Health financing reforms to move towards UHC: international experience

World Health Organization

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Joseph Kutzin | Coordinator, Health Financing | Health Systems Governance and Financing

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Overview

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Core concepts and implications

- UHC and health financing

Lessons from health financing reforms

- Principles derived from theory and practice

Where does “public health” fit?

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DEFINITIONS, CORE CONCEPTS, AND IMPLICATIONS

Universal Health Coverage (UHC), defined

Enable all people to use the health services (including prevention, promotion, treatment, rehabilitation, and palliation) that they need, of sufficient quality to be effective;

Ensure that the use of these services does not expose the user to financial hardship

- World Health Report 2010, p.6

"Towards UHC" from aspiration to practical orientation for sustainability

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No country fully achieves all the coverage objectives

- And harder for poorer countries

UHC as a way to frame policy objectives: a direction, not a destination

- Reduce the gap between need and utilization (equity in use)
- Improve quality
- Improve financial protection

What UHC brings to public policy on health coverage

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Coverage as a "right" (of citizenship, residence) rather than as just an employee benefit

- Critically important implications for choices on revenue sources and the basis for entitlement

Unit of Analysis: system, not scheme

- Effects of a "scheme" on its members is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population – a concern with spillover effects
- Requires "governance for UHC", above scheme-level

A redistributive and therefore explicitly political agenda

Progress requires action across health system (not just insurance/financing)

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Health financing policy directly affects financial protection; policy on medicines does as well

Many parts of the system (service delivery, human resources, medicines, technologies, financing) combine to influence service utilization

Financing may only be complementary instrument for influencing quality (service delivery, human resources/medical education, medicines, technologies, information)

Not all problems derive from financing, so neither should all solutions

How to think about health financing

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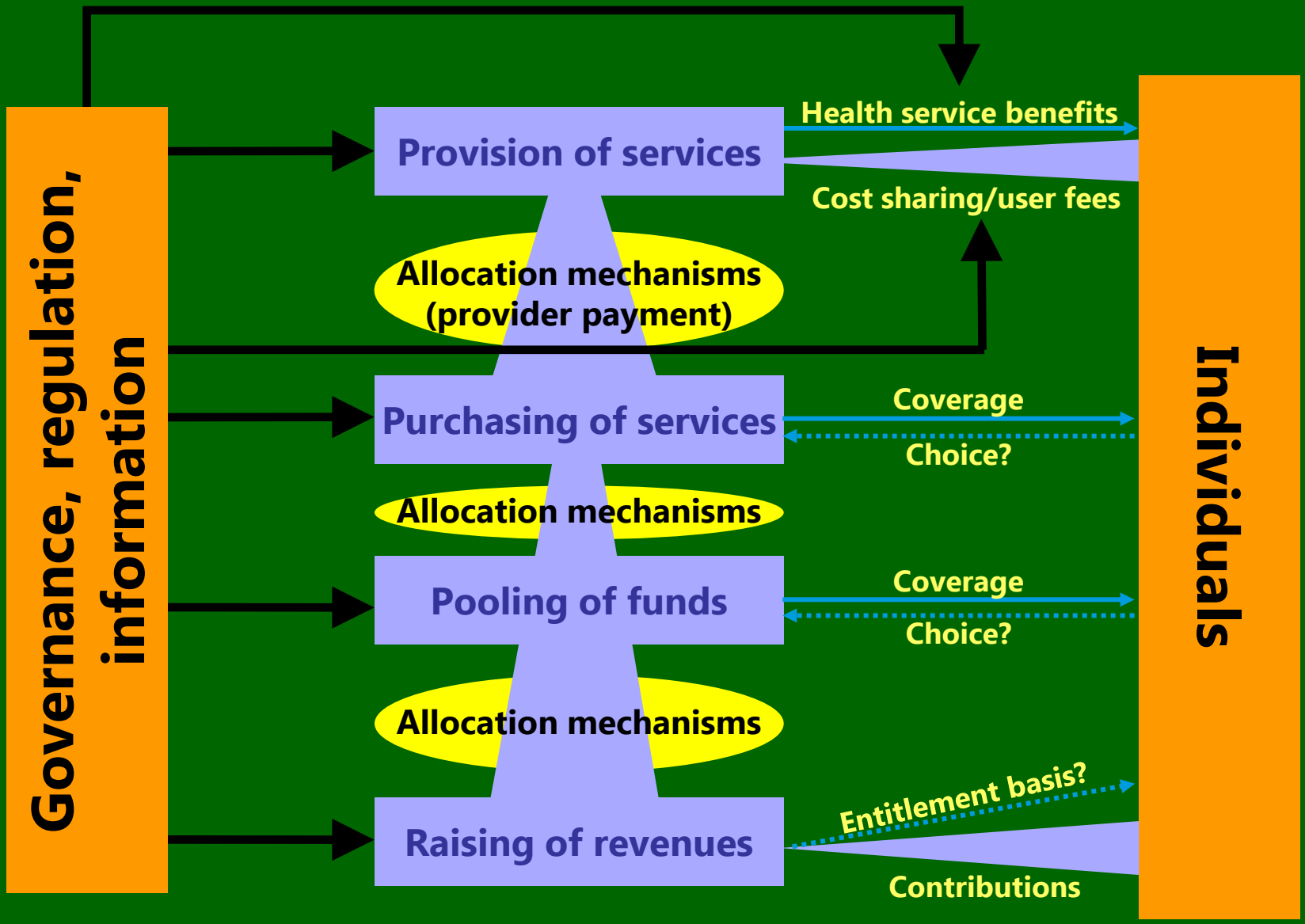
Classifications or models	Functions and policies
"National Health System" (Beveridge Model) "Social Health Insurance System" (Bismarck)	Revenue raising Pooling Purchasing Benefits and rationing
Doesn't help: sources are not systems (but may be politically valuable)	Part of all health financing systems, regardless of label

Just because they call their system "insurance" does not make Germans *more insured* than the British

- Understand systems (and reform options) in terms of functions, not labels or models

Unpacking the scope for policy action on health financing



De-mystifying the labels

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"Health insurance is any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households."

- Professor Indrani Gupta, presented at Conference on Social Health Insurance, Berlin, 5-7 December 2005

"Insurance" vs. "tax-funded system"?

- These labels may have political significance, but are not adequate to describe a system

In fact, many examples of "tax-funded insurance" (in India and elsewhere – both higher and lower income)

- Reflect de-linkage, to varying degrees, of entitlement from direct contribution

To varying degrees, "traditional SHI" is dying - many countries pool budget revenues in national HI programs

Asia:
Cambodia
China
India
Indonesia
Japan
Rep of Korea
Mongolia
Philippines
Thailand
Vietnam

Latin America:
Bolivia
Chile
Colombia
Costa Rica
Dominican Republic
Mexico
Peru
Uruguay

Ex-USSR:
Georgia
Kyrgyzstan
Moldova
Russian Federation
Preparations:
Kazakhstan
Ukraine

Central Europe:
Albania
Bulgaria
Croatia
Czech Rep
Estonia
Hungary
Lithuania
Montenegro
Poland
Romania
Serbia
Slovakia
Slovenia
Turkey
TFYR Macedonia

Eastern Med:
Egypt
Iran
Jordan
Sudan
Tunisia

Africa:
Algeria
Gabon
Ghana
Mali
Rwanda
Kenya

preparations: e.g.
Benin
Burkina Faso
Senegal
Tanzania

Western Europe
Austria
Belgium
France
Turkey
Germany
Greece
Netherlands
Switzerland

Source of slide: Inke Mathauer

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SOME KEY LESSONS FROM HEALTH FINANCING REFORMS

The path to UHC should be home-grown, but…

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Even though broad UHC goals are shared by all…

- Specific manifestations of problems vary, so how the goals should be operationalized will vary as well
- Every country already has a health financing system, so starting point for each country is unique
- Mix of fiscal and other contextual factors also unique

But this should not be interpreted to mean that "anything goes" – combination of theory and practice enables us to be more assertive

- Some "do's" and "don'ts" in health financing policy
- Avoid repeating mistakes made by others

Some policy principles to guide health financing reform(ers)

Move towards predominant reliance on public funding

Reduce fragmentation to enhance re-distributional capacity (more prepayment, fewer prepayment schemes) and reduce administrative duplication

Move towards strategic purchasing to align funding and incentives with promised services, promote efficiency and accountability, and manage expenditure growth to sustain progress

Align policy on benefits and rationing (usually patient cost-sharing) with rest of system and policy objectives

Information asymmetry at core of 1st and 3rd

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Death spiral of voluntary health insurance due to adverse selection

Inefficient and sometimes dangerous overuse of services due to supplier-induced demand

Evidence suggests that these are not small market failures; they are pervasive and deep

1. Funding base for UHC

"No nation achieves universal coverage without subsidization and compulsion."

