

**NIPFP Delhi**  
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# **Money and Medicine... the odd couple**

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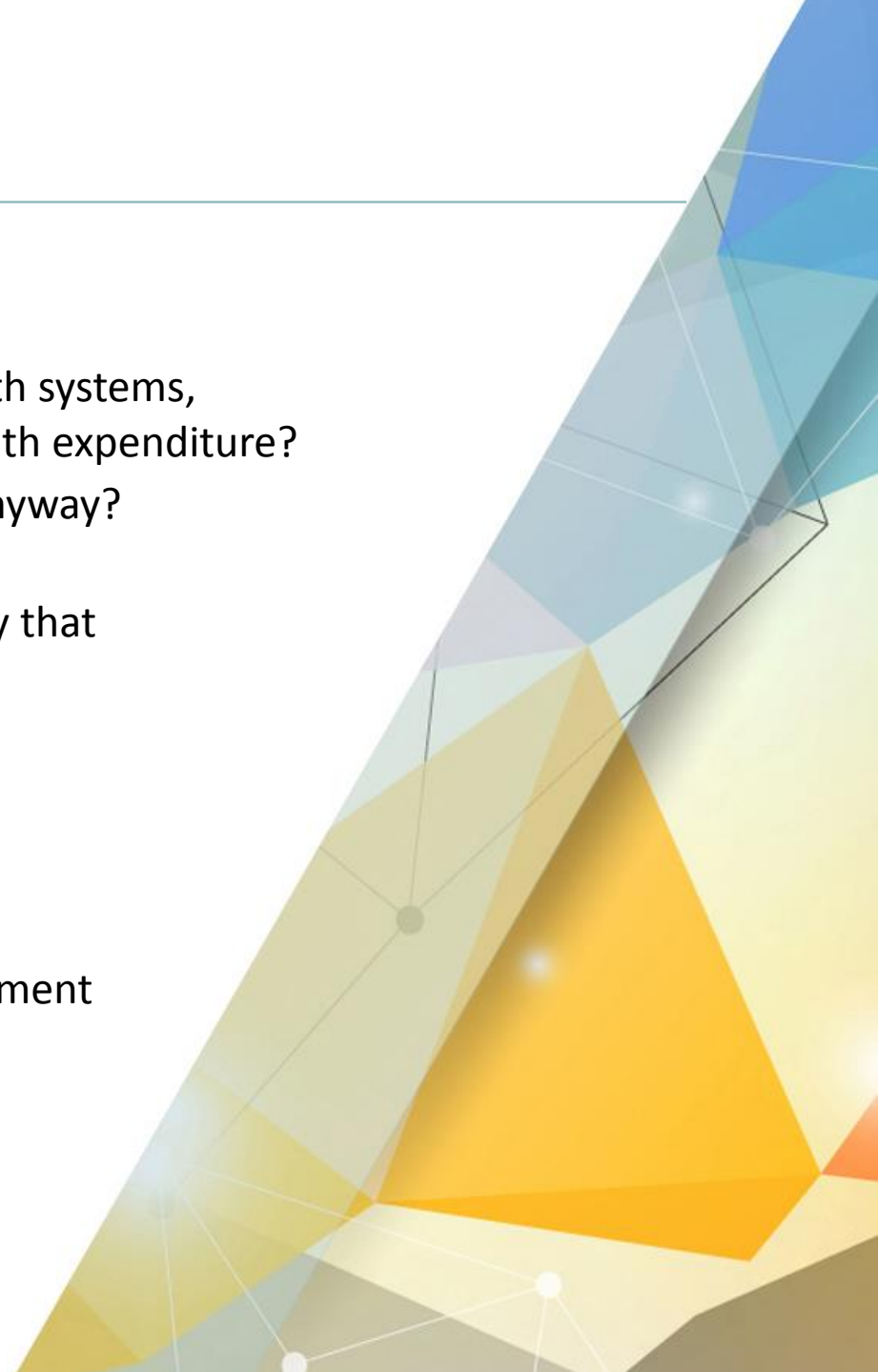
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# Overview

- Who should pay for health?
- Why is the health market unique?
- Why are countries with very different health systems, facing the same challenges controlling health expenditure?
- What is universal health coverage (UHC) anyway?  
What is health for that matter?
- Why is the USA the only developed country that has been unable to achieve UHC?
- Health system drivers
  - information asymmetry
  - moral hazard
  - social determinants of health
- The codification of health services and payment models for doctors
- Brief comparison of a few successful but very different health care systems
- And finally we'll finish with core legal infrastructure requirements.



