%)
- MASs reimburse providers
  - No government regulation on mark-ups, but
  - MASs places caps on reimbursements

PPP for ARVs Is a Model for Other Medicines

- Originally started with AFA; now BOMAID
- Expand coverage to the uninsured
- Government provides ARVs for free to BOMAID
- Public sector patients referred to BOMAID (14,000)
  - Provides C&T
  - Refers to lab
- BOMAID contracts out to Medswana
  - Receives ARVs from CMS
  - Packages/labels for each patient
  - Distributes to provider
- Patient collects medication from private channels
- BOMAID reimbursed by MOH

Convergence of “Transitions” Calls for a New Way of Working

- PPP tender with BOMAID ends early 2014
  - MOH continuation of PPP program unclear
- PEPFAR focus on greater country ownership
- GSK donations expected to end 2014
- New CMS distribution/warehousing contract forthcoming
  - Botswana Couriers – not new to distribution, but new to medicines

What Does this Mean for Maintaining Program Success?

- Funding Gap
  - Not only for ARVs but…
  - To develop capacity for CMS to procure & for MOH to manage new distribution contract
- End of PPP HIV/AIDS Services
  - Could once again overburden the public health system
  - Limit private sector role – “crowding out”
  - Make ARVs susceptible to stockouts
- Multiple transitions may set back successful ART program

Sustaining Investments in the Private Sector Can Help Facilitate Upcoming Transitions

- Multi-sectoral response was key to achieving universal ART coverage
- Implement policies and programs that enable greater access to private sector in underserved areas
  - Licensure has started to consider distribution of providers
  - Contract-in private providers into public health sector
- Build on success of PPP HIV/AIDS service model
  - Assess inefficiencies and costs
  - Identify opportunities to expand ART coverage
  - Expand beyond ART to other essential medicines
  - Implement strategies to expand health coverage through MASs

Health Financing

The Private Sector, through MASs, Has a Role to Play in Reducing Funding Gap

- Expected reduction in fiscal and export revenues, and PEPFAR funding
- Gap in funding for health expected to grow
- Public sector options already explored (additional resource mobilization, increase efficiency of public resources)
- Role of private sector:
  - Raise OOP for services (currently low at 30% by African standards) – not preferred option
  - **Increase MAS coverage**

Current MAS Coverage is Impressive but Shows Significant Room for Growth

- Public sector:
  - Covered (BPOMAS): ~72k employees (55%)
  - Not covered: ~58k employees (45%)
- Private formal sector:
  - Covered (BOMAID, PULA, Botsogo, Itekanele, Doctors Aid, Etudiant, Botlhe, Symphony): ~70k employees (34%)
  - Not covered: ~135k employees (66%)
- Private informal sector:
  - Covered (Itekanele & BOMAID?): ?
  - Uncovered: up to ~70k
- 17% of population covered

Increasing MAS Coverage May Require…

- Assurance of sustainable and financially stable schemes
- Focus on customer protection
- Lower-cost insurance products and distribution channels
- Increased cost effectiveness through wider pooling and cross-subsidization
- Broader customer choice

6 Possible Strategies to Increase Coverage

- Fewer, larger, stronger MASs
- Lower-cost insurance products and distribution channels
- Modify plan choices
- Supportive regulation of MAS
- Stronger risk sharing arrangements
- Resolution of supervisory concerns about collusion between MAS and providers

Fewer, Larger, Stronger MASs Are More Likely to Be Able to Expand Coverage

- 9 MASs for 340k lives
- Fewer and larger schemes → higher cost savings and lower premiums
- Explore modalities (including regulation-induced) for potential MAS mergers

Low-Cost Insurance Products and Cost-Effective Distribution Channels Can Attract New Members

- Develop new products targeted at young people and lower income strata
- Increase ability to reach these populations more cost-effectively
- Empanel providers to guarantee income
- Focus on primary healthcare and on generics
- Combine savings with insurance
- Use age-rating for premium setting
- Explore mobile payments solutions
- Develop innovative distribution channels

Different Membership Choices May Increase Coverage

- Making coverage for government employees and their families compulsory (with partial premium subsidy) – Lowest-hanging fruit?
- Expanding choice of products for public sector employees

A Supportive Regulatory Environment Benefits Current and Future Members

- Good regulation can:
  - Increase financial stability of schemes
  - Protect members
  - Result in lower number of sustainable schemes
- The NBFIRA Act calls for regulation of MAS, but legislation has yet to be written
- Appropriate-touch regulation and supervision would focus on
  - Controlling costs
  - Incentivizing appropriate and affordable reinsurance or risk equalization
  - Rationalizing the setting of premiums and tariffs
  - Expanding product choice
  - Limiting new entries

