

Health financing for Universal Coverage: what's working, and what issues between health and finance?

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Financing health care systems: macroeconomic and fiscal implications of financing universal health coverage

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Overview

- Some general patterns in what works in health finance reforms oriented to universal coverage
- Some key interactions between “health” and “finance” for effective implementation of health financing reforms
 - With some considerations of European experience with the response to the economic and financial crisis

UNIVERSAL COVERAGE: PROMISING DIRECTIONS, SOME POSSIBLE LESSONS



Definition: Financing for Universal Coverage

- "Financing systems need to be specifically designed to:
 - Provide **all people** with access to needed health services (including prevention, promotion, treatment and rehabilitation) 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



UHC is a direction, not a destination

- No country fully achieves all the coverage objectives
- But moving “towards UHC” is relevant to all; all want to...
 - Reduce the gap between need and utilization
 - Improve quality
 - Improve financial protection
- Often, it translates into **reducing explicit inequalities** in benefits and funding per capita between groups
 - Mexico, Thailand, South Africa using this as political driver of their reform agendas
 - Relatedly, UHC as a means to the end (or the embodiment) of having “fairer societies”



Approaching health financing policy...

- “The path to universal coverage must be home grown”
 - UHC goals orient the direction of reform
 - Starting point is the unique arrangements of each country
 - National context (fiscal, administrative, political, social) conditions both what can be achieved and what can be implemented
- This does not mean, however, that we are open to anything – certain approaches are clearly not consistent with moving towards UHC (it’s not “anything goes”)
- Fortunately, some positive examples highlight promising directions

Early 21st century pathways to UHC

- **Thailand** merged several different schemes into one, funded from general revenues, using quasi-public purchasing agency
 - Overcame most but not all fragmentation across schemes, and progressively working to equalize benefits across them
 - Increased service use while reducing catastrophic payments
- **Mexico** addressing its legacy of a fragmented and unequal system by
 - creating a budget-funded insurance program for a defined list of high-cost services for the entire population
 - creating a program of "popular insurance" for informal sector funded largely by central budget transfers to the States, which in turn are responsible for enrolling the population
 - Also reducing gap in per capita funding and benefits across schemes
- **Czech Republic** refined risk adjustment and made 100% of SHI revenues subject to redistribution, reducing risk selection

More examples: differences in details due to differences in starting points/context

- **Ghana** and **Rwanda** have explicit coordination of bottom-up and top-down financing mechanisms to create a virtual national pool, with general revenues as main source
 - Gains in utilization and financial protection
- **Kyrgyzstan** and **Moldova** centralized pool of budget funds, combined with new payroll tax, changed from input- to output-based payment, and increased provider autonomy
 - Impressive gains in geographic redistribution and efficiency
- **Chile** (through the AUGE program) and **Burundi** (through its PBF mechanism) link purchasing to explicit benefits
 - Demonstrable gains in use of defined priority services



These countries took a “functional approach” to health financing policy

- Recognized that the source of funds need not determine how money was pooled, how services were purchased, nor how benefits were specified
- They moved away from thinking in terms of “schemes”
 - Pooled together or coordinated use of different revenue sources (in fact, so do Germany, Japan, Netherlands, Czech Rep, etc.)
 - Progressively increased the size of the compulsory prepaid funds while reducing the barriers to redistribution within it
 - Introduced elements of performance-related payment from the prepaid funds to address specified utilization or efficiency issues
 - **De-linking (somewhat) health coverage from labor force status**
 - Accompanied implementation with analysis

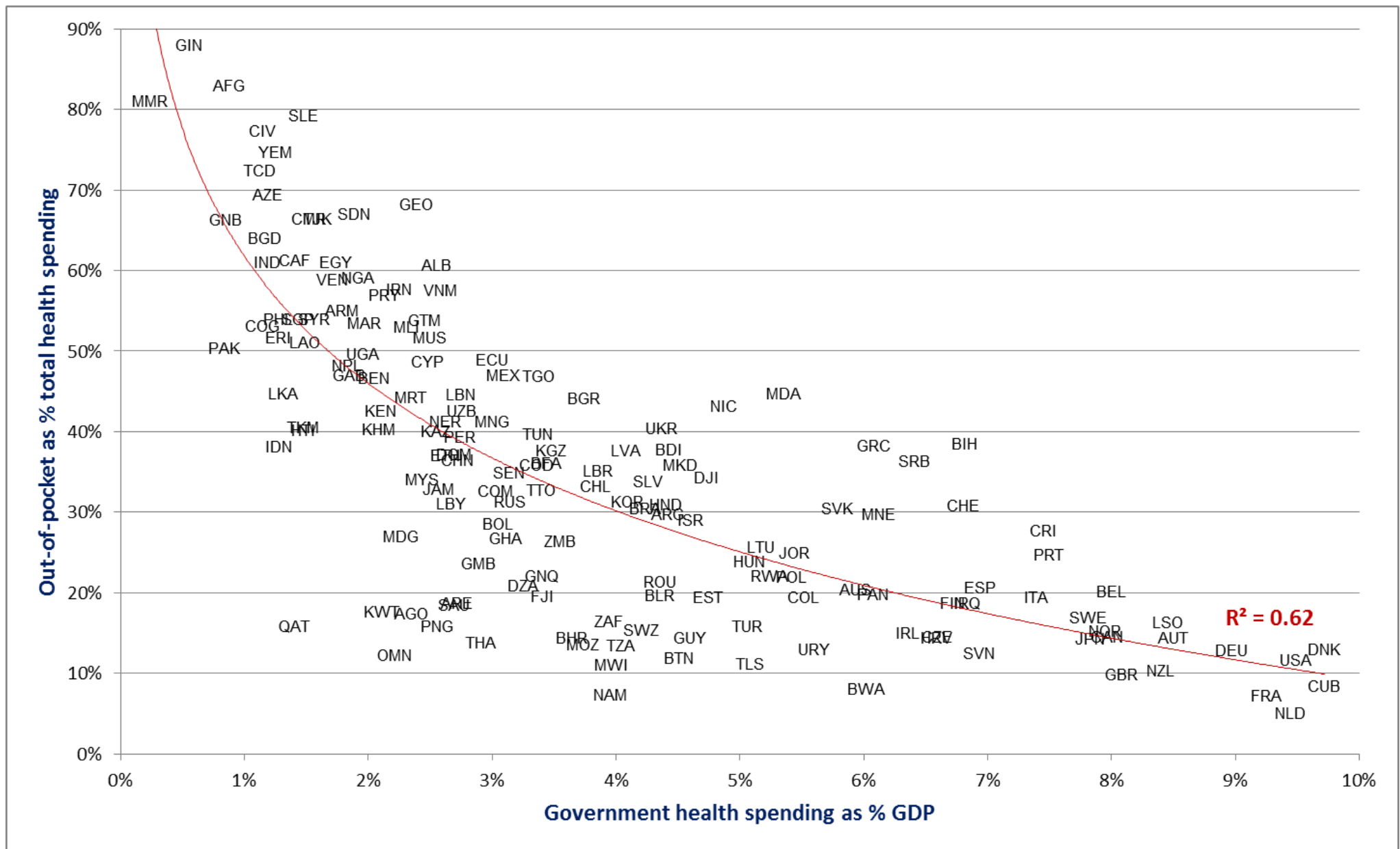
That's the “overview story”