# More than 100 years of history

**The Germans under Chancellor Bismark created the worlds first health insurance in 1883**

**France and UK followed the Bismarkian welfare state**

**The U.S and Australia were experimenting with models of health insurance from early 1900's**

**Most activity occurred after WWII – UK's NHS, Australian constitutional reform, NZ socialised its healthcare system, Netherlands in 1941 ...**

**More recently Indonesia, Thailand and African countries are moving towards UHC**

# A few key terms and definitions

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## What is health?

**Constitution of the World Health Organization:** Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

## What is universal health coverage or UHC?

**World Health Organization:** Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.

## What is health insurance?

The term 'INSURANCE' is misleading



# The World Health Report 2010

## Health systems financing: the path to universal coverage

*“Promoting and protecting health is essential to human welfare and sustained economic and social development.”*

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*“Timely access to health services is a mix of promotion, prevention, treatment and rehabilitation.... This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system.”*

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*“In striving for this goal, governments face three fundamental questions:*

- 1. How is such a health system to be financed? (how much is required?)*
- 2. How can they protect people from the financial consequences of ill health and paying for health services?*
- 3. How can they encourage the optimum use of available resources?”*

# Who should pay for health?

People should be able to choose their own health insurance rather than have government choose it for them

But some people can't afford insurance and aren't able to choose anyway

People who can pay should pay and the government should help the others

If you smoke or drink or are obese you should pay more. It's not fair that I take care of myself and have to pay for those who don't

The government should provide free health for everyone for everything

Are you mad? The taxes required to fund that would send the country broke!

But we already pay for everyone's health because unhealthy and sick people cost the entire nation more in every way

The private health sector can't control costs so the government has to step in and take over

Paying for health is an individual responsibility. I don't want to pay for someone else's health. That's their problem.

Mandatory insurance is a form of socialism!

No it's not. Everyone has to have car insurance and that does not make us socialists!

What are you talking about! The government can't control health costs either. A big expensive bureaucracy is no answer. Let the market sort it out.



# Who does pay for health?



*"The truth is that, no matter what insurance schemes are designed by Congress, we cannot avoid sharing the costs and benefits of health care. If we deny someone care today, we will be paying that cost later, in the form of more expensive treatment or lost years of productive employment...If we make health care less available, we will all live in a poorer nation. Certainly, plenty of health-care dollars are wasted, and there are sensible changes to the system that would improve the cost-effectiveness of care. But, as a rule, abundant access to decent, essential health care is an investment with some of the greatest returns."*

# Why is the health market unique?

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Macro economic principles have limitations in health because the market doesn't behave as it is meant to. The key reasons described throughout the literature are:

- **Asymmetric information**
- **The moral hazard**
- **The social determinants of health**





# Information asymmetry and the limitations of macro-economics

1. Demand relates to outcome - we do not purchase the characteristics of the item we buy. Instead we purchase the promise of an outcome
2. When we buy a car it doesn't matter that we don't have a deep understanding of how a car works – relationship between consumption and outcome does not arise
3. Unpredictability - need for health can go from zero to 100%, in a moment, without warning or fault
4. The actions of others can damage our health without our knowledge.



# The moral hazard

“Insurers call the change in behaviour that occurs when a person becomes insured “moral hazard.” Moral hazard occurs, for example, when an insured person spends an extra day in the hospital or purchases some procedure that he or she would not otherwise have purchased. Insurers originally viewed moral hazard unfavourably because it often meant that they paid out more in benefits than expected when setting premiums—hence the negative term.”

[John A. Nyman](http://content.healthaffairs.org/content/23/5/194.full.html) <http://content.healthaffairs.org/content/23/5/194.full.html>

## A photograph capturing a moment of intense consumer interest in a retail store. A dense crowd of people, primarily young adults, is gathered around large flat-screen televisions on display. Many individuals are leaning over the display cases, reaching out to touch the screens. The scene is crowded and chaotic, with people of various ethnicities and ages visible. The background shows the store's interior with shelves and other customers, suggesting a busy shopping environment. The image is framed by a white border with a subtle geometric pattern on the left side.





