Access and Coverage

Managing and Researching Health Care Systems

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WHO building blocks

THE WHO HEALTH SYSTEM FRAMEWORK

SYSTEM BUILDING BLOCKS

SERVICE DELIVERY 23 Nov
HEALTH WORKFORCE 24 Nov
INFORMATION 22 Nov (seminar)
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES 24 Nov
FINANCING 21 to 23 Nov
LEADERSHIP / GOVERNANCE 23 Nov

OVERALL GOALS / OUTCOMES

ACCESS 27 Nov
COVERAGE 27 Nov
IMPROVED HEALTH (LEVEL AND EQUITY) 29 Nov
RESPONSIVENESS 30 Nov
SOCIAL AND FINANCIAL RISK PROTECTION 28 Nov
IMPROVED EFFICIENCY 30 Nov

Week 8

ACCESS

COVERAGE

QUALITY

SAFETY

WHO 2007
# Outline of the course - Week 1

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<td>20.11.2017 15-17 Uhr</td>
<td>Wilm Quentin and Daniel Opoku</td>
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<td>Introduction and frameworks</td>
<td>21.11.2017 09-12 Uhr</td>
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<td>13.30-17 Uhr</td>
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<td><strong>Presentation by GIZ on health system</strong> related German development cooperation</td>
<td>10.30-12 Uhr</td>
<td>Ursula Bürger, Fachplanerin Kompetenz-Center Gesundheit und Soziale Sicherung, GIZ</td>
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The goal of universal health coverage is that all people obtain the good-quality essential health services, including promotion, prevention, treatment, rehabilitation, and palliation, that they need without enduring financial hardship.

It involves coverage with good health services (scope) as well as coverage with a form of financial risk protection (depth). A third feature is universality – coverage should be for everyone (breadth).

Definition of access

**Access** is the opportunity or ability to obtain the health services needed and to benefit from financial risk protection.

Three dimensions of access:

1. **Financial affordability** (people’s ability to pay for services without financial hardship, taking into account not only the price of the health services but also indirect and opportunity costs. Affordability is influenced by the wider health financing system and by household income)

2. **Physical accessibility** (availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects)

3. **Acceptability** (captures people’s willingness to seek services; is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services)
Coverage as access steps 1 to 3 (vs. unmet need)

**Need (by socio-economic status, ethnicity/migration status etc.)**

- Coverage (financial issues)
- Availability of care
- Waiting, acceptability etc.

Coverage as access steps 1 to 3 (vs. unmet need)

Unmet need

Realised access

Unmet need

x Quality = Outcomes
10 years ago: how to visualize coverage?

Figure 2. The Three Dimensions of Coverage Decisions

1. Population coverage (breadth)

2. Service coverage (depth)

3. Cost coverage (height)
The first Coverage Cube was born ...

Fig. 2: The three dimensions of decisions about the financing of services

Source: Expanded from Busse, Schreyögg and Gericke 2007
... picked up by WHO only a year later ...
... and again in 2010 ...

Fig. 1. Three dimensions to consider when moving towards universal coverage

Source: Adapted from (9, 10).
... copied and modified elsewhere

Fig. 2. Variation in coverage dimensions across the three insurance programs.
There is growing interest in UHC
% population covered by PHI, 2011

Note: Private health insurance can be both complementary and supplementary in Denmark, Korea and New Zealand; and duplicate, complementary and supplementary in Israel.
Global health expenditure in 2000 …

Private (16% VHI, 23% OOP)

56% Public (23% tax, 33% SHI)

600 $PPP
7.7% of GDP

… and in 2012

Private (15% VHI, 22% OOP)

58% Public (23% tax, 34% SHI)

1170 $PPP
8.6% of GDP

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**Low-income country** health expenditure in 2000 ...

Private (1% VHI, 53% OOP)

32 $PPP
2.9% of GDP

38% Public (37% tax, 1% SHI)

... and in 2012

Private (1% VHI, 47% OOP)

83 $PPP
5.1% of GDP

39% Public (38% tax, 1% SHI)

Access and coverage
A Summary of the Findings of the Commission on Macroeconomics and Health

Current levels of investment by developing countries are far less than needed to address the health challenges they face and to scale up health interventions and essential services. The Commission envisages that low-income countries would aim to use their resources more efficiently and increase budgetary spending on health by an additional 1% of GNP by 2007 and 2% by 2015.