- Reality is far more complex, with success requiring careful alignment of different aspects of the system with each other – hard work and no simple solutions
 - “Same reform” in different countries, with different effects
- For example in central/eastern Europe and ex-USSR
 - Reforms introducing compulsory health insurance associated with great progress (Estonia, Slovenia, Kyrgyzstan, Moldova)
 - Reforms introducing compulsory health insurance associated with great problems (Albania, Bulgaria, Kazakhstan, Russia)
- The devil is in the details
 - Which cannot be captured in a cross-country regression
 - Be wary of simple/simplistic solutions offered to your problems

Still, some general lessons

- Importance of public/compulsory funding
- Reducing fragmentation in pooling (or mitigating its consequences)

1. Public/compulsory funding is key



Source: WHO estimates for 2010, countries with population > 600,000

No country with universal population coverage relies on voluntary health insurance as its main financing mechanism

- Compulsory systems work much better; no adverse selection (nor insurer response to it)
- Two conditions for universal coverage (Fuchs)
 - Subsidization (because some will be too poor or too sick to be able to afford voluntary coverage)
 - Compulsion (because some who can afford it are unwilling to buy it)
 - One without the other won't work (subsidies alone not sufficient because rich/healthy will not join; and compulsion without subsidies impose heavy burden on the poor and sick)

USA: the individual insurance market is not a viable option for many people

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
<i>Any of the above</i>	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).