# The patient moral hazard



# The provider moral hazard

Doctors do not always know in advance that much of what they provide may end up as waste, and it's in our interests to keep it that way.



Hmmm, differential diagnosis.  
Could be this, could be that, could  
be the other thing. I'll start with this  
and if it doesn't work I'll do that,  
and if that fails I'll do that other thing.



# Is moral hazard inefficient?

A new theory, however, suggests that much of moral hazard is actually efficient. When the care that was deemed to be welfare-decreasing is reclassified as welfare-increasing, health insurance becomes much more valuable to consumers than health economists have hitherto thought it was. As a result, there is a new argument for national health insurance: efficiency.

A large portion of “moral hazard” health spending actually represents a welfare gain, not a loss, to society.

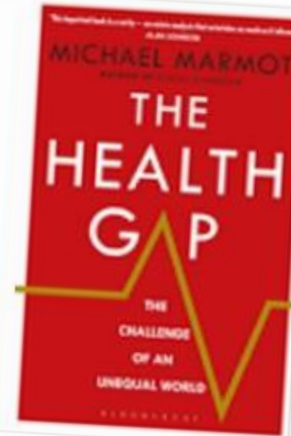
[John A. Nyman](http://content.healthaffairs.org/content/23/5/194.full.html) <http://content.healthaffairs.org/content/23/5/194.full.html>



# What about personal responsibility?

## The Health Gap: The Challenge of an Unequal World

Book by Michael Marmot



4.1/5 · [Goodreads](#)

There are dramatic differences in health between countries and within countries. But this is not a simple matter of rich and poor, for it depends on each society's particular social gradient. ... [Google Books](#)

**Originally published:** 2015

**Author:** [Michael Marmot](#)

# Health to wealth...

Here are ten top tips for health. This list was published in 1999 by England's Chief Medical Officer, but it differs little from the kind of advice you would receive from any public health source in a high-income country.

1. *Don't smoke. If you can, stop. If you can't, cut down.*
2. *Follow a balanced diet with plenty of fruit and vegetables.*
3. *Keep physically active.*
4. *Manage stress by, for example, talking things through and making time to relax.*
5. *If you drink alcohol, do so in moderation.*
6. *Cover up in the sun, and protect children from sunburn.*
7. *Practise safer sex.*
8. *Take up cancer-screening opportunities.*
9. *Be safe on the roads: follow the Highway Code.*
10. *Learn the First Aid ABC: airways, breathing, circulation.*



# ...or wealth to health?

With that in mind, here is an alternative ten top tips for health compiled by David Gordon and colleagues at University of Bristol.

1. *Don't be poor. If you can, stop. If you can't, try not to be poor for long.*
2. *Don't live in a deprived area. If you do, move.*
3. *Don't be disabled or have a disabled child.*
4. *Don't work in a stressful, low-paid manual job.*
5. *Don't live in damp, low-quality housing or be homeless.*
6. *Be able to afford to pay for social activities and annual holidays.*
7. *Don't be a lone parent.*
8. *Claim all benefits to which you are entitled.*
9. *Be able to afford to own a car.*
10. *Use education to improve your socio-economic position.*

# Why are countries with very different health systems, facing the same challenges controlling health expenditure?

The problem is patients who don't look after themselves. They need a price signal...that'll stop 'em!

No! The problem is greedy doctors all out there ripping off the system!



# We know a lot about what works and what doesn't work

**PATIENTS DON'T READ THE PACKET INSTRUCTIONS ON THEIR ILLNESSES AND DOCTORS ARE HUMAN!**

**One size does not fit all**

**Health is infinitely variable and highly nuanced**

**Mandatory or voluntary**

If not mandatory, insurers have no option other than to insure everyone as if they are sick.

