Comparison of Private Sector Hospital Involvement for UHC in the Western Pacific Region

Peter Cowley* and Annie Chu
Division of Health Systems, World Health Organization Regional Office for the Western Pacific, Manila, Philippines

BACKGROUND

Many transitional economies in the Western Pacific Region (WPR) have been moving away from the public sector fully funding and providing health care services. Many governments are looking to the private sector for their expertise in organization and bringing efficiency to the provision of health care. Public hospitals are also gaining more financial and administrative autonomy, with more hospitals moving across the spectrum from fully public to mixed public and private models with for-profit behavior. With rising demand for modern and high-quality health services and severe fiscal constraints on public financing for health services, the private sector has recently expanded its presence in the health care sector. This transition has been particularly rapid in Viet Nam, China, and the Lao People’s Democratic Republic (Lao PDR). The role of the private sector in the provision of health care services dominates the hospital and primary health care (PHC) sectors in Japan and Korea, where there is a long history of private hospitals using social health insurance and state budget funding to advance hospital-based contributions to universal health coverage (UHC). The major challenge in this transition is aligning both public and private hospitals to achieve equitable access to services, better quality, and improved efficiency.

Through a series of public hospital reforms, including granting various levels of autonomy in managing public hospitals and introducing some forms of public–private partnerships, the governments of Lao PDR, China, and Viet Nam have attempted to make public hospitals work more efficiently. The move toward fully autonomous public hospitals is one aspect of Viet Nam’s broader “social mobilization” policy that has also led to increased private investment in state hospitals along with government granting them more decision rights in generating and retaining revenues. In Lao PDR, the private hospital regulations recently introduced more attractive incentives for private investors, such as allowing 100% foreign-owned investment, land concessions, and tax or duty exemptions on medical equipment and supplies. In addition, through Lao
PDR’s Decree 349, state-owned health facilities are allowed to retain 15% of their revenues to be used for staff incentives. In 2012 the China State Council, in the Twelfth Year Plan, outlined a target for the share of the for-profit private sector at 20% of all beds. In 2014, China’s Ministry of Health (MOH) outlined specific areas for private-sector growth, including premium services, rehabilitation and geriatric care. A year later, the policy statements from the “Main Tasks of Deepening Medical Reform 2015” began to describe a mixed system where “public medical institutions lead joint development with non-public medical institutions” (p. 313).

In Viet Nam, under Decree 93/2014, public health facilities are allowed to use other resources or receive loans for the establishment of new units on a hospital’s premises and for new hospitals that are run as a joint venture unit, as a corporate hospital by employing a “trademark,” or building on the reputation of an existing public hospital. In Viet Nam, public health providers (paid for out of MOH budgets) are allowed to work in these private for-profit-oriented facilities, including joint ventures or private for-profit hospitals. In China, policies encouraging the role of the private hospitals in providing care are actively being implemented. In Viet Nam, the government has targets for the private-sector provision of hospital beds and, similar to the government in China, these targets are for 20% of hospital beds to be provided by the private sector in Viet Nam by 2020 (and by 2015 in China, p. 315).

Though there are other countries in the WPR that have experienced growth in the private hospital sector, the growth in China and Viet Nam has been characterized by government supply-side recurrent cost support (and strong interest in the case of Lao PDR) with an evolving set of institutions and regulations that better define this support. Furthermore, these three countries share a history of structural transformations as a result of moving from a centrally planned economy to a market-based economy.

This commentary summarizes the growth of private hospitals in these three countries. Aspects of this private hospital growth are then described according to some UHC attributes such as quality, accountability, equity, and efficiency. The commentary concludes with potential action steps for increasing the contribution of the private hospital sector toward attaining UHC in China, Viet Nam, and Lao PDR.

PRIVATE HOSPITAL GROWTH TRENDS IN LAOS, VIET NAM, AND CHINA

Private for-profit hospitals are generally considered to be legal entities set up for the purpose of producing goods and services and are capable of generating financial gain for their owners. In China and Viet Nam, the absence of significant regulation, along with some but not adequate amounts of government financial support, has resulted in an increase in commercial activities within the buildings of nominally public hospitals. These commercial activities can stretch from markups on drug sales to addressing “patient-requested services” to commercialization of certain departments such as lab or X-ray services to employee (usually doctor) ownership of the hospital. In China and Viet Nam, the definition of what constitutes a private for-profit hospital needs to take into consideration that public hospitals have commercial interests and that profit-centric hospitals still receive substantial salary and other recurrent cost support from government. The growth of the private hospital sector in Lao PDR, Viet Nam, and China is shown in Table 1.

Though the private hospital sector has grown in Lao PDR, China, and Viet Nam as a percentage of total hospitals, the growth of private hospitals as a percentage of total hospital beds is less significant, as shown in Table 2.