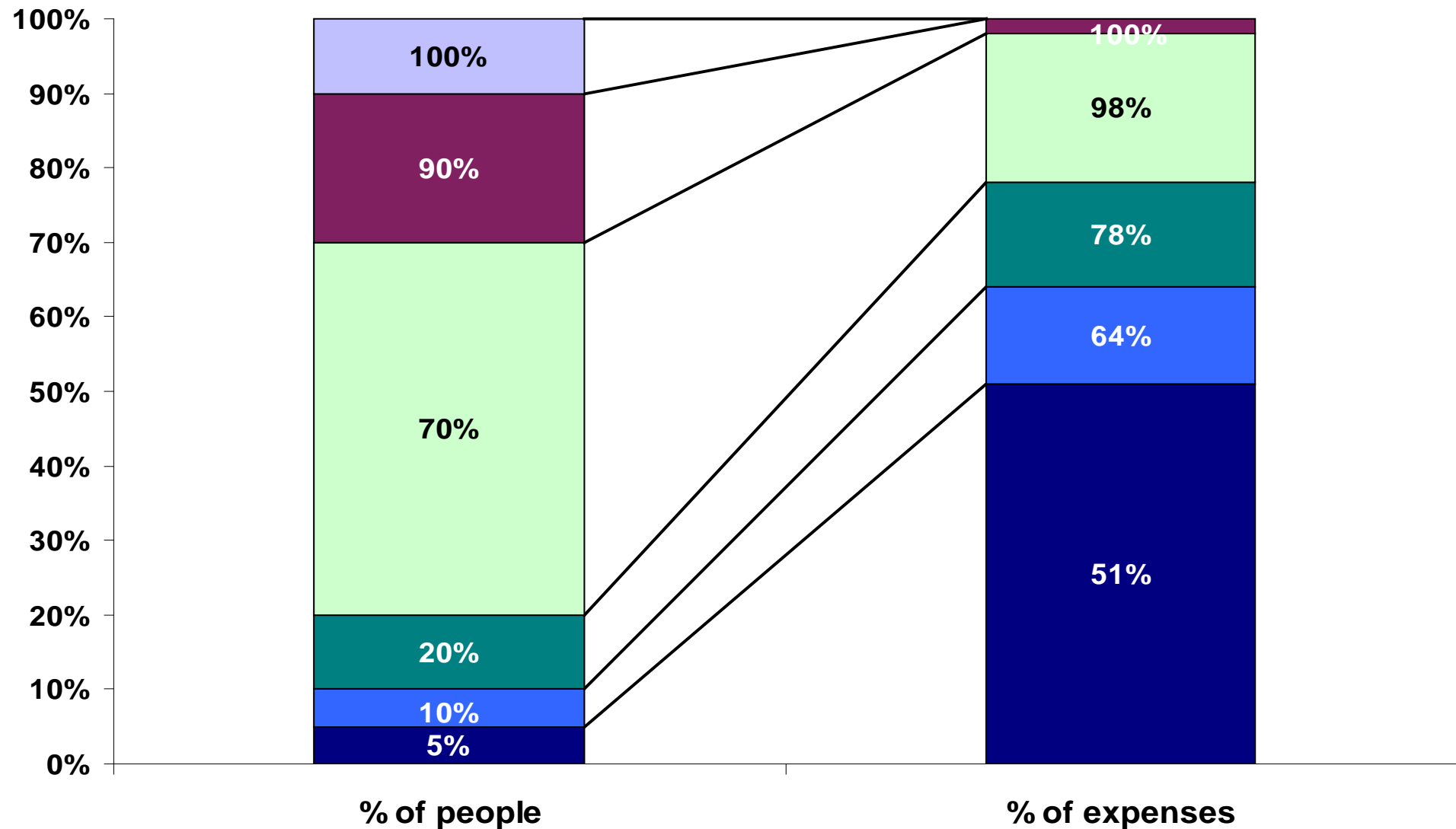


2. Fragmentation in pooling is an obstacle to be addressed for progress towards UHC

- A system is **fragmented** when there are barriers to the redistribution of prepaid funds
- Fragmentation of pooling limits the ability to cross-subsidize
 - Can only cross-subsidize within pools, not between pools (unless there is central re-distribution mechanism)
- Fragmentation is a concern in virtually all health financing systems
 - Especially when you divide the population into different schemes with different benefits and funding levels per capita
- So while we want more pre-payment, we don't want more pre-payment **schemes** if this means more fragmentation



Why pooling matters: concentration of total health expenditures, France 2001



Source : CNAMTS/EPAS (and Agnès Couffinal)



What matters for effective risk pooling?

- Size

- Thai Universal Coverage scheme is one pool for 47 million people, enabling universal coverage with government spending on health only accounting for about 3% of GDP

- Diversity

- If aim is to ensure redistribution from the rich to the poor and the healthy to the sick, pool needs to include rich, poor, healthy, and sick (!!)

The US program for the poor is a good example of bad pooling

- “The problem is Medicaid is breaking right now. Medicaid is going insolvent. But more importantly, the way Medicaid works right now, most doctors don’t even take Medicaid. Every time a Medicaid patient walks into a doctor’s office, they lose money. It’s an unsustainable system and it’s ending up giving people second class health care. They’re not getting good access to good care.”

- House budget committee Chairman Paul Ryan, CBS news interview, 5 April 2011

How do contributory systems in Europe differ from the US Medicaid approach?

- Like the US Medicaid program, European countries with contributory health insurance systems (e.g. Germany, Netherlands, Czech Republic, Slovakia, Switzerland) use tax revenues to subsidize coverage for those deemed too poor to pay for themselves
- Unlike the US, those European countries enable those subsidized to be in the same insurance pool as everyone else, spreading their risks across the whole population
- Unless the pooling arrangements are changed, Medicaid will always be a “poor program for the poor”, with a high-risk population relying on a financing mechanism that offers limited scope for redistribution



Summary of our guiding principles for health financing reform: from scheme to system

- Operational principles to guide progress
 - **Explicit complementarity** of different funding sources
 - Focus on **reducing fragmentation** and expanding pool size (**more prepayment, not more prepayment schemes**)
 - Recognize that real progress will require an explicit role (and often, increased levels) for **general revenues**
 - Create **unified information platform** across all schemes to lay foundation for universal financing system
 - More money and larger pools not enough: need to move towards **strategic purchasing** to address inefficiencies and make progress on defined, measurable objectives by **linking payment to core benefits** (e.g. free deliveries)

WHAT DOES HEALTH NEED FROM FINANCE?



What we need

- Money
- Responsible fiscal management to enable counter-cyclical spending
- Stability and predictability of revenue flows to enable effective purchasing and realization of promised benefits
- Aligning public sector financial management with health financing reforms, especially given importance of general revenues for real progress towards UHC
- Common understanding that cost containment is not the same thing as efficiency

What we need to give back

- Accountability

- Transparent use of public funds
- Getting results – outputs, outcomes, efficiency, equity
- Public reporting

- Cost/expenditure management

- No open-ended commitments (ex post spending well-predicted by ex ante budgets)
- Responsible processes (e.g. budget impact analysis required for any package expansions)

1. Rationale for counter-cyclical fiscal policies for social and health expenditure

- Need for health care during the crisis increases
- Drop in public expenditure leads to an increase in private spending which in turn reduces financial protection for the poor who may forgo seeking care
- Utilization of services and quality of care during a crisis decrease despite increased needs
- Utilization decreases less where the cost of seeking care is low

Where the cost of seeking care is lower, the reduction of utilization is also lower

Country	Changes in Utilization of Routine Health Care Since the Crisis				N
	Reduce	Same	Increase	Net Change (Reduce - Increase)	
United States	26.5	66.5	7.0	19.5	1901
France	12.0	82.7	5.4	6.6	868
Germany	10.3	83.0	6.7	3.6	879
Canada	5.3	89.3	5.4	0.0	1032
Great Britain	7.6	84.4	7.9	-0.3	757
5 Country Avg	15.2	78.3	6.6	5.9	5437

“Reductions in routine care today might lead to undetected illness tomorrow and reduced individual health and well-being in the more distant future.”

