Health Financing for Universal Health Coverage: Some Key Issues

May 23, 2013
One Motivation:
Significant Inequalities in Health and Financial Outcomes
Inter-Group Variation in Health Status in Other Countries

- **Indonesia**: Risk of infant death in lowest socioeconomic grouping was twice as high as the highest ranked socioeconomic group.

- **Mongolia**: National Infant Mortality Rate (IMR) of 33 per 1000 live births; IMR varied across the different ‘Aimags’ (States) from 20 to 58 (per 1000 live births).

- **India**: *Ratio* of female to male life expectancy at birth varied across states, from 97% (Bihar) to 107% (Kerala)
Significant Financial Risks of Ill Health

Out of Pocket Spending on Health as a share of National Health Spending in Asia and the Pacific, 2007

Source: Mahal 2010
Out of Pocket Payments on a Single Hospital Stay as a Proportion of Income Per Capita (%) by Income Group: China & India, 2004

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>421</td>
<td>625</td>
<td>131</td>
<td>136</td>
</tr>
<tr>
<td>Poorest 20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richest 20%</td>
<td>113</td>
<td>95</td>
<td>69</td>
<td>77</td>
</tr>
</tbody>
</table>

Source: Yip and Mahal 2008
Universal Coverage as a Potential Solution
Normative Principles underlying Universal Coverage

• *Universal Declaration of Human Rights (Article 25.1)(1946):* “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.”

• *WHO Constitution:* “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…”

• Good Health is an element of *Minimum Capabilities* necessary for participating in society (Nussbaum 2004)
This right to health does not mean the right to be healthy, however!

Health services of good quality, (physically) accessible, affordable and acceptable are in reach of all members of the population of interest (AAAQ principle)
Recent Country Efforts towards Universal Coverage

- **58th World Health Assembly Resolution (2005):** “…urges states to plan the transition to universal coverage of their citizens …for health care and improving its quality, to reducing poverty, … and to achieving health for all”

- Significant share of populations of Thailand, Taiwan, the Republic of Korea and Mongolia enjoy broad-ranging healthcare benefits

- Large increases in numbers of people in China, and somewhat fewer in India and Vietnam, are covered under relatively generous government supported programs. Others have signed on to the goal of universal coverage (e.g., Fiji, Myanmar)

- But what about countries with a long tradition of public sector financing and provision?
What is new in this ‘push’ towards universal coverage?

- **Greater magnitude of resources available**: higher economic growth & concerns about the destabilizing effects of economic inequality, including from the impact of the Asian financial crises, including in the future.

- **Application of lessons** from (a) the health reforms of developed countries in the 1980s and 1990s; and (b) developing countries’ own unimpressive performance
Public Spending on Health as Share of GDP (%), 1995-2009, Selected Countries

Source: WHO National Health Accounts Data
Health Financing for Expanded Coverage
Raise Resources → Pooling → Allocate Resources → Payments

Adding one more Element to the Financing Discussion

• Affordability: The Scarcity and Choice Problem

• How are resources to be collected and pooled?

• How should payment for health interventions be organized?

• How should the supply of health interventions be managed?

• Stewardship
Affordability: The Scarcity & Choice Problem

• Which health interventions/services should be financed and/or mandated by the state and how much should be left to households’ own devices?

• Which households, if any, should receive state subsidies?
Which health interventions should be emphasized?

Classifying Health Conditions (Baeza & Packard 2006)

Frequency of Occurrence

Cost of Treatment

- Low Cost, High Frequency
  - (flu, diarrhea, minor injuries)
  - (minor headache)

- High Cost, High Frequency
  - (chronic conditions)
  - (heart attacks, traffic injuries, other acute conditions)
The Government Ought to Focus its Efforts on…

- Health conditions that require High Intensity Treatment, irrespective of frequency, \textit{except when}…

- Low intensity conditions have large preventive effects (infectious disease), or if the individual is poor

- There are interventions that are not easily classified on the diagram, but have large future benefits for the individual – exercise, reduction of smoking, nutrition

- High intensity treatment that is neither cost-effective, nor necessary (cosmetic surgery) should not be covered
Who should be provided government subsidies?