It should be noted that in the case of China, not all of the private hospital beds can be characterized as being for-profit in nature, as opposed to the statistics from Lao PDR and Viet Nam, where the numbers of private hospitals and numbers of hospital beds are reported from the private for-profit sector. A recent report from the World Bank and the World Health Organization (WHO), Deepening Health Reform in China—Building High Quality and Value-Based Service Delivery,

Table 1

| Country | Number of Private Hospitals (% of Total Hospitals) 2010/2011 | Number of Private Hospitals (% of Total Hospitals) 2016 |
|---------|----------------------------------------------------------|----------------------------------------------------------|
| Lao PDR | 0 (0%)                                                   | 17 (7.9%)                                                 |
| China   | 7,068 (34%)                                              | 16,432 (56.4%)                                            |
| Viet Nam| 133 (10.6%)                                              | 185 (13.7%)                                               |

*Source: World Bank Group et al., Jacob, and Yip and Hsiao.

| Country | Number of Private Hospital Beds (% of Total Hospital Beds) 2010/2011 | Number of Private Hospital Beds (% of Total Hospital Beds) 2016 |
|---------|-----------------------------------------------------------------------|---------------------------------------------------------------|
| Lao PDR | 0 (0%)                                                               | N/A                                                          |
| China   | 374,000 (11%)                                                         | 1,234,000 (21.7%)                                           |
| Viet Nam| 6,285 (3.0%)                                                          | 14,185 (5.6%)                                               |

*Estimates do not include the private beds established in public hospitals. Source: Jacob and Yip and Hsiao.

Table 2

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but they represent In Lao PDR, Studies reveal that public and present evidence showing that nonstate hospi-
(p. 324). Nguyen and Wilson report In Viet Nam, Nguyen report that it is The impli-
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CHARACTERIZATION OF PRIVATE HOSPITALS BY UHC ATTRIBUTE

Morgan and colleagues suggest that the private sector should contribute toward the attributes of quality, accountability, equity, and efficiency of service provision, in order to best support a mixed health care system moving to achieve UHC.\(^5\) Using these attributes, a brief summary of private hospital contributions is presented, highlighting data from China and Viet Nam.

Quality

When summarizing the quality of private hospital care in China and Viet Nam, one overarching theme is that private hospital care is quite variable and poorly regulated. In fact, the World Bank and WHO\(^4\) report that it is “widely believed that private providers are more likely than public counter-
parts to engage in false advertising, over-treatment and fraud-
ulent billing practices” (p. 324). Nguyen and Wilson report problems such as overtreatment with private hospital care in Vietnam.\(^6\) Despite problems of quality with private hospital care in China, Eggleston and colleagues report that average inpatient mortality rates per 1,000 admissions for nongov-
ernmental not-for-profit and for-profit hospitals in China do not differ from those found at government hospitals and that this holds for similar size, accreditation level, and patient mix.\(^7\)

Equity

Private hospitals have a fundamental problem addressing equity in that they meet the needs of those who can pay, whereas public hospitals focus on those who cannot pay for the costs of private hospital care. As those who can pay increasingly utilize private hospitals, there is less interest by this group in ensuring adequate resources for public hospitals. This scenario can result in a two-tiered system of care (and a decline in equity) with a resultant increase in the overall costs of health care. This two-tiered system is exem-
plified by trends in many countries where distribution of benefits at the primary health care level favors the poor and hospital-level services benefit the better-off.\(^8\) The impli-
cations of this outgrowth are that the poor lack access to those services that public hospitals can no longer provide and can be forced to access private hospital services, with an increased risk of financial catastrophe and impoverishment.

Efficiency

Despite popular beliefs that private ownership of hospitals results in greater efficiency, the evidence does not support this. These studies compare private hospital operators with other types of ownership, which differ considerably in their methodological approaches.\(^4\) Studies reveal that public and not-for-profit hospitals are more efficient than those in pri-
vate ownership. One study concludes the opposite but could not demonstrate any significant differences between the dif-
ferent types of hospital ownership.\(^9\) In Viet Nam, Nguyen and Wilson\(^6\) present evidence showing that nonstate hospi-
tals demonstrate more flexibility in the use of their human resources and shorter average lengths of stay than state
hospitals. For China, Chu, Zhang, and Chen conclude that medical insurance reforms have improved the performance of Chinese hospitals, whereas public subsidies have decreased performance.\(^\text{10}\)

**MAXIMIZING PRIVATE HOSPITAL CONTRIBUTIONS TO UHC**

Morgan, Ensr, and Waters describe how changing the performance of the private sector will require interventions that target the health sector as a whole, as opposed to providers alone,\(^\text{5}\) whereas various other studies\(^\text{1}\) point to the need for having well-functioning government mechanisms in order for the private hospital sector to meet its potential role in contributing to achieving UHC. Such mechanisms can include business model regulation, professional self-regulation, and national health insurance, which, when implemented, can enable the achievement of UHC. Institutions such as the MOH, Ministry of Finance, and National Health Insurance Corporation (and their respective roles and responsibilities) are necessary for well-functioning government mechanisms to shape and maximize the private hospital contribution to UHC.