Sharing Risk Between MASs, Providers, and Members Benefits the Whole Industry

- Optimal distribution of risks may result in lower costs, higher uptake, and higher utilization
- VAT-inclusive co-pays can be a barrier to care—in particular expensive and inpatient care—and to scheme membership
- Provider payment system does not balance risk distribution between members and providers
- Replace proportional co-pays with lump-sum co-pays, at least for inpatient care
- Consider removing VAT on care services
- Consider introducing elements of per diem and capitation in FFS system

Resolution of Supervisory Concerns about Collusion May Lower Costs

- Empaneling providers can reduce costs and facilitate risk-sharing arrangements
- Collective negotiations of tariffs can result in:
  - Lower tariffs and premiums
  - Stronger trust between MASs and providers
- Both concepts raise legitimate concerns with the Competition Authority
- Engage with Competition Authority to address concerns while increasing flexibility in the health sector

MASs Have Unique Role to Play in Increasing Coverage

- Private sector can play important role in preparing for PEPFAR transition
- MASs represent solid basis for increasing coverage and access to essential services
- Mix of public and private strategies to increase coverage:
  - Strengthen viability of the industry
  - Introduce and distribute products attractive to uncovered populations
  - Increase cost effectiveness
  - Expand choice

Sustaining PEPFAR Investments in Priority HIV Services

Health NGOs are Highly Dependent on Donor Funding

- More than 300 health-focused NGOs; donor funding is main source of revenue by far
- Mainly focus on HIV prevention and care services
  - HCT
  - Condom distribution
  - OVC
  - SMC
  - HBC
- NGOs and the services they offer are particularly vulnerable during the PEPFAR transition

NGOs Have Limited Commercial Experience

- Very limited income generation activities
- Twinning with private corporates for skills mentorship
- Outreach to private corporates for CSR donations (e.g., through BOCONGO PPP Forum)
- Little systematic consideration of commercial opportunities for health NGOs→ selling high-quality, in demand services to corporates

NGOs May Have Commercial Opportunities to Cross-Subsidize

- Appealing to have one service provider that can offer a variety of services
- A few NGOs may be positioned to offer a broad service offering to corporates if they shift paradigms to a commercial lens
- May be able to maintain social mission by cross-subsidizing less marketable services
- NGOs may be able to compete on price and quality, if they price accurately and market their services
- However, the market for commercial opportunities is less than total donor funding for NGOs→ not a panacea

Significant Work to Actualize NGO-Corporate Partnerships at Scale

- Quantify corporate demand for health and wellness services for employees including:
  - Health, stress and financial management counseling
- Assess NGO supply capabilities
- Broker partnerships where supply and demand meet→ Value-add to members for umbrella organizations like BOCONGO or BBCA
- Assist NGOs in pricing their services, marketing and pitching a service offering, negotiating a contract, and reporting on outputs

Expanding SMC through the Private Sector

- Strong commitment to leveraging private health providers to expand SMC in ten ACHAP-supported districts
  - Training private providers in SMC
  - Contracting-in private providers for campaign days at per procedure reimbursement
- 47,000 men covered by MAS in target SMC age range
  - SMC agenda driven by BPOMAS and Pula
  - Represents 12% of total Botswana SMC target
  - Relatively small contribution but “low-hanging fruit”

Better Utilize MAS Structure to Promote SMC

- Advocate for more schemes to cover SMC as a HIV preventative benefit at a standard rate
- Ensure that tariff rate for SMC is set by independent actuarial analysis
  - If tariff rate is not accurate, private providers may not want to provide service
  - Perceived discrepancy between some tariffs and OOP rate
- Donors or GoB can support independent actuarial analysis to introduce additional tariffs for other high-priority services like HIV counseling in private pharmacies

Consider Private Provider Circumstances in Providing SMC

- SMC is a time-consuming service when all elements are taken into account:
  - Counseling
  - Post-procedure follow-up visits
- Need a certain number of SMC clients to both build clinical skills and make service viable
- Networking and branding trained providers in SMC could help build a trusted service provision point for SMC in the private sector
- May be more effective to have a smaller number of private GPs offering SMC at higher volumes (with marketing support) than a larger pool

Parting Thoughts

- Sustaining investments in the private health sector can help facilitate upcoming transitions
- The private sector, through MASs, has a role to play in reducing the funding gap
- Sharing the risk between MASs, providers, and members can help expand coverage
- NGOs may be able to cross-subsidize important HIV care services through stronger commercial linkages

Discussion

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