Source: Lusardi A et al. *The economic crisis and medical care usage*. Harvard Business School, 2010.

Institutional counter-cyclical arrangements helped navigating through the crisis

Estonia: EHIF accumulated **reserves** that provided a buffer when payroll tax income drops

- Save during good times, spend during bad times
- But similar institutional arrangements not in place to protect the budget for public health

Moldova, Lithuania & Slovakia: institutional arrangements for budget transfers

- falling revenues from health insurance payroll contributions triggers increased general budget transfers
- supports vulnerable groups unable to contribute financially

2. Importance of aligning health financing reform and PFM systems: a Kyrgyz example

- Initiation of “Single Payer” reform in 2001, in 2 regions
 - Definition of guaranteed benefit package for entire population, including formal co-payments and exemptions
 - Eliminating pool fragmentation and separating purchaser from providers
 - Change in the purchasing methods to population and output based payment, linked explicitly to benefit package
 - Gradual increase of provider autonomy in management
- Year 1 results
 - Reduction of informal payments, growing awareness of benefits
 - Efficiency gains through massive downsizing unneeded infrastructure enables reduces fixed costs

The public sector management response

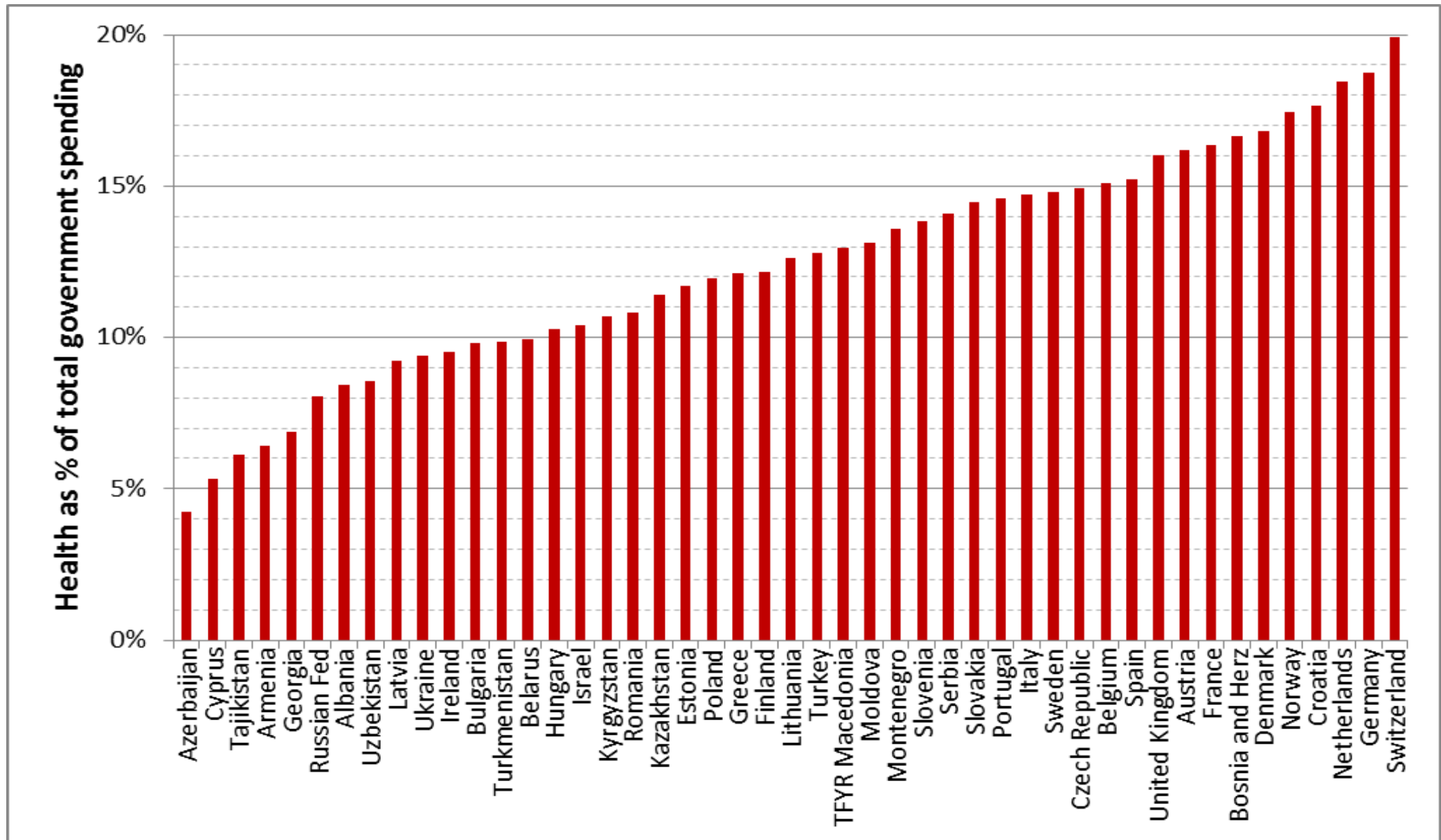


- Reforms led to both less infrastructure and more transparent reporting of patient payments
- But overall budget formation with MOF had not changed
 - Budgets still prepared according to number of beds
 - So 2002 budget envelope was reduced (fewer beds interpreted as "less need", so efficiency gains were punished)
- Success in formalizing some informal payments similarly "rewarded"
 - Newly visible "revenues" taken into account in budgeting, causing reduction in public finance, punishing transparency