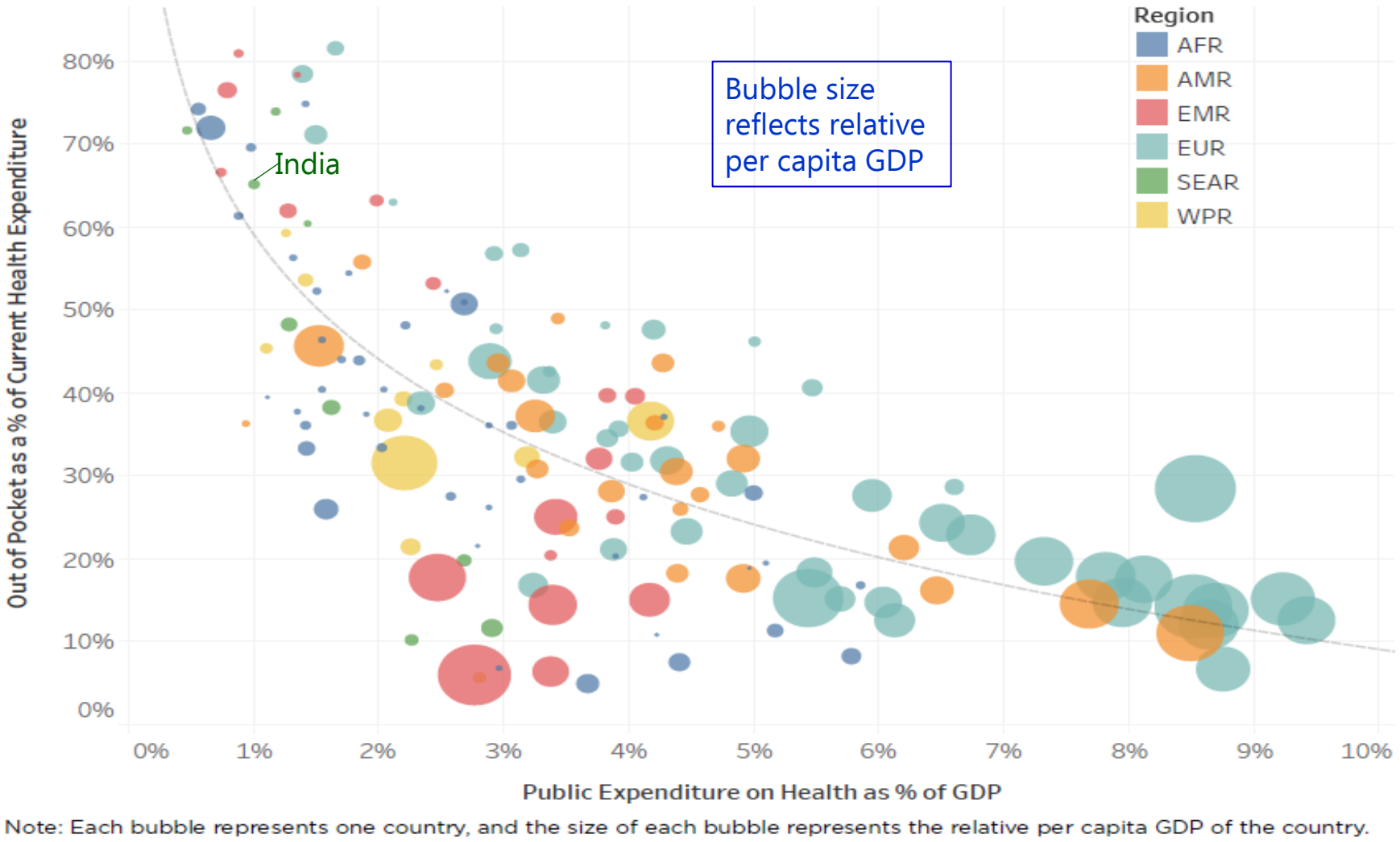
- Victor Fuchs (1996). "What every philosopher should know about health economics." *Proceedings of the American Philosophical Society* 140, p.188.

- "Compulsion" doesn't mean making everyone contribute; it refers to the revenue source being some form of taxation)
- Also refers to mandatory/automatic basis for entitlement

Public funding sources (mandatory social insurance contributions, general tax revenues) are essential

- For most LMICs, it will be general tax revenues that are at the core of this agenda (high informality)

Public spending matters (fiscal, priorities, AND policies)



Note: Each bubble represents one country, and the size of each bubble represents the relative per capita GDP of the country.

WHO (2018). New Perspectives on Global Health Spending for Universal Health Coverage. Estimates for 2015.

Voluntary health insurance (VHI) won't get you there

"…health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals."