**Business Model Regulation**

Though the legal form of operation for private hospitals in Viet Nam (joint venture model of public–private partnership, business cooperation contract, or foreign-invested enterprise) is somewhat outlined (especially the capital requirements, operational licenses, need for qualified personnel, potential vehicles for foreign investment, and scope of services), there is limited definition and enforcement of the business operation of these private hospitals. The opaqueness of various permutations of hospital joint ventures deserves mention, because there are no substantial guidelines or regulations for public–private partnerships. For example, the original decree in Viet Nam specified that private hospitals be not-for-profit, but this requirement was not enforced as early as pre-2010\(^\text{11}\) (p. 2). Furthermore, the Nossal Institute report\(^\text{11}\) mentions that numerous regulations on hospital physical facilities, human resources, and prices do not appear to be enforced with regard to private hospitals. Nguyen and Wilson state that the “governance characteristics of the private sector (in Viet Nam) result from its small business dominance and immaturity of the regulatory and professional environment”\(^\text{6}\) (p. 305). They also describe that though the minimum investment for foreign investors in hospitals in Viet Nam is 2 million USD, domestic investors can own any size business based solely on their financial capability.

Clarity by government on what constitutes a for-profit basis for hospital operations is critical, because it establishes the legal identity of the hospital, thereby enabling the hospital to potentially take out loans. Furthermore, government through ministries of finance needs to provide greater clarity around what constitutes a for-profit basis model of operation, in order to provide a more sustainable basis of operations, especially around what tax regulations are applicable, what import tariffs are used, and what types of incentives are available (tax exemptions, land for free or at discounted prices, low-interest loans, and so on). The lack of sufficient capital has been identified as a bottleneck to expanding the role of private hospitals in Viet Nam, China, and Lao PDR. The relatively small size of these hospitals (compared to public hospitals) is due in part to capital financing bottlenecks. Part of the reason for the lack of capital is prevailing opaqueness around identifying and enforcing appropriate private hospital business regulations. The ensuing regulations that are associated with the legal identity of the hospital must be enforced by relevant governmental authorities.

**Professional Regulation**

Quality is another UHC attribute that hospitals in China, Viet Nam, and Laos PDR can improve upon. With private hospitals, mechanisms such as setting up accreditation systems and regulatory bodies for health worker practices are of critical importance. As Nguyen and Wilson\(^\text{6}\) describe, self-regulation in Viet Nam is a poorly understood concept. There are few controls around professional standards about practicing beyond the scope of allowed expertise; resulting in misleading advertising, overcharging, lack of price lists for services, and overordering of pathology and radiology services. Government has an obligation to improve and monitor the performance of professional self-regulating bodies, including but not limited to accrediting bodies, professional licensure agencies (especially those around license to practice hospital-based medicine), and hospital incident monitoring agencies. Government also has an obligation to link the performance of these self-regulation agencies to the general public. Unfortunately, in China, Viet Nam, and Lao PDR, professional associations that can provide a quasiregulatory role for hospitals and their providers are little more than professional forums, with little capacity to monitor the quality of private hospital provided care. Of particular concern in the region is the trend for hospitals to use fee-for-service-based purchasing (or selling of drugs at hospitals with high markups) as a method of increasing revenue where regulatory failure conditions exist. Governments are struggling to regulate not only private hospitals but also public hospitals, despite the fact that they have somewhat more authority over...
public hospitals and therefore would be assumed to be in a position to monitor them even more closely than private hospitals.

**National Health Insurance**

The role of national health insurance (NHI) as a form of revenue raising, pooling, and purchasing is increasing in Viet Nam, China, and Lao PDR. In China, national health insurance schemes have experience with purchasing services from private hospitals; however, in Lao PDR and Viet Nam this is generally not the case. Indeed, NHI–Bismarkian systems (funded by employer/employee contributions and one or multiple health insurance risk pools) have been characterized by greater decentralization, greater use of private providers, and more widespread use of fee-for-service payment to hospitals compared to national health service–Beveridgian systems (government general tax-funded and government-provided care). By engaging the private hospital sector with national health insurance, the government has expanded its relationship with the private sector from being solely a regulator to one of a contractual partner. This is a crucial step in not only increasing the technical efficiency of hospital operations but also controlling the costs of hospital-based care, especially through the use of case-based reimbursement methodologies, such as diagnostic-related group bundled payments, which may help increase the quality of medical care. By engaging with the private hospital sector with health insurance, there is an increased ability for government, through health purchasing agencies of national insurance programs, to improve efficiency and also improve quality beyond that provided in a more regulatory-based environment alone. Increasingly, national health insurance agencies are encouraged to include quality of care and efficiency indicators/results as part of their performance-related payments to hospitals. The transition to private hospitals being a full UHC partner is seen in Korea, where there is a legal mandate for private providers to participate in NHI, in turn contributing to the supply-side readiness for UHC. Furthermore, health insurance agencies can push very strongly, such as is done in Korea, for private hospitals to voluntarily obtain accreditation.