3. Fiscal sustainability: a slippery concept

- It applies at the level of overall public spending (overall fiscal balance)
- At a sectoral (e.g. health) level, the concept is less clear
 - How much gets spent depends on a country's overall fiscal context and the priority that government gives to each sector in its budget
 - So the “fiscal sustainability” of public spending on health depends in part on choice: it is not merely an external constraint

Level of health spending that governments choose to sustain varies widely in Europe

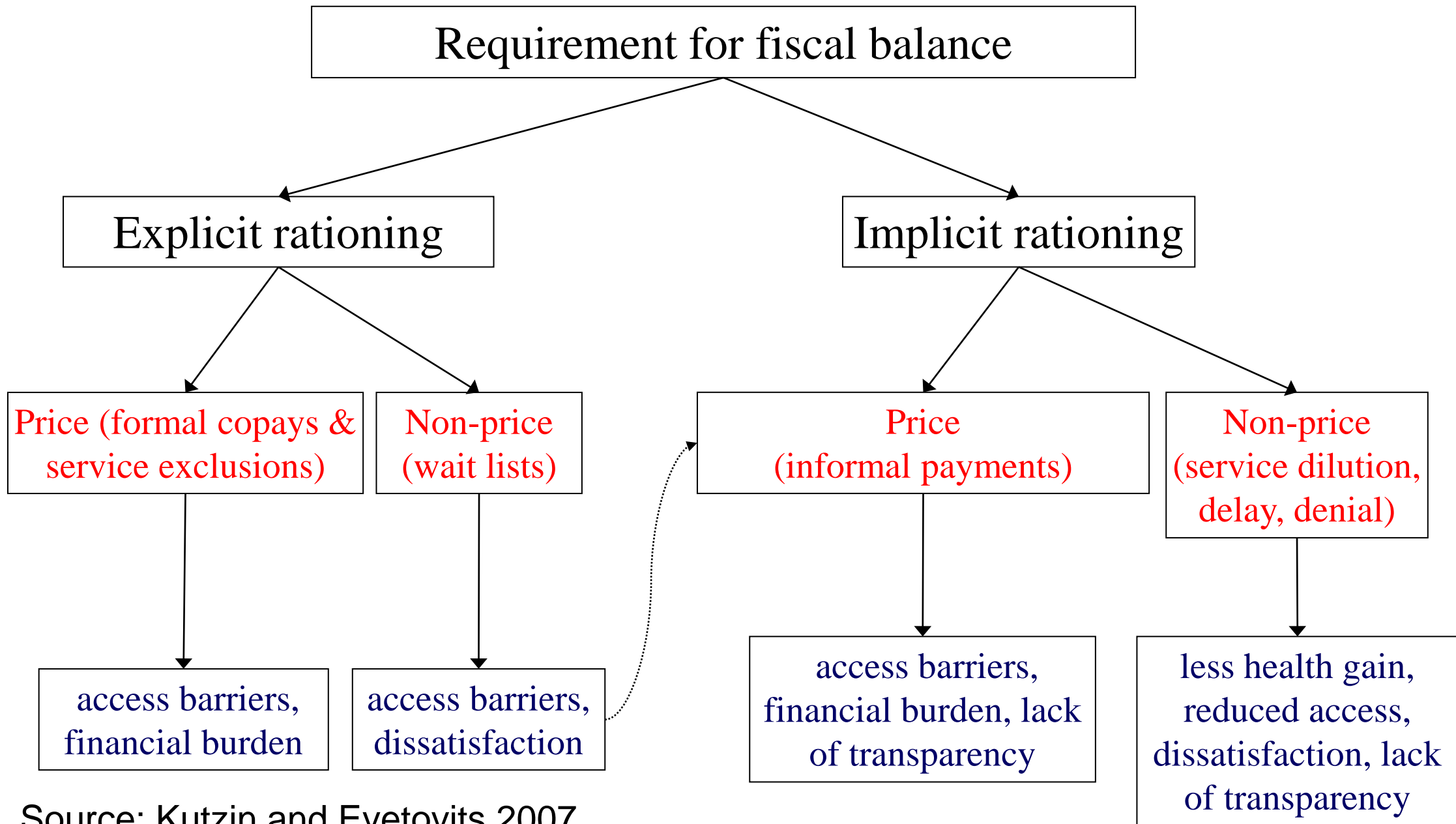


Source: WHO estimates for 2010, countries with population > 600,000

Fiscal sustainability ≠ efficiency

- All systems ration, but different approaches have different implications for policy objectives
- Budget constraints matter, and the need for fiscal balance must be respected
- Increases the attention that must be paid to system **efficiency**: getting the most, in terms of progress on health finance policy objectives, within the constraints of available resources
 - Implies a need to do more than just “cut the budget”; need priorities, and reforms in how the system operates