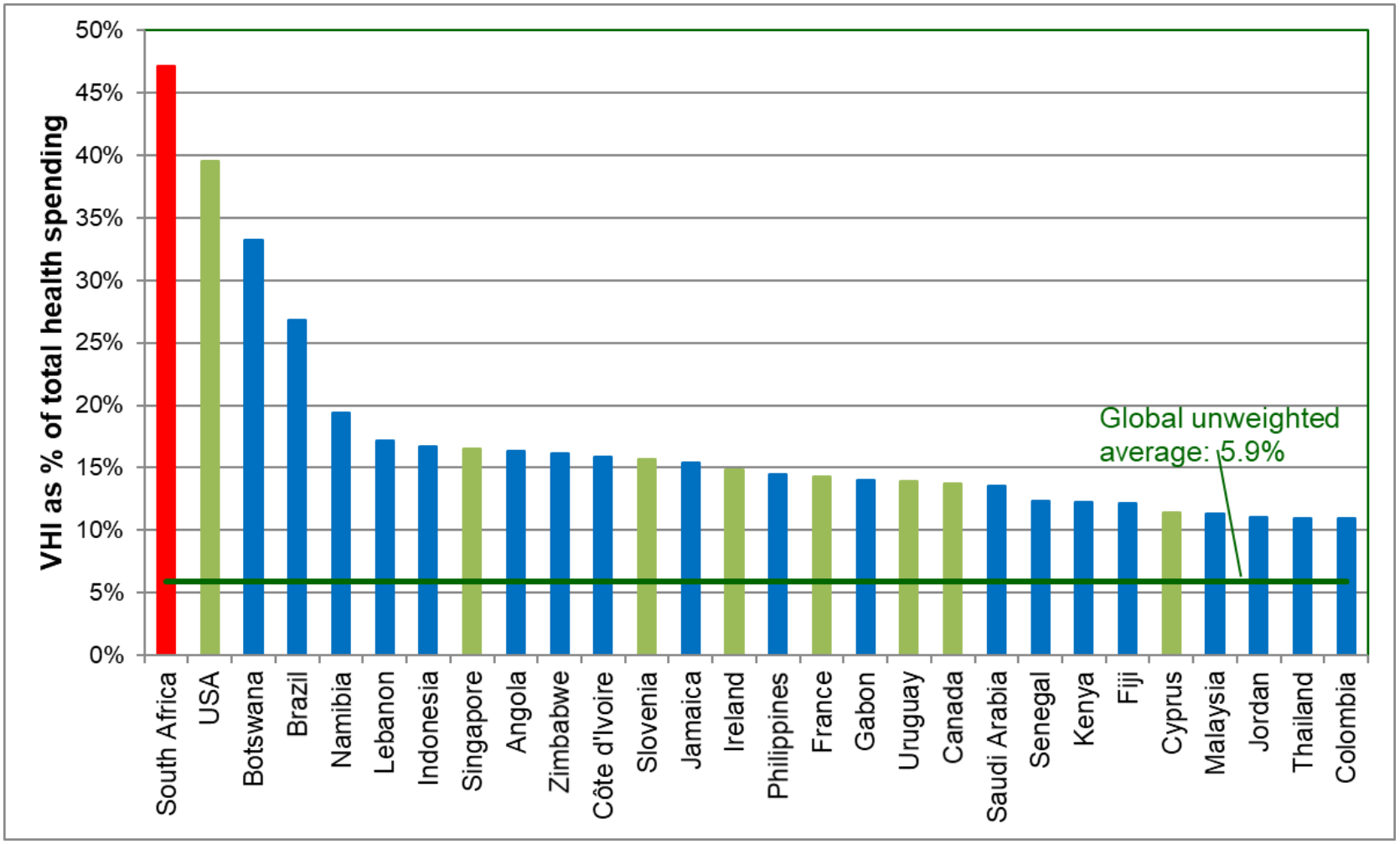
- Mossialos and Thomson 2001

"Ownership" (e.g. commercial, not-for-profit) of VHI schemes is not the cause; it is the nature of VHI markets

Issue is a core "market failure" in health: information asymmetry leads to adverse selection

- Leads to a "death spiral" as unfettered market forces uninsure the population that needs it most
- Conflict between the objectives of the system and that of the scheme

It is why few countries rely on VHI, including most high-income countries



Source: WHO Global Health Expenditure Database, estimates for 2015

VHI is not necessarily a problem; but beware potential of negative spillovers

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Population coverage with VHI compared to percent of health spending via VHI

Country	Voluntary health insurance		
	Population coverage	Share of health spending	Role
France	90%	14%	Complementary
Slovenia	84%	16%	Complementary
UK	9%	4%	Supplementary
Kenya	1-2%	12%	Duplicative
South Africa	16-17%	47%	Duplicative

Source of European VHI population coverage data: Sagan and Thomson 2016; data for latest available year

2. Pooling reforms: principles and threats

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How pool structure contributes to UHC

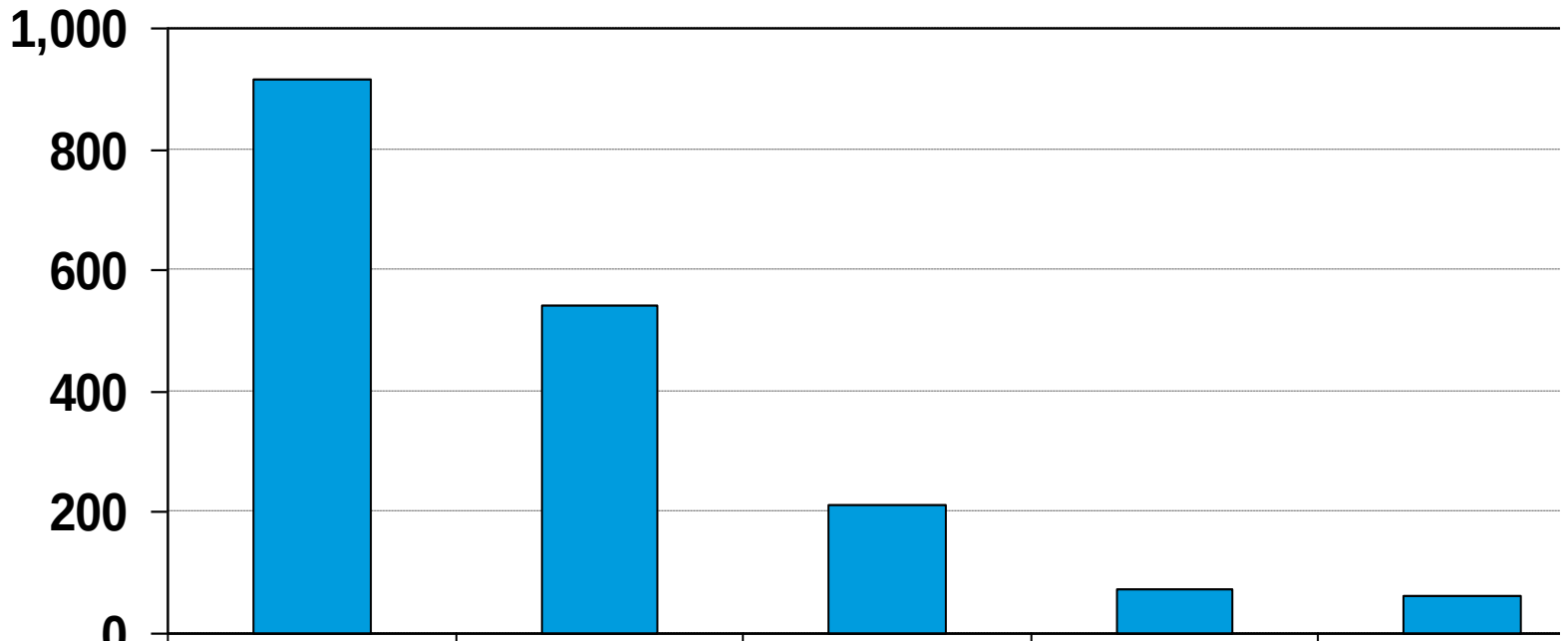
- Maximize redistributive capacity – hence political limits
- Key attributes for pools: large and diverse, with compulsory/automatic participation

Fragmentation is a threat and takes many forms

- Different insurance schemes
- Insured and uninsured (traditional SHI in LMICs)
- Sub-national units
- "health programs"

Different schemes for different groups drove inequitable funding in Thailand: served "the workers" at the expense of "the people"

Public insurance expenditure per capita, 1992



	Civil Servants	Social Security	Low Income	Elderly	Vol health card
Baht per capita	916	541	214	72	63

Source: Khoman (1997)

Countries have addressed pool fragmentation

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Re-configure and consolidate into larger pool(s)

- Thailand, Korea, Turkey, Scandinavian countries 1990s

Pool budget funds and wage-linked contributions

- Kyrgyzstan, Moldova, Ghana, Japan, Netherlands…

Compensation (↑ funding in non-formal sector scheme)

- Peru, Thailand, Mexico

Enable redistribution across pools

- Equalization grants/adjusted capitation (China, Germany)

"As-if pooling" by sequencing pre-conditions

- "Pool the data" first: harmonize information systems to enable inequities to be documented, and provide foundation for a future unified system (Korea, Kyrgyzstan)

3. Strategic purchasing of health services

Defined: linking allocations to providers to information on either/both their performance and the health needs of the population that they serve…

…while also managing expenditure growth and avoiding open-ended commitments (to deal with conflict of interest enabled by supplier-induced demand)

Because no country can just spend its way to UHC

In practical terms, what moving from passive to strategic purchasing looks like

Passive → Strategic

- resource allocation using norms
- little/no selectivity of providers
- little/no quality monitoring
- price and quality taker

- selective contracting
- performance-based payments
- quality improvement and rewards
- **price and quality maker**

Strategic purchasing can take many forms

Key attribute is how providers are held accountable for performance and the use of funds

Moves away from 2 bad extremes

- Rigid input-based line-item budgets
- Unmanaged fee-for-service

Aligns payment with benefits to realize the promise and minimize risk of unfunded mandates

Data (and data analytic capacity) is at the core of this agenda

- There is no strategic purchasing without data

Supplier-induced demand and payment systems (evidence confirms theory)

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Fahs 1992 study in US (Pennsylvania):

- physician practice with two groups of insured patients
- Cost-sharing introduced for one, and their use fell
- In response, intensity of use by the other group of patients increased

China vs Thailand

- Both greatly increased public spending and affiliation to health insurance programs during 2000s
- In Thailand, service use and financial protection improved due to coherent provider payment policies that managed spending growth (operating within a budget).
- NOT the case in China

Chinese Public Hospitals: "perfect alignment" of wrong incentives

Source of slide: Prof. Winnie Yip

All staff of the hospital are investors in the CT scanner with objective to maximize its use