Targeting the Needy

- Geographical Targeting (Poor regions)
- Income or Proxy Means Targeting (Assets, Education, Job)
- Identification of Needy Groups by Local Communities
- Self-identification
Potential Consequences of Not Targeting: The case of the Arogyasri scheme, Andhra Pradesh India

• Fully tax-financed scheme covers 900+ tertiary interventions for the ‘poor’ in the state of Andhra Pradesh

• Poor person is anyone who holds a ‘ration card’ (to access subsidized food-grains outlets). This covers the vast majority of the population.

• >64 million of 80 million residents of insured. The scheme ran into serious financial problems in only its third year of operation.
Collecting, Pooling and Managing Resources

• What is pooling & why is it useful?

• How should resources be collected?

• What form should pooling take?
Pooling

e.g., (a) General Tax Revenues; (b) Social Security Fund, (c) Voluntary Insurance Contributions
Case for Pooling

- **Pools Health Risks Equitably**: Enhances high risk individuals’ access to care; enhances poor individuals’ access to care

- **Enhances Efficiency**: Economies of scale in using funds

**Key Challenge**

- **Political**: low risk individuals & richer groups potentially trade-off greater contributions against some increased efficiency in resource use.
Multiple Pools: The Case of Thailand

• Civil Servants Medical Benefit Scheme (8% of population):
  Source of Funds: General Revenues
  Expenditure: AUD 330 per person

• Social Security for Formal Sector (16% of population):
  Source of Funds: Employer, Employee & Govt. Contributions
  Expenditure: AUD 70 per person

• ‘Universal Coverage’ Scheme (75% of population)
  Source of Funds: General Revenues

• Separate Funds (pools) for infrastructure and health promotion
Single Pool Models: Sri Lanka, Malaysia

- Single public/autonomous purchaser obtains services for all through a common provider (usually the public sector) (Sri Lanka, Malaysia)

- Single purchaser obtains services from public and private providers (proposal under ‘1Care for 1Malaysia’
Collecting Resources for Health Services

- Taxation (General Revenues)
- Payroll Taxes into “Social Insurance”
- Voluntary pre-payment (Micro-health insurance, private insurance)
- Voluntary or mandated Self-insurance (medical savings accounts)
- Out of pocket expenses
Which ways of raising resources are to be preferred?

- **Criteria**: Should be difficult to avoid; should be ‘stable’ as a source of funds; and generally contribute to the goals of risk and equity pooling.

- **Payroll Taxes or General Revenues?**
  Distinction between payroll taxes & general revenues does not seem crucial because of cross-subsidies, evasion, undermining of equity pooling

- What should be the *role of voluntary pre-payment mechanisms*?
  Limited spread in Asia (except for Philippines), problem of risk/adverse selection, but possible way station on the way to ‘universal coverage’.

- **Out of pocket payments and medical savings accounts** – means of addressing moral hazard; large scale use demolishes risk and equity pooling
How should payment for health interventions be organized?

- Who should manage the funds?

- How should providers be paid?

- How can funds be used to create incentives for users of health services for increased preventive activities?
Who manages the funds?

- What would we like the manager to do? Be an effective purchaser, enter into contracts with providers, pay claims, promote efficiency in the provision of health services (including the integration of primary and higher levels of care) and quality of services.

- Recent Chinese Experience: Chinese urban health insurance system funds were managed by the Ministry of Labour. Has focused primarily on balancing its budget.

- Indian Experience:

  Ministries of Health managing budgets in each state for their health facilities – low responsiveness and no sanctions;
  ‘Autonomous entity’ manages funds for Arogyasri scheme in Andhra Pradesh – pricing of services based on contracts, oversight committee (not transparent: no formal evaluation of its performance)
How should providers of Health Services be Paid?

Types of Payment Mechanisms

• Fee for Service (FFS) – all countries in the region, and co-exists with insurance in Thailand, Korea and Philippines (also Australia)

Prospective Payment Systems (for example)

• Salary (with or without bonus) – Ministry of Health facilities in the region, ASHA worker in India (salary + bonus)

• Capitation: Per capita payment per enrollee, or per patient, or on the seriousness of a condition (DRG) – Thailand, Taiwan, India, Indonesia, Mongolia

• Global Budgets: (Thailand, Taiwan)
How should Providers be Paid?