Tradeoffs inevitable, but improving efficiency can lessen severity

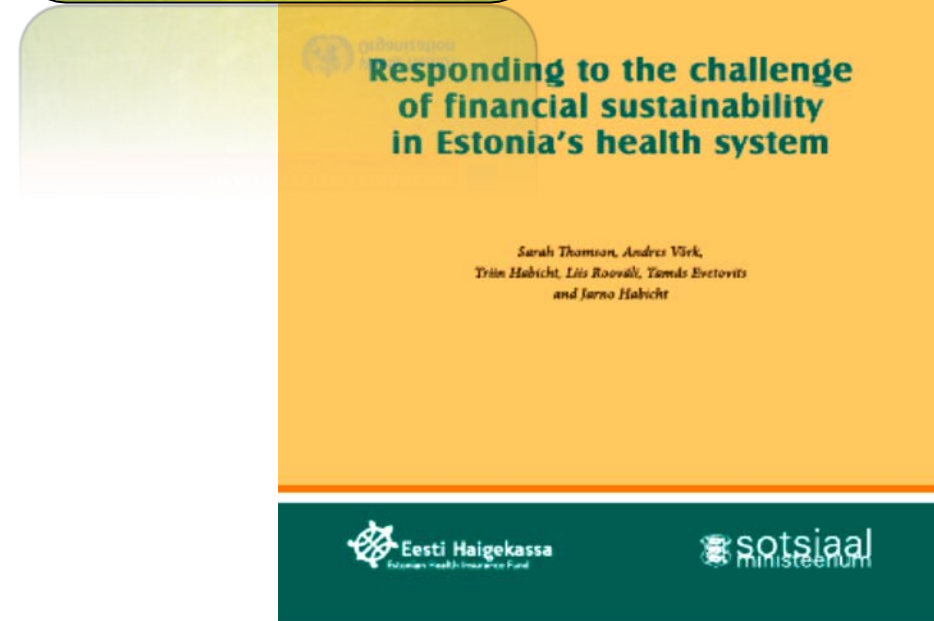
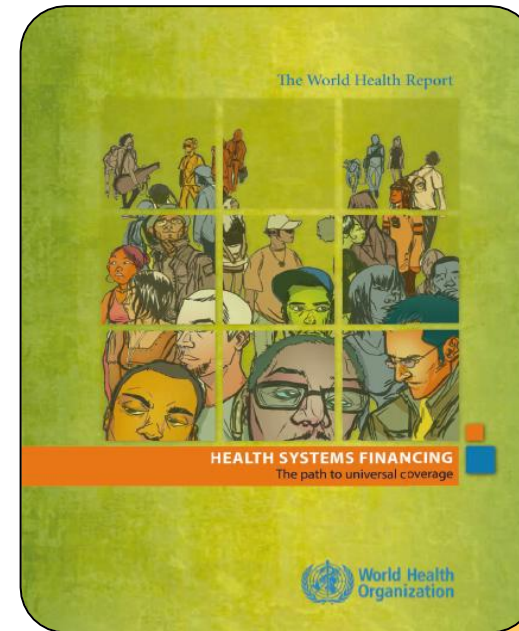


Doesn't mean that health sector should ignore wider concerns with fiscal sustainability

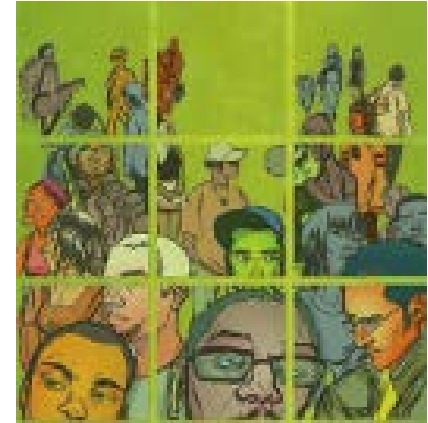
- Health is one of the main drivers of overall public spending increases over the past few decades
- Fiscal authorities (national and international) have a legitimate concern that government health spending not get “out of control”, e.g.
 - No open-ended obligations
 - Budget impact analysis be required for any proposed expansion of benefits
 - Ex ante expenditure plans do not get undermined by ex post bailouts of loss-making public facilities

But need to balance and ensure we don't lose sight of health policy objectives

- Sustainability is meaningless if not linked to health system objectives
- Financial sustainability should not be seen as a policy objective worth pursuing for its own sake
- If it was an objective, then a simple cost cutting exercise would do the job...
- ...and both equity and efficiency would suffer.