Takeaways from this experience

If "insurance" is only about injecting money to meet a perceived "gap", you will fail and maybe worse off

Pervasive information asymmetry requires public intervention to protect patients and protect finances

Avoid open-ended commitments/mechanisms (it's not only about price; quantity matters too)

Understand the purpose of payment systems

- NOT to "pay the cost" for providers
- Give explicit incentives to providers to improve efficiency (altering their cost structures) and quality
- Be wary of large costing exercises pretending to give "the truth"; this is economics, not accounting

How purchasing can drive system change

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Influencing providers

- No gains from strategic purchasing if public providers can't respond (autonomy)
- "Regulating" private provision through conditions of the contract (e.g. data, review price setting…)

Towards unified/interoperable data platform on patient activity, even if multiple schemes (Kyrgyzstan and US State of Maryland vs Ghana)

- Ongoing analysis of data to inform decision-making – needs to be at the core of any reform

Variation in practice patterns can be identified with a provider payment database

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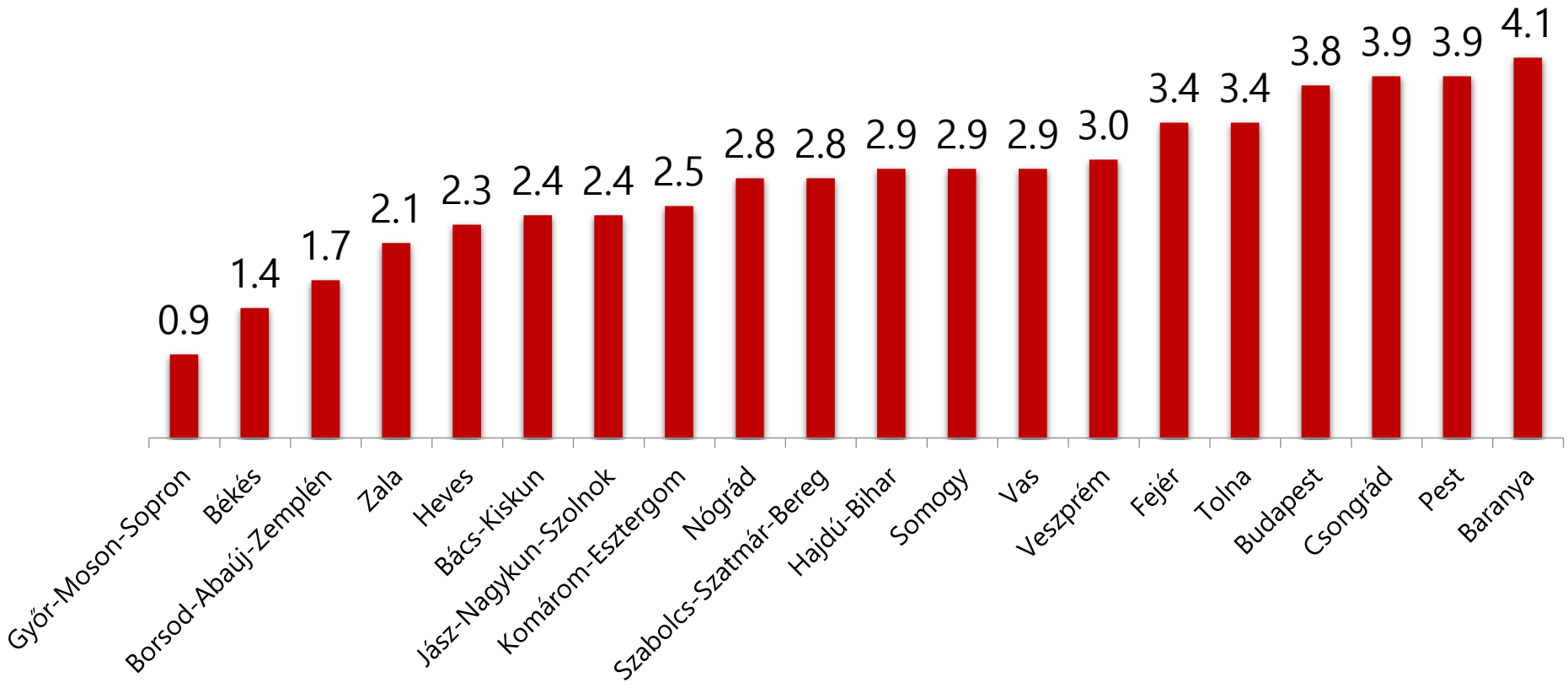
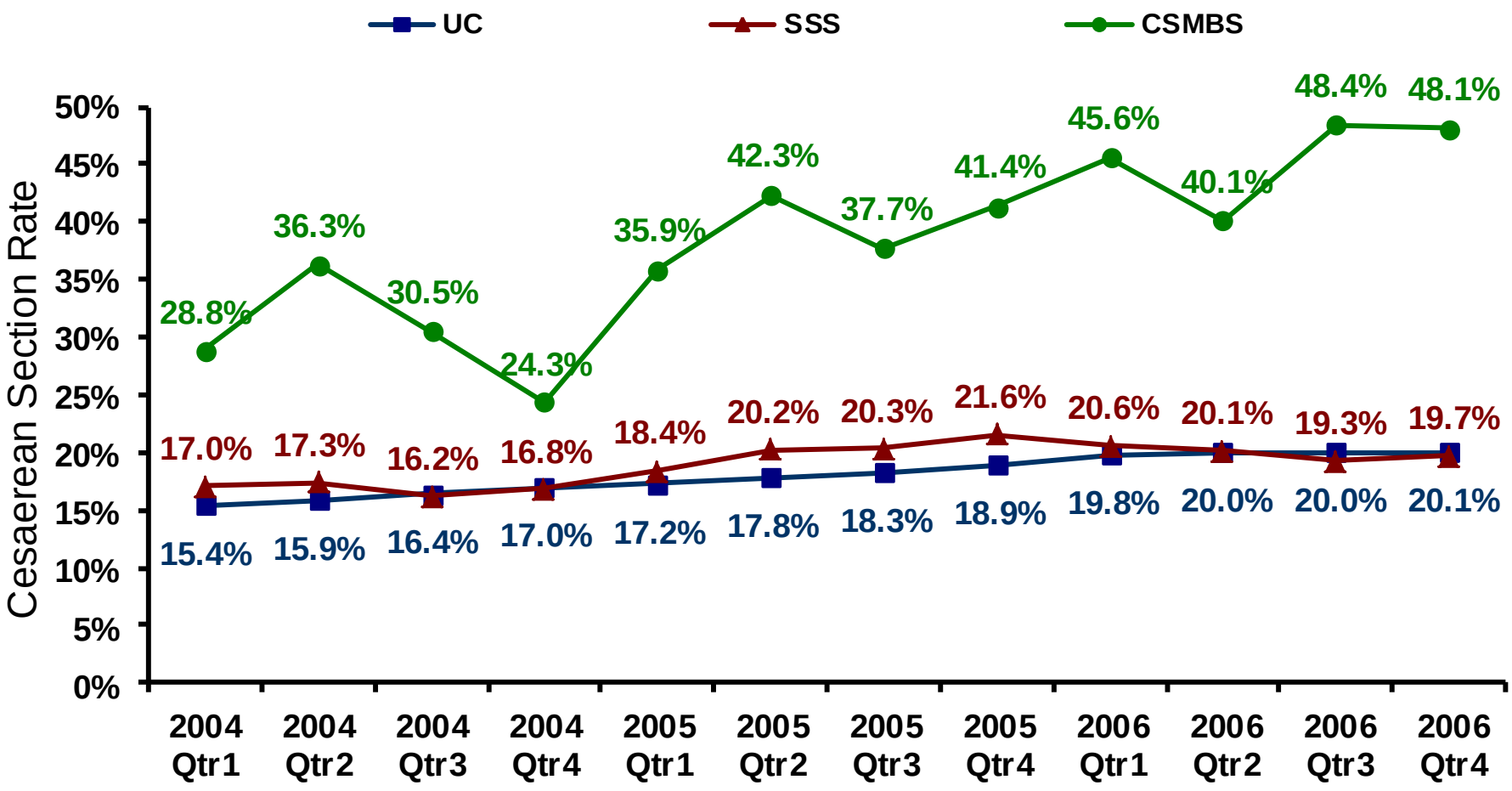
Tonsillectomy rate in different counties of Hungary (age group of 0-14)