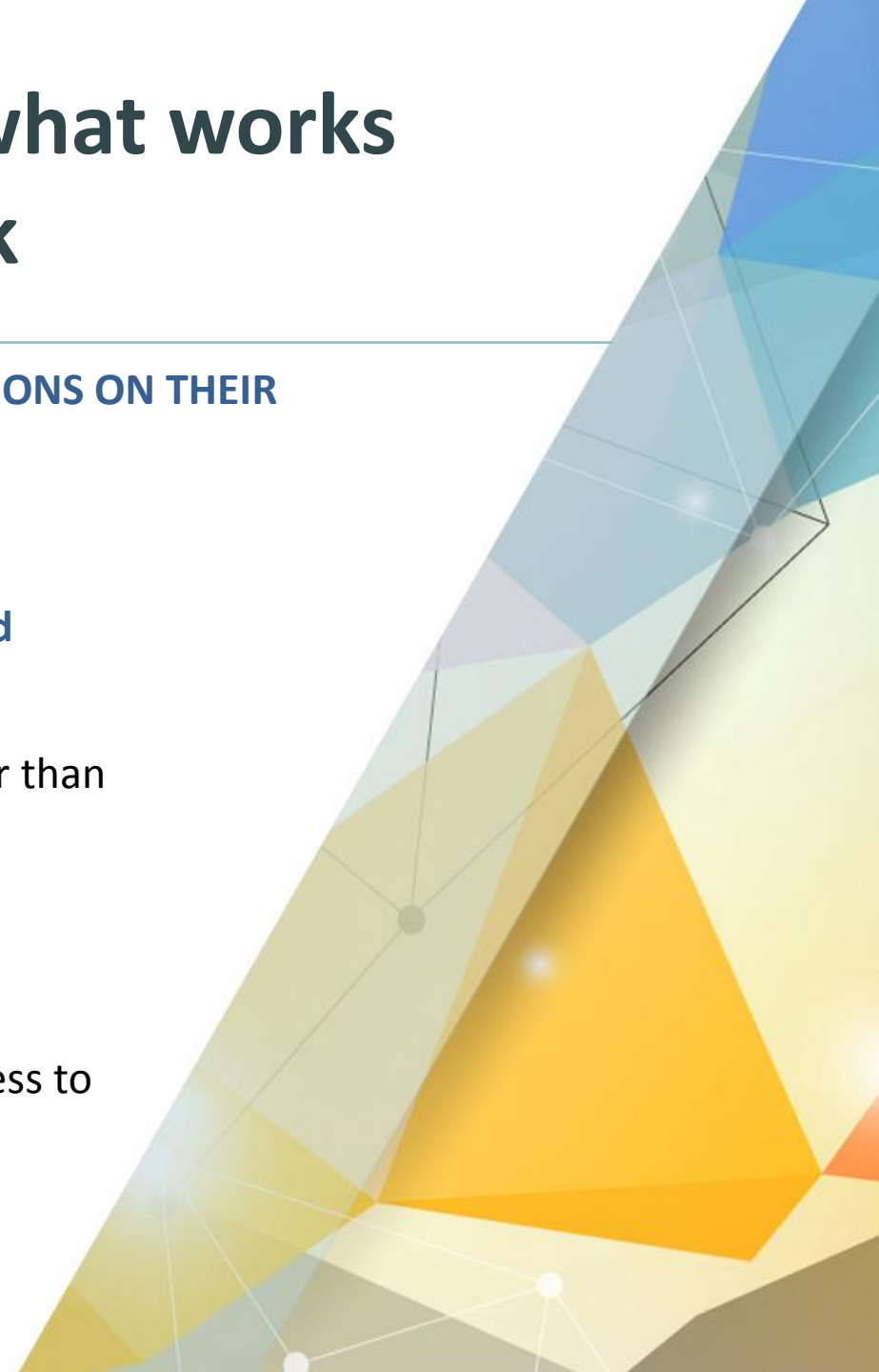
**Community rating and risk pooling**

**Pre-payment v direct contributions**

Even the smallest co-payment can prevent access to needed care

**Primary v tertiary care**

**Government regulation**



# What happened in the USA?

1915 earliest proposals for Government health financing

Harry Truman was the first president to seek UHC for rich and poor

1942 wage and price controls post war lead to employers attracting workers by offering health insurance

October 1943 IRS decided cost of health insurance was a deductible expense for employers and not taxable income for employees

*“The tax advantage sowed the seeds for the emergence of private health insurance and the failure to enact a public program enabled those seeds to blossom”*