www.who.int/whr/2010



Thank you

EXTRA SLIDES



Accounting for government spending on health

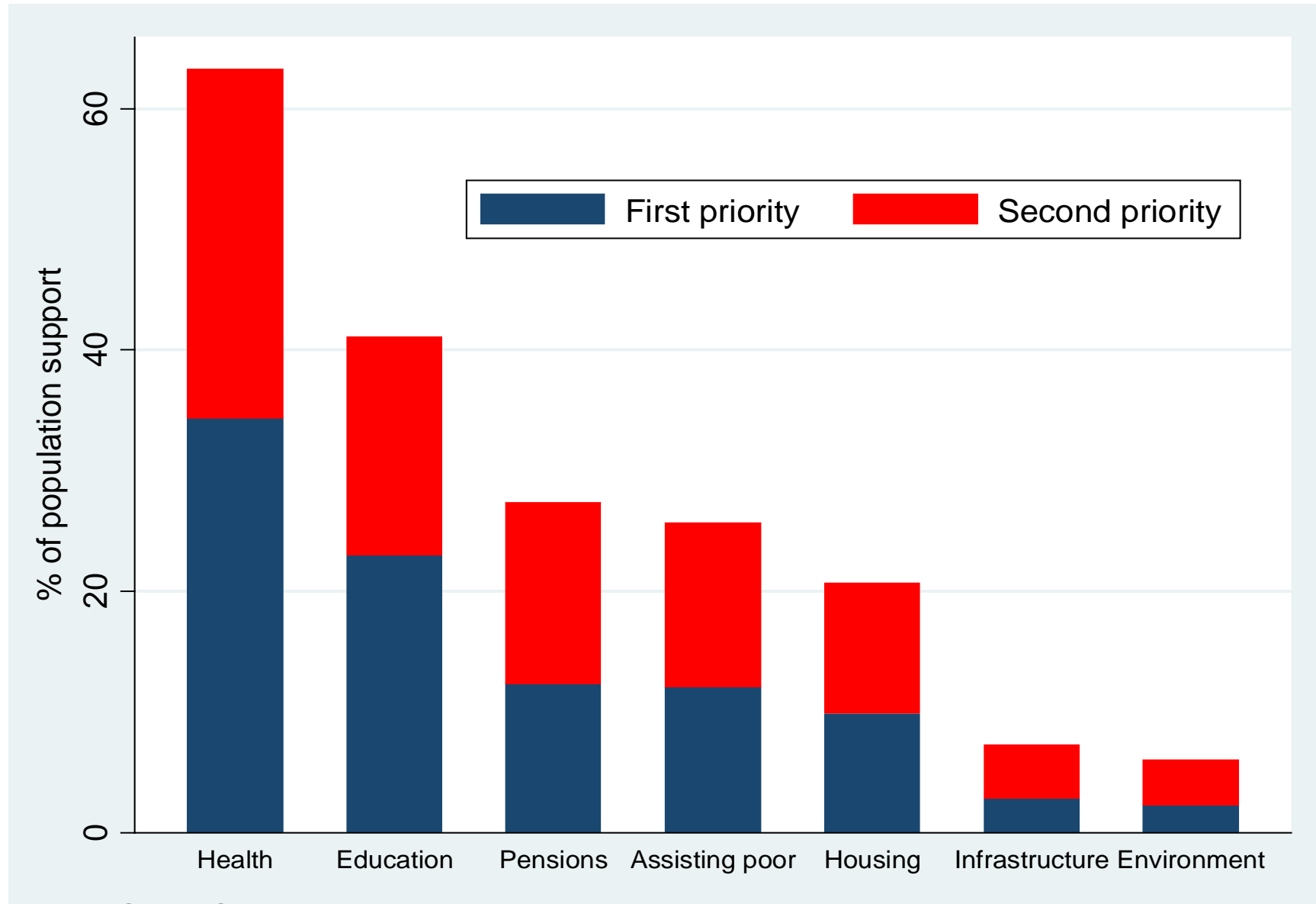
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal capacity

Public policy priorities

It's a choice, and health spending is the top priority for more spending across Europe



Source of slide: Owen Smith, World Bank

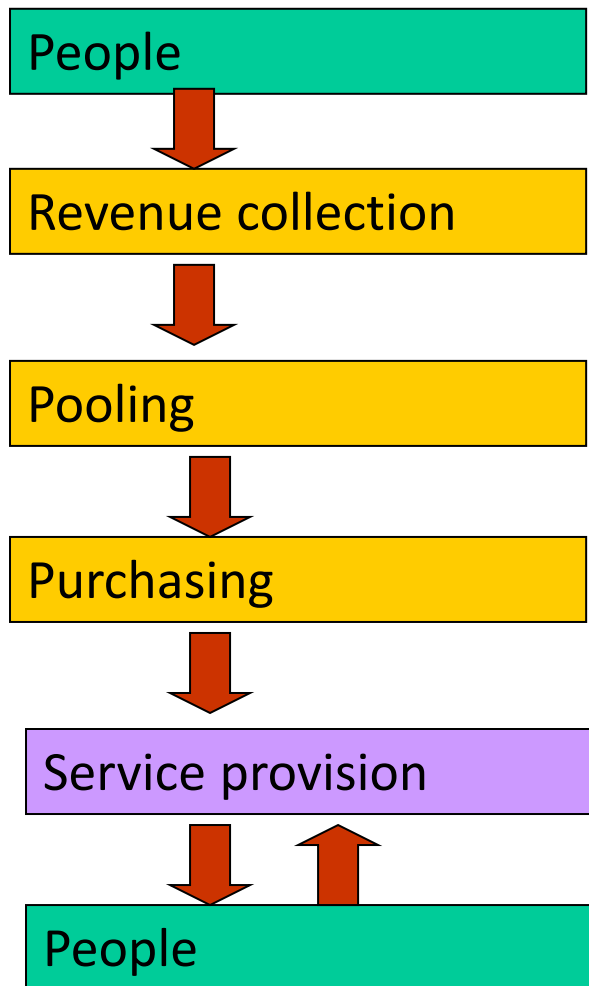
Does UHC = Universal Health Insurance??

WHO'S APPROACH TO HEALTH FINANCING POLICY

Does UHC = UHI?