Source: MoH/ESKI, Hungary

Thailand used the data to identify perverse incentives



Source: Electronic claim database of inpatients from Thai National Health Security Office, 2004-2006 (N=13,232,393 hospital admissions)

4. Principles related to benefits and cost-sharing

First, see these as flip sides of the same coin (what the purchaser doesn't pay for, in full or in part)

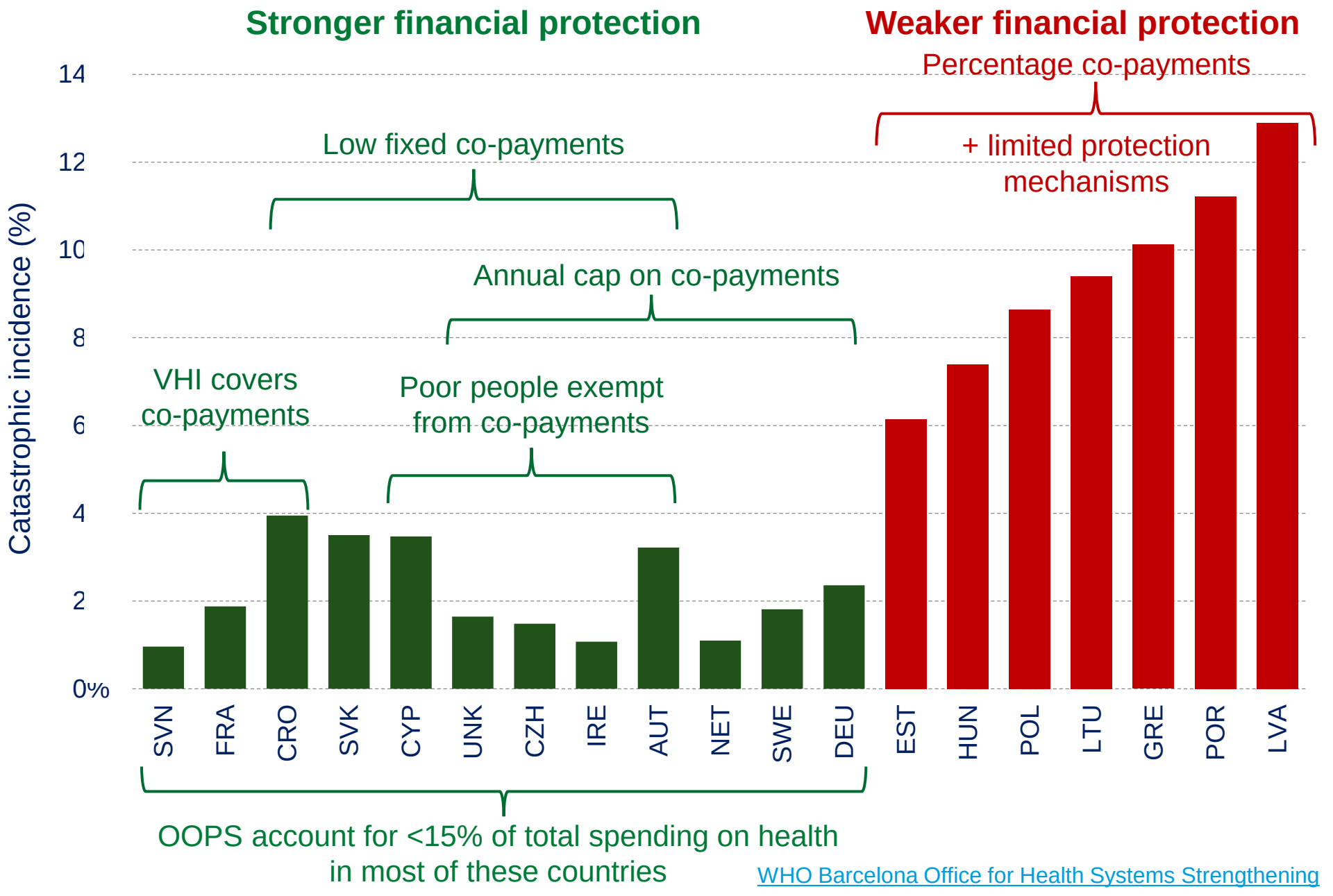
Clarify the entitlements and obligations of the population, and communicate these in layman's terms, especially for first contact (e.g. by level of care)

Align promised benefits with provider payment

Establish mandatory analysis of cost-effectiveness and budget impact of proposed additions to benefits

If co-payments/user fees, design for understanding and to protect against financial risk

New evidence on co-payment design



Simple & people-centred co-payment design works best

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1
Replace percentage co-payments with low fixed co-payments

2
Exempt poor people and regular service users

3
Cap all co-payments per person (not just for medicines)

Feasible everywhere

Requires more administrative capacity

Source: WHO Barcelona Office for Health Systems Strengthening (2018)

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WHERE IS PUBLIC HEALTH?

Principle vs practice

In principle, “public health services” part of the “services” within the concept of UHC

In practice, inadequate attention (focus more on personal services)

- Politcial reality of “public goods”

Financing of public health services

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Important but not interesting?

- Public goods? Just budget it

In practice, it's getting more interesting

- Can fund more efficiently or less
- Clarify services and functions
- Budget structure
- Implementation under fiscal decentralization

Beyond services: rethinking the scope for collective financing

Not many health services are public goods

- Vector control
- Mass health education (e.g. billboards)

But if we think about health system functions…

- Disease surveillance
- Information systems
- Cold chain

Polio, for example

The resources accompanying the Global Polio Eradication Program are building/strengthening disease surveillance programs (more than polio)

Reframe as surveillance (a public health function)

- Does budget structure enable this, or do we have surveillance within programs such as HIV, TB, polio, etc.?
- Financing this function as a public good, and doing so efficiently, may require restructuring of budgetary programs in health

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CLOSING REFLECTIONS

Summary messages

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No blueprint, but core principles to guide reforms

More public; defragmented; strategically purchased; align benefits

UHC unit of analysis – systemwide design; spillovers

Don't be constrained by traditional notions of insurance

Data systems for purchasing key foundation for future development

Don't neglect public health functions and reforms to finance them

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EXTRAS

China and Thailand illustrate importance of purchasing and accountability

From 2000-2010, both countries greatly increased public budget spending on health to move to near universal affiliation of their population to insurance programs

- Thailand's reform was entirely budget-funded
- China increased subsidies, with government paying about 80% and individuals 20%