*“In 1940 less than 10 million Americans had health insurance. By 1950 that number had exploded to 76.6 million. Suddenly over half the American population had private health Insurance and enrolment was growing rapidly”*

S Altman and D Schactman, *Power, Politics and Universal Health Care*.  
The inside story of a century long battle



# Obamacare

- **A near universal mandate**
- **An employer “mandate” (in the form of a monetary penalty)**
- **Insurance reform ending exclusions for pre-existing conditions, refusals to issue, caps on lifetime benefits, and rescissions of coverage**
- **An individual mandate (originally limited to children)**
- **Medicaid expansion for low-income individuals**
- **Tax credits for low-income individuals and small business to buy private coverage**
- **State-run insurance exchanges for individuals and small business (originally including a national plan and a public option)**
- **Financing so that the program will not add to the federal deficit**

S Altman and D Schactman, Power, Politics and Universal Health Care. The inside story of a century long battle

# How are doctors paid?

Guinness L & Wiseman V: Introduction to Health Economics 2011

Payment type	Advantages	Disadvantages
<b>Fee-for-service</b>	Provides direct incentive to increase effort (useful where under provision of services)	Incentive to increase service provision beyond what is necessary. Cost escalation
<b>Capitation</b>	No incentive to over supply. Strong incentive to improve efficiency of care delivery. Good control of costs	Incentive to undersupply. Increased pressures may cause providers to sacrifice quality. Cream skinning (enrol less sick people)
<b>Salary</b>	No incentive to over supply. No incentive to compete for patients. Good control of costs	No incentive to improve efficiency. Incentive to reduce services or quality of care.
<b>Performance based funding</b>	Increases the provision of targeted services and the quality of care (if targeted)	Gaming. Cheating by over reporting activity. Effort taken away from unrewarded services

# Medicare Benefits Schedule

# SNOMED CT

ACHI  
meand  
Australian Classification  
of Health Interventions  
by aliceremyns.com

The global  
language of  
healthcare

- **Codes are used differently in different countries**
- **Hospital coding and billing is not always the same as medical billing and it's a very important but poorly understood distinction**

# Developments in the UAE and KSA

UAE has adopted ICD-10 CM / CPT framework and insurance has recently become mandatory

Abu Dhabi was the first Emirate to adopt DRGs and Dubai is now doing the same

KSA has adopted ICD-10 AM / ACHI framework. ICD coding has become mandatory and DRGs are being developed

# Indonesia and Australia

## **Indonesia (approx. 5% GDP)**

largest single payer in the world. Commenced UHC on 1 January 2014. Mandatory coverage. Integrated prior systems that had operated mostly for the poor. Employer/employee contributions for formally employed or monthly contributions for informal workers. JKN separately administered by BPJS. Both public/private providers. Capitation and FFS for doctors and prospective case based payments for hospitals.

## **Australia (approx. 10% GDP)**

Tax payer funded UHC. Commenced 1 July 1975 as Medibank (later Medicare). Mandatory coverage with community rating. Medicare separately administered by DHS. States run public hospitals. Incentivised additional private health insurance. Blended FFS and salary for doctors and activity based funding for hospitals.

# How much private sector involvement is too much?





# Here's what happened with 10 variables!

StarHub 4G 4:56 pm 79%

thesaturdaypaper.com.au

SATURDAY PAPER

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## Centrelink's debt collection 'pushed him over the edge'



Centrelink's use of 10% debt recovery fee could be unlawful, welfare groups say

Centrelink staff tell welfare recipients they agree debt system is 'unjust and call...

Centrelink scandal: union reports appeals against welfare debts at 'record' 1...

### BREAKING NEWS:

Senate inquiry set to examine the Centrelink automated debt crisis and problems in the Department of Human Services.