By 2012, budgetary spending on health had increased by 1% of GDP (39% of +2.2% of GDP)
Lower middle income country health expenditure in 2000 ...

Private (2% VHI, 59% OOP)

108 $PPP
3.9% of GDP

34% Public (29% tax, 5% SHI)

... and in 2012

Private (2% VHI, 55% OOP)

36% Public (31% tax, 5% SHI)

235 $PPP
4.1% of GDP

108 $PPP
3.9% of GDP

19
Ghana health expenditure in 2000 ...

- Private: 6% VHI, 32% OOP
  - 82 $PPP, 3.0% of GDP

- Public: 50% (50% tax, 0% SHI)

... and in 2012

- Private: 2% VHI, 29% OOP
  - 68% Public (53% tax, 15% SHI)

- Public: 68% (53% tax, 15% SHI)
  - 195 $PPP, 5.2% of GDP

Ghana health expenditure in 2000 ...

- Private: 6% VHI, 32% OOP
  - 82 $PPP, 3.0% of GDP

- Public: 50% (50% tax, 0% SHI)

... and in 2012

- Private: 2% VHI, 29% OOP
  - 68% Public (53% tax, 15% SHI)

- Public: 68% (53% tax, 15% SHI)
  - 195 $PPP, 5.2% of GDP
Upper middle income country health expenditure in 2000...

Private (8% VHI, 43% OOP)

263 $PPP
5.3% of GDP

47% Public
(27% tax, 19% SHI)

... and in 2012

Private (7% VHI, 32% OOP)

56% Public
(29% tax, 27% SHI)

766 $PPP
6.0% of GDP

Access and coverage

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High income country expenditure in 2000 …

- Private (16% VHI, 19% OOP)
  - 2390 $PPP
  - 9.6% of GDP

- 60% Public
  - (22% tax, 38% SHI)

... and in 2012

- Private (15% VHI, 19% OOP)
  - 4520 $PPP
  - 11.6% of GDP

- 61% Public
  - (21% tax, 40% SHI)

Access and coverage

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coverage (financial issues)

1ST DIMENSION
Population coverage (WHO?)

- Is the whole population covered to have access to health care?  → “universal health coverage”
- If yes, how is this regulated (e.g. through constitution, law)? Does this include foreigners, tourists, illegal immigrants etc.?
- Is it actually achieved or are there practical hurdles preventing parts of the population from accessing health care even though they are entitled to (e.g. because it is necessary to apply for a health insurance card)?
- What criteria constitute the basis of entitlement, e.g. residence, nationality, membership in insurance scheme, residence in specific geographical areas, insurance contributions, etc.?
• Is membership of an insurance scheme compulsory? If yes, for whom and on what criteria (e.g. occupation, residence)? Are there any excluded groups, if so, what are they (e.g. unemployed, indigent)?

• Are non-wage-earning portions of the population (poor, unemployed, elderly, etc.) covered as well – and how is this achieved (e.g. membership as dependents of contributing members, tax-financed contributions, free membership)?

• Are there any groups or conditions in which some groups or individuals can join voluntarily (“opting-in”) or leave the statutory system in favour of private arrangements (“opting out”)?

• Are there any conditions (e.g. income limits, status as self-employed) under which groups or individuals are not permitted to join the health insurance scheme(s)?
Population coverage in high-income countries without universal coverage in 1975
Does it make a difference? Importance shown usually by U.S. data; here: access problems in 2012 for U.S. adults

- Experienced cost-related access problem: 63% uninsured, 27% insured all year
- Serious problems/unable to pay medical bills: 42% uninsured, 15% insured all year
- Spent $1,000 or more out-of-pocket: 39% uninsured, 42% insured all year

Source: 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries.
Who is (not) covered?