This was successful and reflected each country's political commitment

The results achieved were quite different, however

Architecture & engineering of each system

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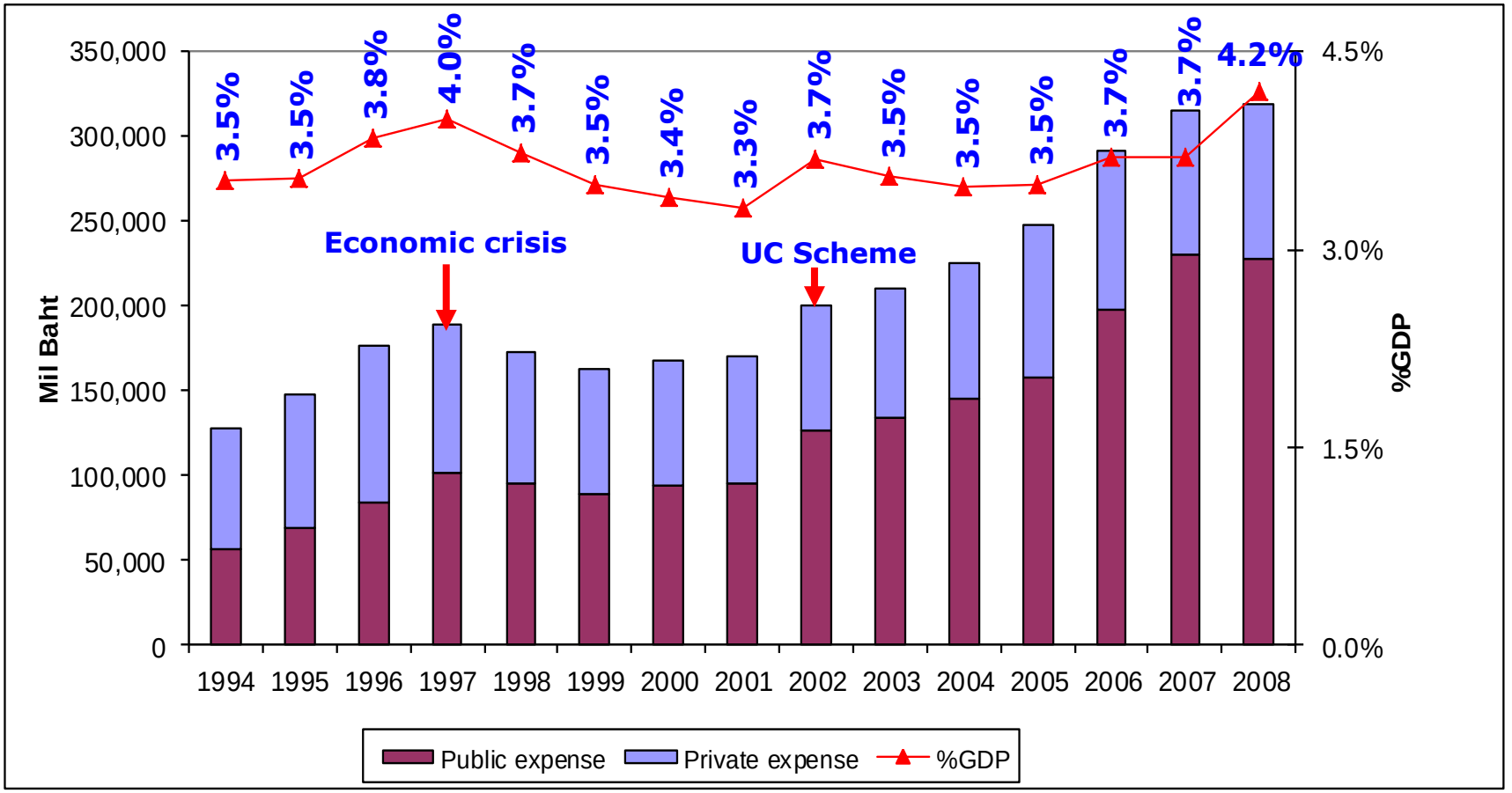
Architecture shared similarities

- In each country, transferred budget revenues to insurance funds
- Purchaser-provider split, and provider managerial autonomy

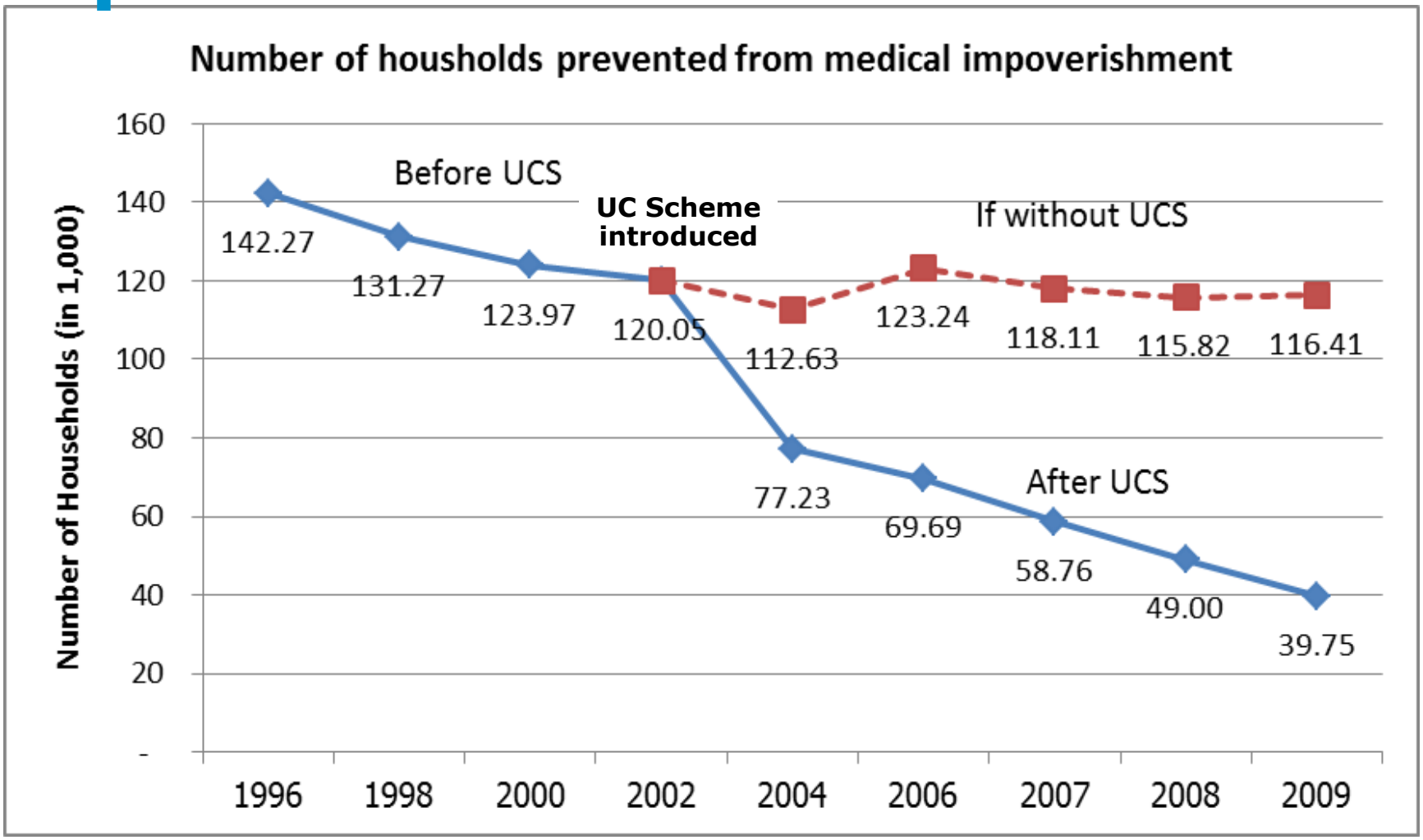
Engineering was very different

- Provider payment and benefit package design
- Provider accountability very different as well (Thailand: improve results within budget; China: make money)

Thailand's success in expanding coverage, increasing public spending, and managing overall costs



Evidence on financial protection from health impoverishment



Total 291,790 households prevented from health impoverishment in 2004-09 as a result of UC Scheme