Centrelink robo-debt 'abject failure' and arguably unlawful, Victoria Legal Aid says



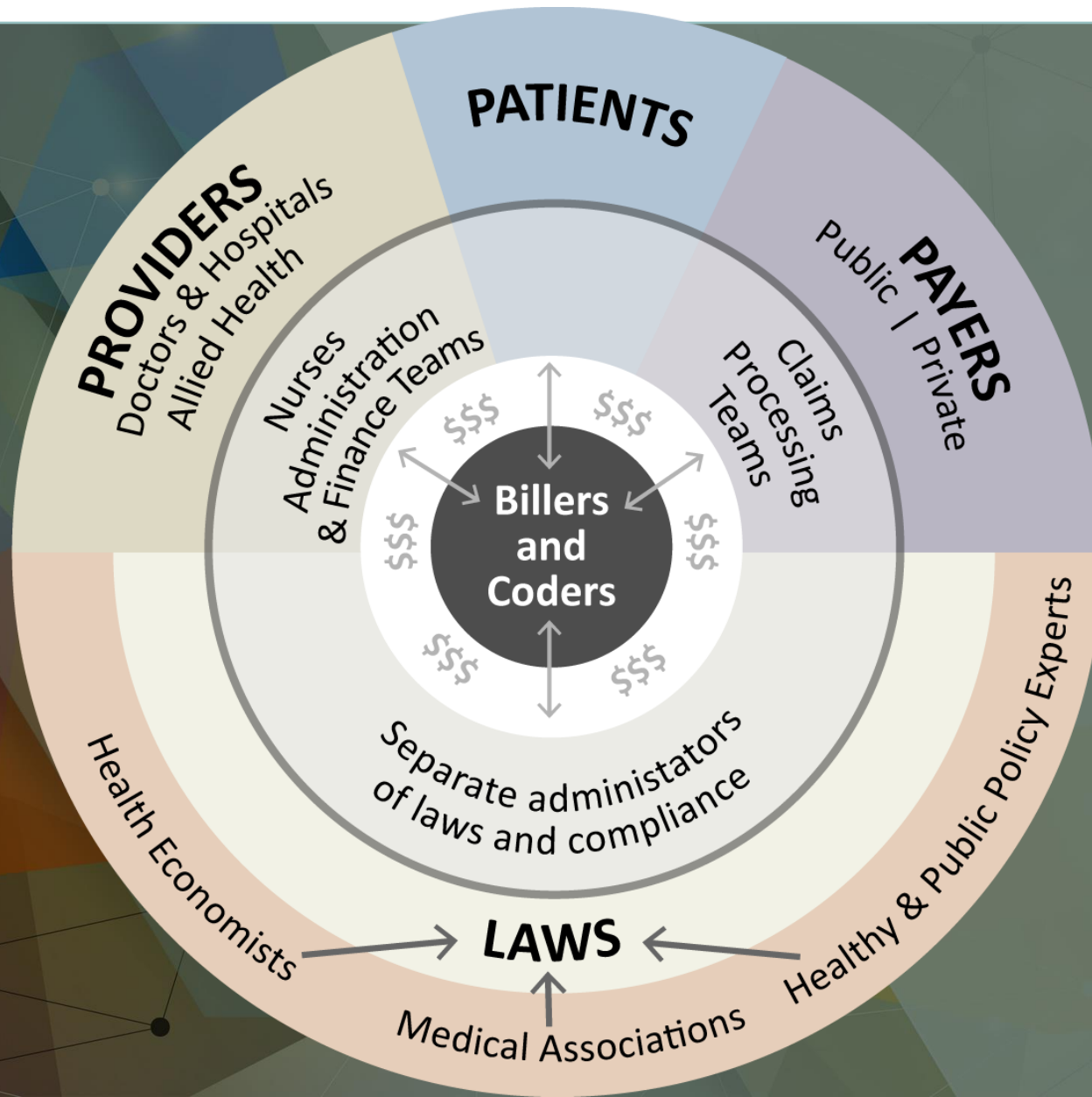
Centrelink Sinks To A New Low In Growing Debt Fiasco

Centrelink staff told not to fix mistakes in debt notices - whistleblower

Centrelink debt system: government knew of error risks 'for decades'

Coalition orders review of IT projects after census, Centrelink and tax office wo...