INTERREGIONAL CONSULTATION
ON
HEALTH INSURANCE REFORM

Seoul, Republic of Korea
3-7 April 1995

In countries with less than universal coverage, such as Indonesia, Thailand, Viet Nam, Morocco and Egypt, participants observed that those that are insured are those who tend to be better-off economically than those who are not covered. The insured include typically the civil servants and employees in private or state enterprises. Usually excluded in the early phases of health insurance development are the farmers and other self-employed in the rural areas, whose incomes are likely to be lower on average, although in the case of Thailand and Indonesia, coverage of these groups had expanded through community-based schemes.
Trickle-Down and Bottom-Up Expansion of Health Care

“Coverage” by access to tax-financed provision
Putting this pre-UHC into the cube ...
Looking at a few examples

- Thailand without a missing middle (but rich partly excluded)
- Vietnam as an example of missing middle
- Ghana as an example of an immature pro-rich system

Population coverage in low and middle-income countries – an example

Inequalities in reproductive, maternal, newborn and child health interventions, combined

This story will guide you through eight interactive dashboards. Begin by exploring the latest situation of inequality and then view change over time.

http://www.who.int/gho/health_equity/en/
Countries with better averages have (relatively) small inequities between income groups ...
Access and coverage

... while countries with worse averages have large inequities between income groups!

Worst performers (by average)

http://www.who.int/gho/health_equity/en/
Differences for poor across countries are larger than for rich!

http://www.who.int/gho/health_equity/en/
coverage (financial issues)

2ND DIMENSION
The benefit basket also matters: e.g. dental care

Skipped Dental Care Because of Cost in Past Year

- Covered in basic package
- Complementary coverage high
- Not covered

Own elaboration based on data from 2016 Commonwealth Fund International Health Policy Survey in Eleven Countries.

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Entitlements and benefits (WHAT?)

Most health care systems have some form of a uniform/standard/minimum package of benefits to which the persons covered are entitled. This can be explicit, i.e. a list states all the benefits available under the statutory system (or separate lists exist for various sectors). In many other countries, it is implicit, i.e. based on traditions and routine.

• If an explicitly package exists, which types of benefits are included (esp. around the edges, e.g. physiotherapy, psychotherapy, dental care, rehabilitation)?

• How is it established? Who is involved in the decision-making process (e.g. government, parliament, delegation/devolution to local and/or self-regulating actors)?

• Are the decisions made in form of an “old boys agreement” or based on explicit criteria and/or following health technology assessments?
What is included in “the” benefit package? A model

“All” possible health benefits

Covered benefit categories
e.g. “inpatient curative care” (HC 1.1), “pre-natal care” (HC 6.1)

Actually covered benefits
e.g. cervical cancer screening with Papanicolau Test; toxoplasma serology in the first trimester
"All" possible health benefits

Covered benefit categories

Actual benefits

Representative institutions, e.g. Parliaments (Law)

Planning Bodies Coverage Commissions using HTA

Third-party Payers

Advisory bodies

(Social) Courts

Criteria
Criteria for decision making on health baskets (I)
Considerations for 1st (legal) level

• How comprehensive should the basket be (e.g. because complementary insurance is politically desired)?
• For the core/standard basket: What is determined to be “medically necessary” in the country? Approach can be by benefit categories and/or by indication (e.g. infertility)
• Should these services/goods be in the benefit basket for the (competitively) organized insurance system (more appropriate for individual services)? Or in parallel baskets (services for which competition is not desired; population-based services etc.)?
• What are the criteria to be applied for deciding upon the “actually covered benefits”?
Criteria for decision making on health baskets (II)

*Dunning-Committee 1991:*
1. need/necessity,
2. effectiveness,
3. cost-effectiveness,
4. can be left to individuals
## Conceptualization of “need” in Sweden

<table>
<thead>
<tr>
<th>Priority group</th>
<th>Description of care needed</th>
</tr>
</thead>
</table>
| 1              | • Care of life-threatening acute diseases and diseases which, without treatment, will lead to a longer disability or premature death.  
• Care of serious chronic diseases.  
• Palliative care in the final phase of life.  
• Care of people with reduced autonomy. |
| 2              | • Prevention with a documented benefit.  
• Rehabilitation etc. according to the definition of the Health Care Act. |
| 3              | Care of less serious acute and chronic diseases. |
| 4              | Care for reasons other than disease or injury. |

Source: Hjortsberg and Ghatnekar (2001)
Further considerations ...