Pro-poor results from an untargeted approach

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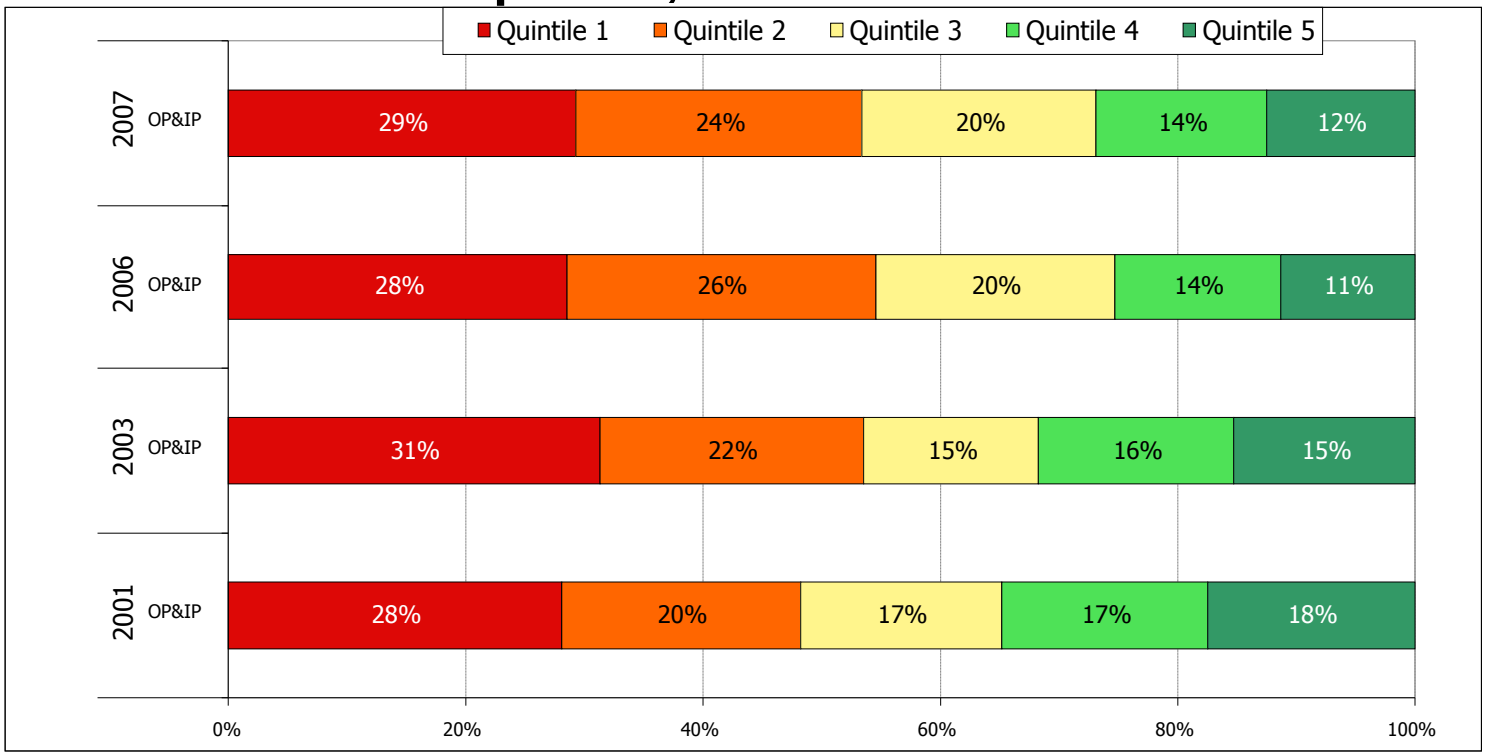
Capture of public subsidies for health by income quintile, 2001 to 2007



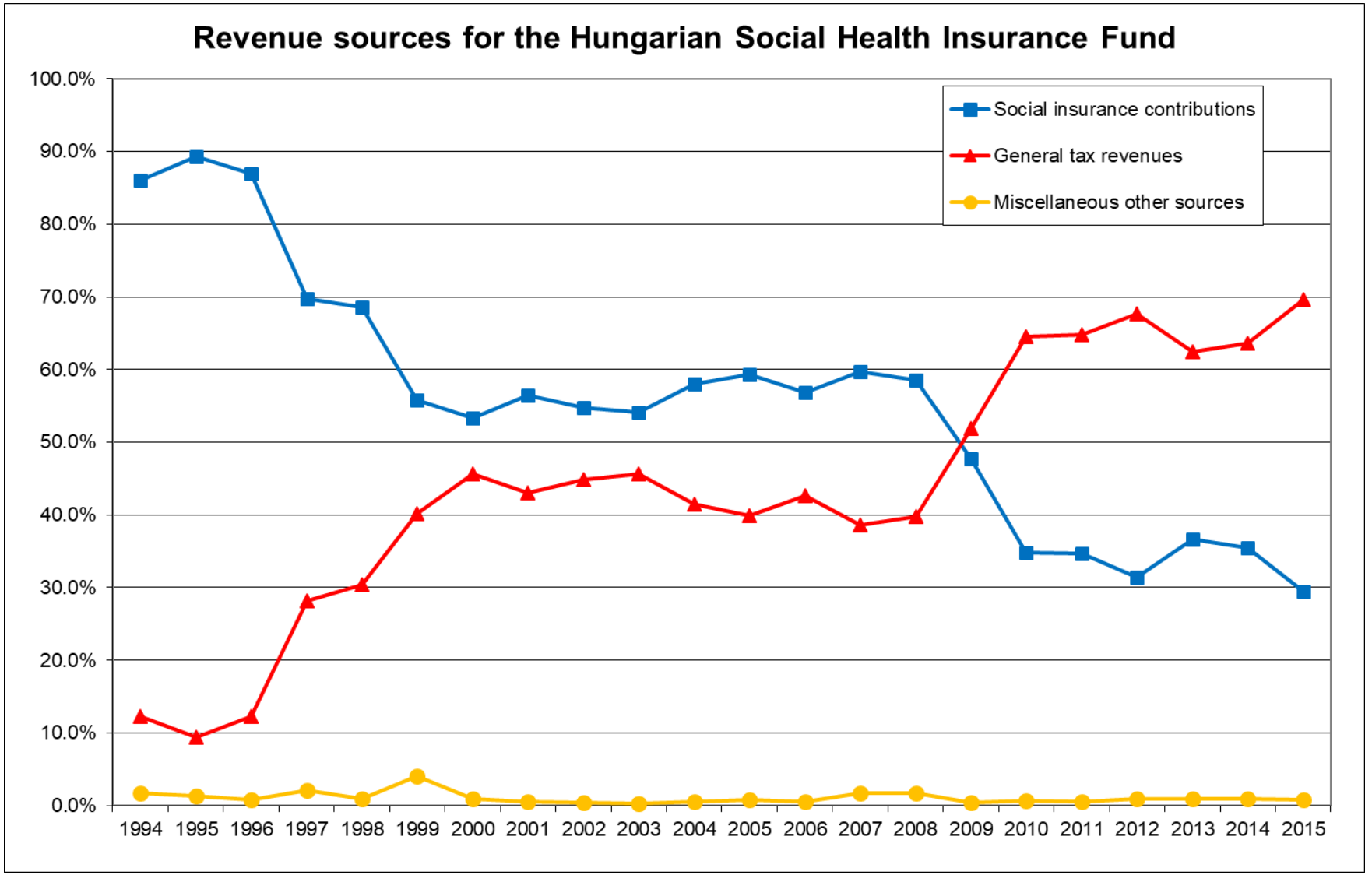
Prior to UC reform, 35% of spending captured by richest 40%. By 2007, this fell to 26%, while poorest 40% of the population received 53% of the subsidies.

China: better for doctors than for patients

China's insurance funds pays providers (all levels) by fee-for-service with no cap on overall reimbursements, and fee schedule overpays diagnostic tests (especially for high-tech) and drugs, and under-pays labor time (e.g. for primary care consultation)

- Hospital admissions increased by 2.5 times
- Caesarean section rates jumped to 36%
- No progress overall in financial protection
- Health expenditure per capita grew at 4-5% faster than GDP growth – out of control??

For example in Hungary



Source: Szigeti et al. (forthcoming). "Tax-funded social health insurance: an analysis of the revenue sources of the Hungarian system."