**CONCLUSIONS**

This commentary reviewed the growth of private hospitals in China, Viet Nam, and Lao PDR and briefly described how private hospitals in these countries contribute to the UHC attributes of quality, accountability, equity, and efficiency. The commentary then identified some key steps that governments can take to enhance the contribution of the private hospital sector to UHC (as a “full UHC partner”) in China, Viet Nam, and Lao PDR, through measures related to business model regulation, professional regulation, and national health insurance. Indeed, these key steps are guided by the WHO Western Pacific Regional Office’s Regional Action Framework on Improving Hospital Planning and Management in the Western Pacific.

Key discussion points around business model regulation begin with government providing greater clarity around what a for-profit model of operation is and what the ensuing regulations associated with the private for-profit model of operations are. Government must outline what institution is charged with ensuring that these regulations are met. Accountability is only in place when compliance with these regulations is monitored and acted upon. This regulatory model is crucial, irrespective of whether a country is more self-regulatory or government regulatory focused in terms of achieving UHC, for accounting for any government supply-side contributions and provides support to private hospital applications for new loans. When private hospitals grow in size (partly as a result of new capital), they experience economies of scale in operations, thereby making regulatory compliance easier.

Another key discussion point is around strengthening regulation as it relates to equity. For instance, the concentration of private hospitals in comparatively wealthy urban areas in all three countries needs to be counterbalanced by government incentives (through capital loan support or tax and land rent relief) and regulations (through hospital certificate-of-need procedures) to shape a rural private hospital health care market. Encouraging and regulating where to place hospitals only addresses one component of the inequity associated problems with private hospital care. Other business regulatory measures that promote equity can include mandating information on patient rights and obligations, in addition to mandatory reporting on violation of those rights.

In many countries, including China, Laos PDR, and Viet Nam, the growth of NHI has been constrained by the percentage of workers who are employed in the formal sector. The collection of employer-based contributions or other national health insurance contributions (either as part of general income taxation or as a separate tax) is difficult in an environment where there is a high prevalence of informal (or no) employment. As the ratio of formal sector employees grows as a percentage of total adults of working age, national health insurance becomes a more sustainable and significant portion of health care funding.
Because NHI can pay private hospitals by claim (or even by global budget), the opportunities expand for private hospitals to contribute to UHC, because a national insurance purchaser can begin to shape the behavior of private hospitals along quality, accountability, equity, and efficiency attributes. This is because there would be a contractual relationship between government and private hospitals (with a dedicated source of health care funding from government) that goes beyond solely a regulatory environment.

Problems remain, because even if policy makers expand the role of NHI reimbursements to private hospital care and assuming high coverage rates for NHI, there are many private hospital care equity issues. In fact, many NHI reimbursements still leave the patient with high out-of-pocket expenses, especially if balance billing is allowed. As Nguyen and Wilson point out, “Without the appropriate controls, it is to be expected that many private providers will increase profits by charging higher medical fees where possible and using more technical services than necessary” (p. 308). The role of health information systems and research to better understand how equity is being addressed with the increase in private hospital-based care in China, Viet Nam, and Lao PDR cannot be stressed enough and also applies to public hospitals.

Despite the potential limitations of private hospitals and, perhaps more important, the capacity of the government to regulate private hospitals in helping a country achieve UHC, there are success stories such as Japan and Korea, where private hospitals constitute the vast majority of hospitals, and these countries are widely recognized as having achieved UHC. Nonetheless, further regulation of the private hospital sector through business-related regulations and professional (staff) regulations is needed in China, Viet Nam, and Laos. Though some shaping of the private hospital sector toward improving their contribution to UHC can occur with the implementation of NHI (and still not widely evidenced performance-based payments/pricing), relying mainly on linking private hospitals to NHI is not enough to tap the full potential that private hospitals have in achieving UHC. Providing greater clarity around the various private hospital models of ownership/operation in China, Viet Nam, and Laos and government regulation around the obligations of each model is crucial. In these three countries, government also has a responsibility of providing more regulatory oversight over professional clinical-related practices. Though there is theoretical scope for a voluntary professional regulatory system in these countries, the current state of voluntary professional regulation (accreditation) processes

necessitates that government continue to strengthen its professional regulatory oversight of private hospitals.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors report no conflict of interest.

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