- Economists are certain that the answer is...
- “It depends”
 - More specifically, depends what we mean by “health insurance”
- The “insurance function” of health systems:
 - Access to needed care
 - Financial protection
 - German citizens are not “more insured” than British citizens, just because of the label they attach to their system or the source of funds that is used
- Insuring the entire population is an objective of health systems, but insurance as any specific set of institutional arrangements is not (but we know some things to avoid)

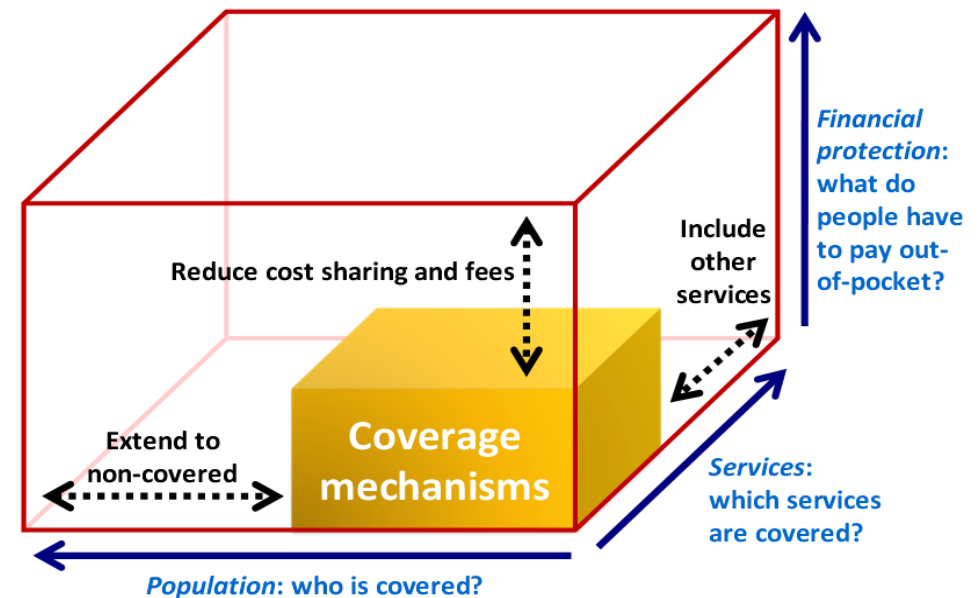
What kinds of choices need to be made?



and also
this:

Reforms to
improve how
the health
financing
system
performs

This



Breadth, depth and scope of
coverage; level and distribution of
utilization, extent of catastrophic
and impoverishing payments...



What do we mean by “health financing policy”?

Classifications or models

- “National Health System” (Beveridge Model)
- “Social Health Insurance System” (Bismarck)

Old thinking, not helpful for analyzing systems and choices

Functions and policies

- Collection
- Pooling
- Purchasing
- Benefits and rationing

Relevant to all countries and essential for analyzing systems and choices

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



Theory and evidence have taught us a few things

- No country gets to UHC relying principally on voluntary health insurance
 - Some who can afford it won't join, and some can't afford it
 - Compulsion or automatic entitlement is essential
 - Issue is compulsory vs voluntary, not public vs private
- Because there are always some who can't contribute directly, all countries with universal population coverage rely on general budget revenues (in whole or in part)
 - And the larger the informal sector, the greater the need for using general revenues (but sources are not systems!)
- To sustain progress, need to ensure efficiency and accountability
 - “Strategic purchasing” as a critical strategy for this (and also for capacity strengthening, given the linkage between information and resource allocation)



Principles of our approach⁽¹⁾: insuring the population as a core objective

- All financing systems (other than pure out-of-pocket) are systems of insurance – assess performance by how well they do this job, not by what they are called
 - WHO is committed to the objectives of health financing reform, but not to any particular institutional form or model
 - Similarly, our core conceptual foundations are universal. We don't have separate concepts for low, middle, and high income countries (but of course, because the starting point and other aspects of context differ, so will the relevance of different policy choices)



Principles₍₂₎: **sources are not systems**

- Effective policy, and policy analysis, requires thinking in terms of functions rather than models
 - Source of funds does not have to determine how they are pooled, how providers are paid, and how benefits and co-payments are specified
- Labels/models...
 - Can be politically useful in particular contexts as a communications tool (“we are changing to an insurance system”)
 - But should not restrict our thinking about the choices that need to be made with respect to pooling, purchasing, benefit package, etc.



But...communication of this can be difficult

- **Thinking** in terms of functions may be correct, but **speaking** in terms of models is common and appears easier to convey for politicians and the public
 - “We are implementing a new social health insurance scheme” is easier than “we are reducing fragmentation in pooling”.
- Difficult terrain, given that many individuals and agencies are wedded to their models and frameworks
- Nevertheless, conceptual clarity is essential for good policy
 - For example, recognizing that financial protection and access can be provided from general revenues as well as “insurance contributions”



Communications challenges, continued

- Need to ensure that we communicate effectively while also thinking correctly and comprehensively
 - In Russia and Azerbaijan for example, it was important to say that “we are changing to an insurance system” as the means of communicating that “we need fundamental reform of our health financing system”. It did not mean a change to a fully contributory system.
- But also essential to **avoid terminological imperialism**
 - In any given country, what matters is the terminology that they are comfortable with and understand
 - WHO’s job is to ensure that, regardless of what words are used, the approach to financing reform is comprehensive and oriented to the objectives associated with universal coverage



WHO's position

- WHO is committed to help countries sustain progress towards Universal Coverage
- WHO is NOT committed to any particular model
 - We care about access, quality and financial protection, not the label (Germans are not more “insured” than the British)
- WHO does NOT believe in magic
 - Slogans or isolated instruments do not work
 - “just free care” or “just SHI” or just “results-based payment” unlikely to work: the pieces need to be coordinated
 - Requires a comprehensive approach to address a complex, ever-changing set of challenges
- While the goals of universal coverage are broadly shared, each country's context and starting point differs; thus, the path to universal coverage must be “home grown”
 - But some approaches are clearly not consistent with UHC, and we will make clear our views, as needed, in the policy dialog process