USA a well-documented example of this problem

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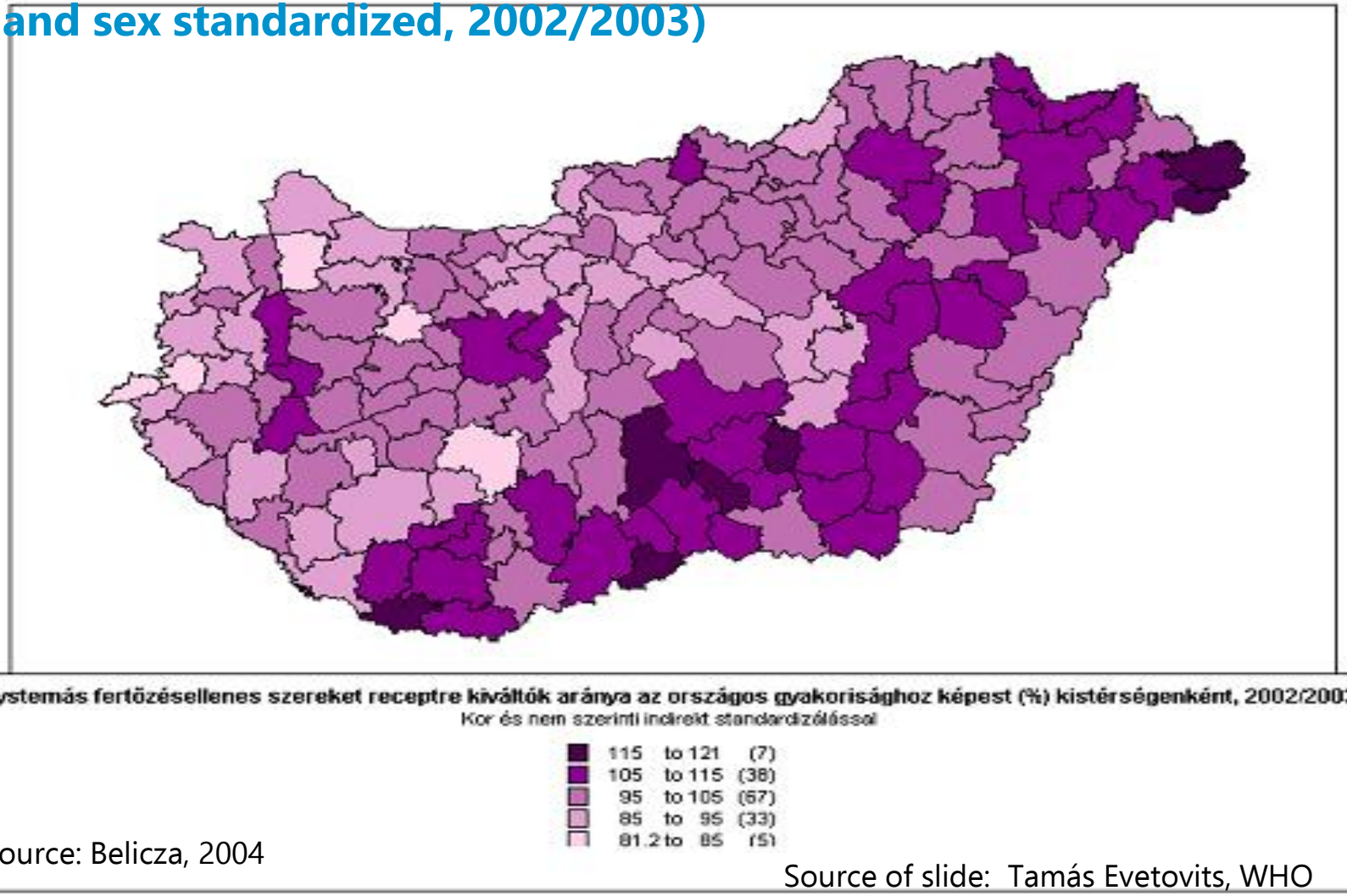
Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	Total 26 million	Health problem**	No health problem	poor <200% FPL	non-poor 200%+ FPL
Found it very difficult or impossible to find coverage they needed	43% 11 million	53%	31%	49%	35%
Found it very difficult or impossible to find affordable coverage	60% 16 million	70	46	64	54
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	35% 9 million	46	20	38	34
Any of the above	71% 19 million	83	56	77	64

Note: FPL refers to Federal Poverty Level.
*Bought in the past three years.
**Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

are buying?

Variation in use of antibiotics in Hungary

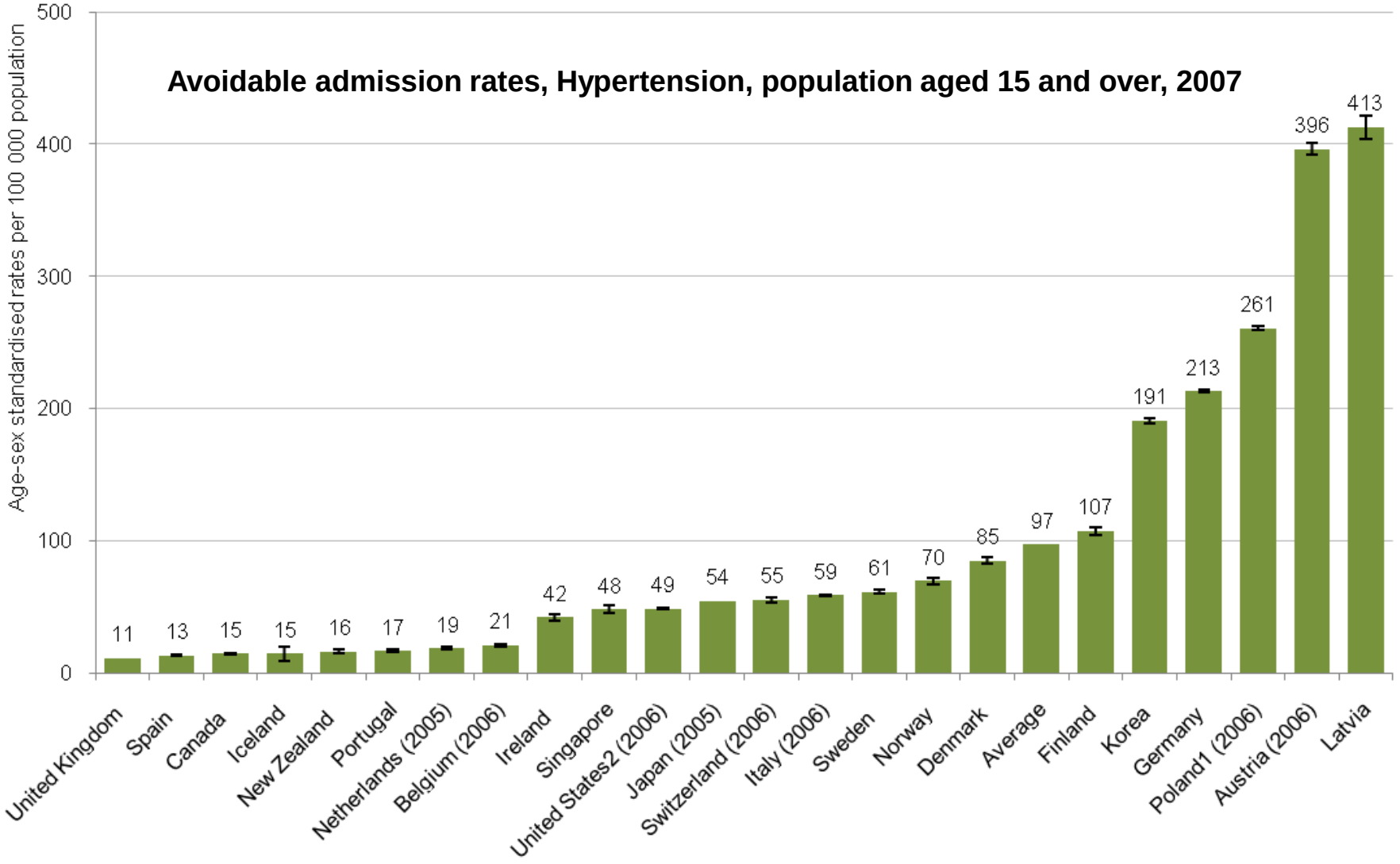
(age and sex standardized, 2002/2003)



Source: Belicza, 2004

Source of slide: Tamás Evetovits, WHO

Primary care sensitive conditions



1. Includes transfers from other hospital units, which marginally elevates rates. 2. Does not fully exclude day cases.

Source: OECD Health Care Quality Indicators Data 2009.

Additional (practical) revenue principles

Predictability – as an enabler for planning over the medium term

- e.g. alignment and practical links between multi-year budget plans and annual allocations

Stability in flows – as an enabler for efficiency, especially for service purchasing

- Regular flow of funds essential for reliable contracting, fee setting, and payment