# My health system



# Challenges in Australia - no one owns health!

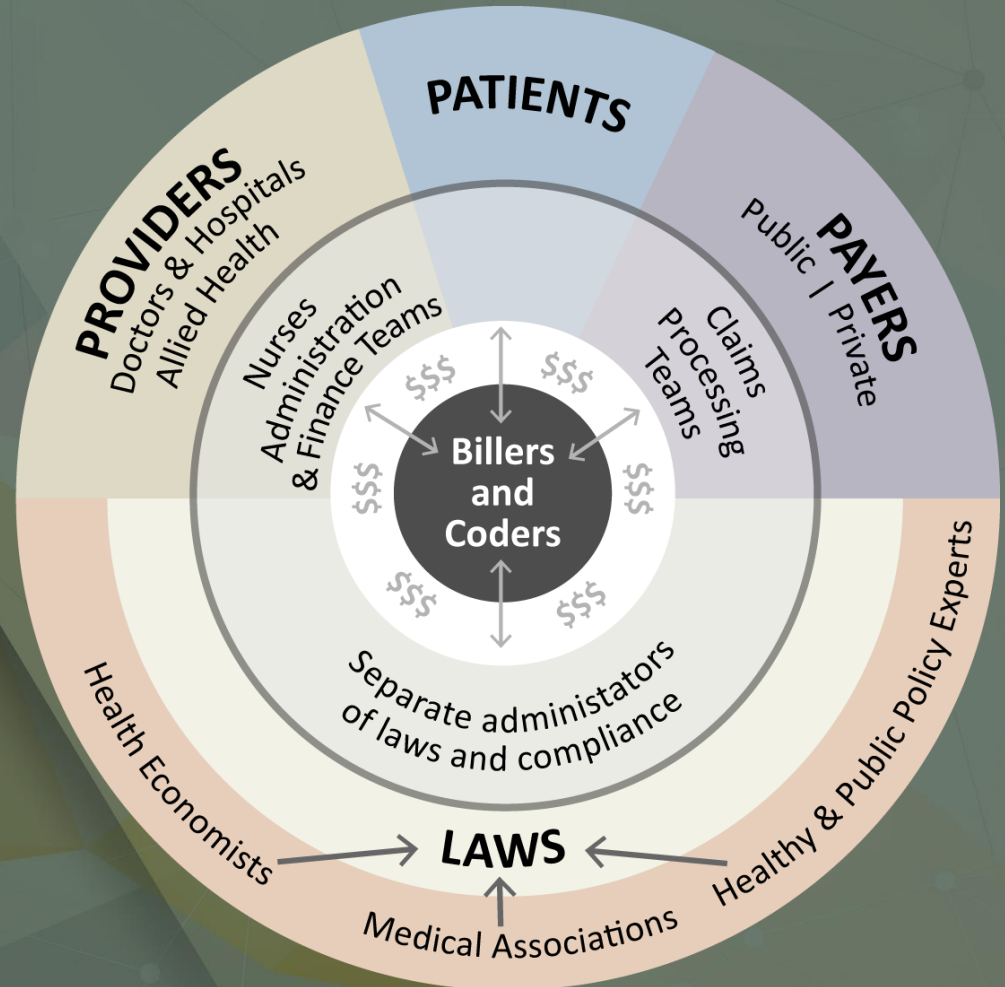
The laws became bigger and bigger while the administration became smaller and smaller

We split functions across two separate departments who don't communicate well

We kept adding to the original foundation without understanding the damage we were doing.

Medicare as a department, administering a brand, has lost its authority

It's like the wild west out there!



# So why do we need government involvement?

Because health spending is or will become a significant proportion of any countries' GDP

Because healthcare systems haemorrhage money

Because providers have no incentive to reduce their costs as that just reduces their incomes

Because private payers are equally responsible for system leakage. Start thinking about the health sector like the banking sector

Because as compassionate societies we need to protect the poor, disabled, elderly and the mentally ill who will make up about 25% of an average comparative population

Because every dollar spent on health is a dollar that cannot be spent on education, transport, defence...



# Basic legal infrastructure requirements

**Tight regulation and ongoing reform...but not like this!**

Separate scheme administration

Robust audit and prosecution  
which cannot be left to computers

A new recognised field of research  
applied health law and health  
insurance lawyers

Health insurance law is every bit as  
complex as banking or tax law yet  
we leave it to chance



# Opportunities for India

- India currently has more health insurance schemes than states
- Focus on tertiary care will not be sustainable long term
- Floating family coverage model will not be compatible with a modern, mobile youth population
- Cashless transactions are improving
- What can realistically be achieved with 2.5% GDP?
- Other priorities



# Thank you and Questions



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