**benefit basket as one piece in mosaic**

- **Technology** (drug, intervention ...)
  - Legal criteria “service category covered” and “need/ necessity” (is this technology intended for use for a condition covered by the public system/ UHI?)
  - HTA assessing safety, effectiveness/ patient benefit, cost-effectiveness
  - If evidence insufficient: “Coverage for evidence development”

  **Technology in benefit basket**

  - Exclusions or limitations (certain patients, certain providers etc.) based on evidence for subgroups (equity concerns?)
  - Steering of usage, e.g. guidelines, cost-sharing, to ensure appropriateness

  - Number of services x payment (costs/ patient) = expenditure (budget impact)

  - Possibly adjustment for quality

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Access and coverage
## Benefit packages in UNICO countries

### Explicit Benefit Packages in UNICO countries, 2011–12

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<th>Country and program</th>
<th>Description</th>
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<tr>
<td>Argentina—Plan Nacer</td>
<td>Positive list: Combines health conditions, clinical procedures, and other broad categories.</td>
</tr>
<tr>
<td>Brazil—Primary Health Care Extension Strategy (PHCES)</td>
<td>Positive list: Health conditions and clinical procedures, ICD-10 codes not used.</td>
</tr>
<tr>
<td>Chile—AUGE</td>
<td>Positive list of prioritized health problems, further detailed as a set of guaranteed services with their protocols.</td>
</tr>
<tr>
<td>Costa Rica—CCSS</td>
<td>Not explicit: Only broad categories. However, for pharmaceuticals, negative list exists.</td>
</tr>
<tr>
<td>Georgia—MIP</td>
<td>Positive and negative lists: Broad categories of services included, and also some explicit exclusions.</td>
</tr>
<tr>
<td>Ghana—NHIS</td>
<td>Negative list: Comprehensive benefit package with an exclusion list.</td>
</tr>
<tr>
<td>Guatemala—PEC</td>
<td>Positive list: Health conditions (and population groups).</td>
</tr>
<tr>
<td>India—NRHM, RA, and RSBY</td>
<td>Not explicit in NRHM, positive list in RA and positive and negative lists in RSBY. ICD-10 codes are not used.</td>
</tr>
</tbody>
</table>
3RD DIMENSION ➔ SEE FINANCIAL PROTECTION (NOV 28)
Urban-rural discrepancies are very great between countries – with definite scope to learn from another.

5.10. Physician density, rural vs urban areas, 2015 (or nearest year)

5.9. Physician density, by level 2 regions, 2015 (or nearest year)

Waiting (here: >4 weeks for a specialist appointment) is a general problem, but some countries see improvements and others not.
REALISED ACCESS & UNMET NEED
Realised access: Inequity of physician visits by income (and equal need); in many countries visible – and a real problem in certain ones with poor seeing GPs and rich seeing specialists.
5.6. Unmet care needs due to cost, by income level, 2016

Note: Either did not consult with/visit a doctor because of the cost, skipped a medical test, treatment, or follow-up that was recommended by a doctor because of the cost, did not fill/collection a prescription for medicine, or skipped doses of medicine because of the cost. “Low income” is defined as household income less than 50% of the country median. Sample sizes are small (n < 100) in the Netherlands and the United Kingdom.

Source: Commonwealth Fund International Health Policy Survey 2016.
Unmet need in EU-27
(for costs, distance, waiting), 2008-2014

Own elaboration, data: EU-SILC, 2015
Compare Latvia & Estonia: almost same average but very different in equity terms.

Unmet need in EU-27 by income quintiles (for costs, distance, waiting), 2014

Own elaboration, data: EU-SILC, 2015
Inequalities in unmet need due to income > age > employment > education > gender

3.12.3. Inequalities in unmet need for a medical examination, EU27 average, 2010

Eurostat Statistics Database, based on EU-SILC.

Unmet need