Implications of Provider Payment Systems

• **FFS and similar systems** create incentives for providers to over-supply services and raise costs of health service provision.

• **Prospective payment systems** do just the opposite, with DRGs somewhere in between. Here the concern is with quality of services.

Global Budgets and DRGs: limit health expenditures but create incentives for relatively more profitable interventions.

• Various types of **bonus/performance payments** when accompanied by prospective payment systems can help address issues such as under-treatment. Also needs credible quality monitoring.

• Payment system can create incentives for providers to improve integration of primary care and higher-level services (fund-holding).
How should providers be paid?
Implementation Issues

• Provider response depends on organizational structure – can providers respond to incentives? Do public sector providers get to keep the bonuses and extra funds? (Hospital autonomy experiments)

• Are costs of healthcare properly accounted for setting DRG, payment per enrollee, or payment per admission? Too low a rate could lead to providers not agreeing to contracts. Improper cost calculations could lead to incentives to over-produce certain types of services

• Salary and capitation fees are easy to implement.

• However, informational requirements for DRGs and pay-for-performance type of arrangements (bonuses) can be very complex (the case of Thailand).
What do we know about the working of provider and consumer payment mechanisms in Asia & the Pacific?

*The Answer:* Very Little

- Some evidence that in China, prospective payments in a sample of hospitals result in a slower increase in health spending and use of diagnostics relative to another sample of hospitals that were paid on an FFS basis.

- In Korea and in China, providers direct patients away from services for which prices are controlled.

- In Thailand, FFS payment resulted in rapid increases in the cost of inpatient care under the civil servant scheme, leading to a shift to DRGs.
Incentives (including paying consumers) for Behaviour Change

- Transfers conditional on exhibiting certain healthy behaviours (antenatal visit, immunization, subsidize gym membership)

*Indonesia*: Program Keluarga Harapan (conditional on health centre visits for designated check ups/immunization and school enrolment)

*Philippines*: Pantawid Pamilyang Pilipino Program (conditional on preventive checkups and immunizations at health centre and school enrolment)

Bangladesh and India also have conditional cash transfer programs related to health services.

- *Sri Lanka and Thailand*: do not allow visits to higher level facilities without referral (in Thailand, there is a large co-payment for such a visit). System is more lax in India and Laos.
Public Providers: Four Cases

- *Kerala, India*: Allowed for additional funds through competitive payments to be retained/distributed at the facility level; and increased accountability via oversight committees. Led to significant infrastructure improvements, but concern at bonus for doctors.

- *China*: Essentially converted public facilities into private providers, by providing them with only 5% of the their pre-market reform budget. Associated with large increases in diagnostic and drug use and medical expenditure inflation.

- *Cambodia*: Health equity funds that follow users of health services – as long the health facility is in the public sector. No competition.

- *Philippines*: Decentralized authority over health facilities to local governments. Increased innovation but greater interregional inequality.
Developing Partnerships with Governments on Evaluating Health Financing Interventions

• Most governments and non-governmental organizations in the region are ill-equipped to undertake such evaluations (Thailand being the exception) – such as on financial risk protection, access to care.

• Many countries/organizations are involved

• Entry into this club is difficult. Need to form partnerships, perhaps with smaller organizations involved in such activities at the district or provincial level. Secondary data
Design and Test Improved Targeting Methods

• How do the current targeting methods stack up in terms of accuracy?

• Exploring improvements in birth and deaths registration to better identify people, testing incentives for better registration

• Identify approaches that help improve targeting and undertake randomized evaluations
Payment Practices for Healthcare Providers

- Systematic review of approaches to pay providers in the region, especially by non-governmental and private entities

- Evaluate existing payment practices in countries in the region and draw implications for policy

- Design payment interventions and cost health services

- Possible partners: The World Bank, Asian Development Bank, AusAID, Managers of Risk Pools