Technische Universität Berlin

Health financing in high income countries: lessons for countries in transition

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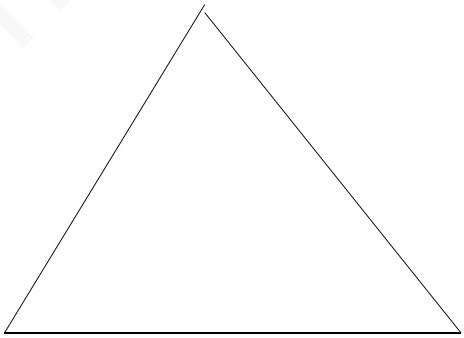
(WHO Collaborating Centre for Health Systems Research and Management)
&
European Observatory on Health Systems and Policies

European Observatory on Health Systems and Policies

Third-party Payer



Population **Providers**

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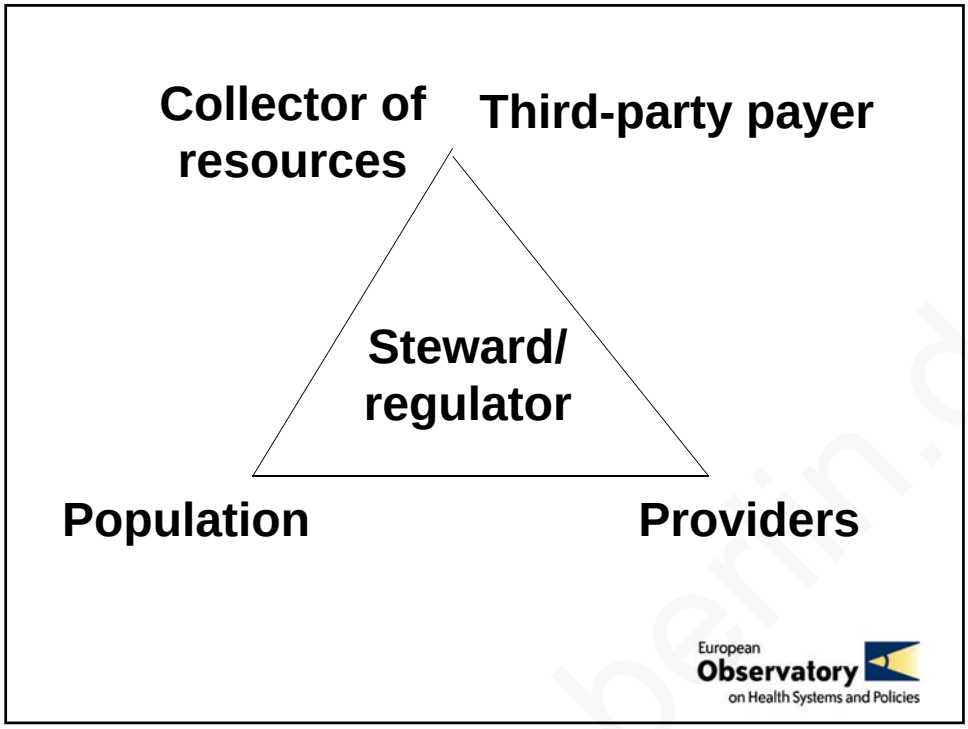
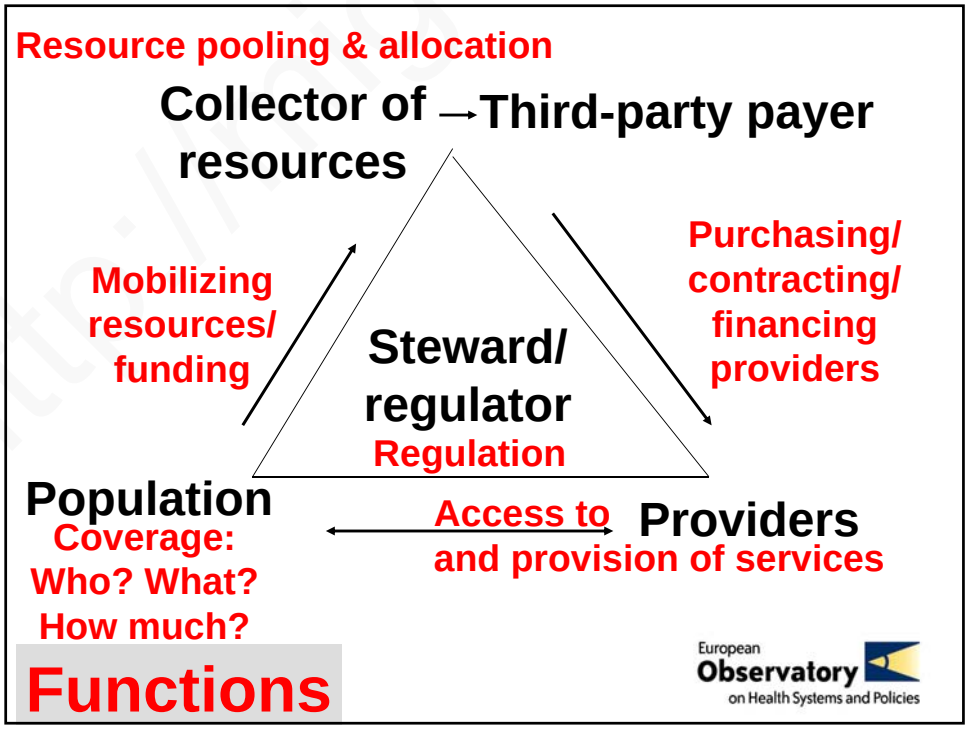
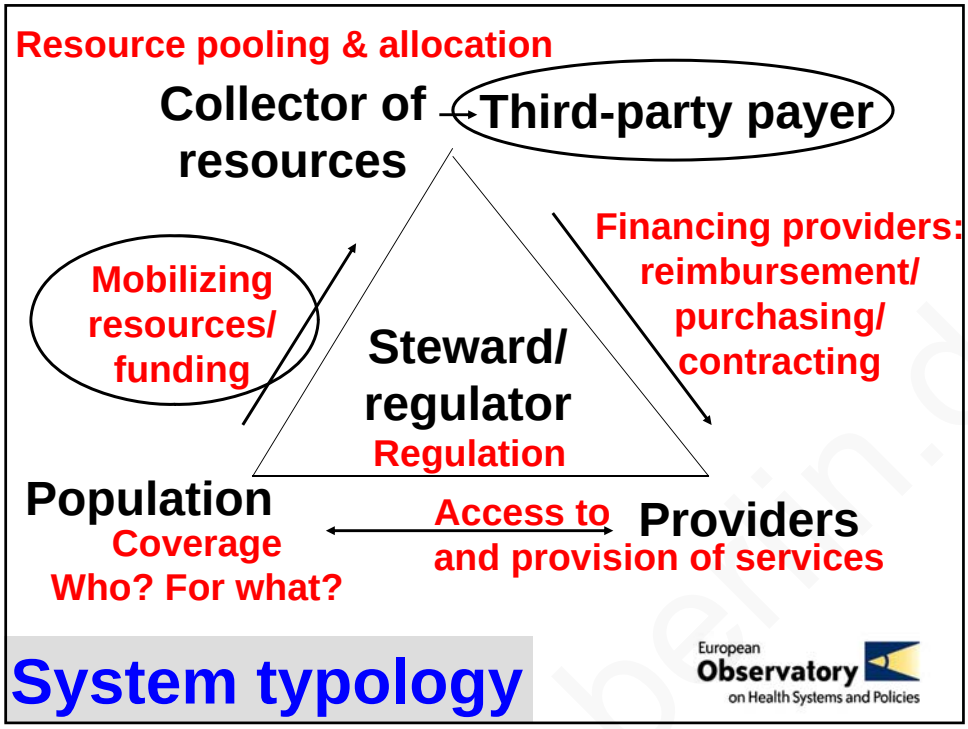
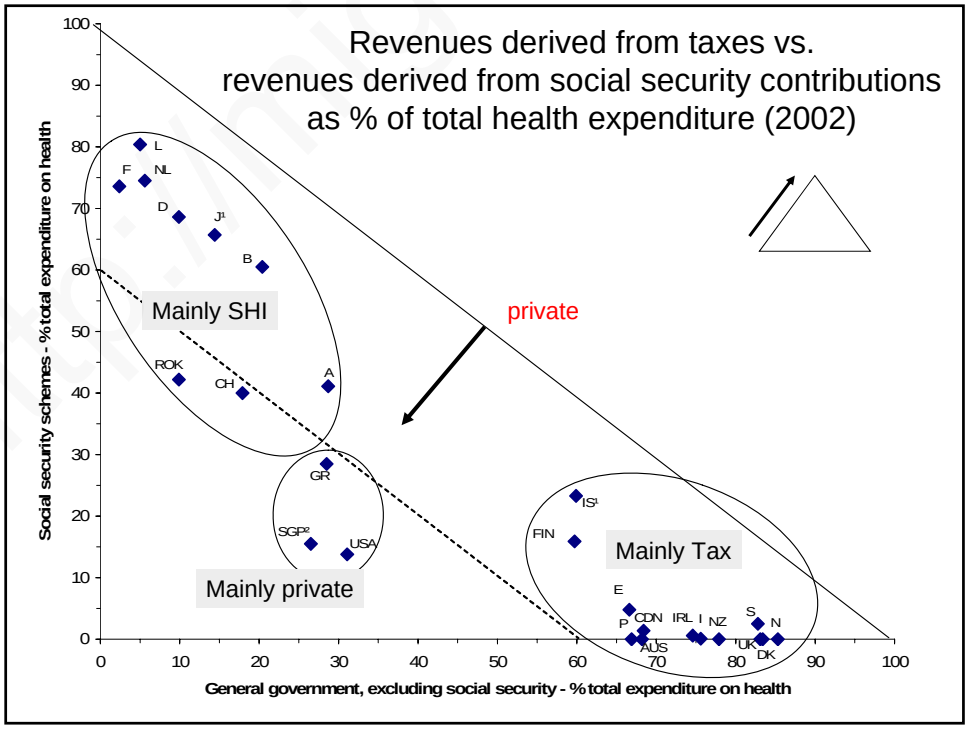





Resource pooling & allocation
Collector of resources
Third-party payer
Mobilizing resources/ funding
Steward/ regulator
Regulation
Financing providers: reimbursement/ purchasing/ contracting
Population
Coverage
Who? For what?
Access to and provision of services
Providers
System typology
European Observatory on Health Systems and Policies


Revenues derived from taxes vs.
revenues derived from social security contributions
as % of total health expenditure (2002)
Social security schemes - % total expenditure on health
General government, excluding social security - % total expenditure on health
Mainly SHI
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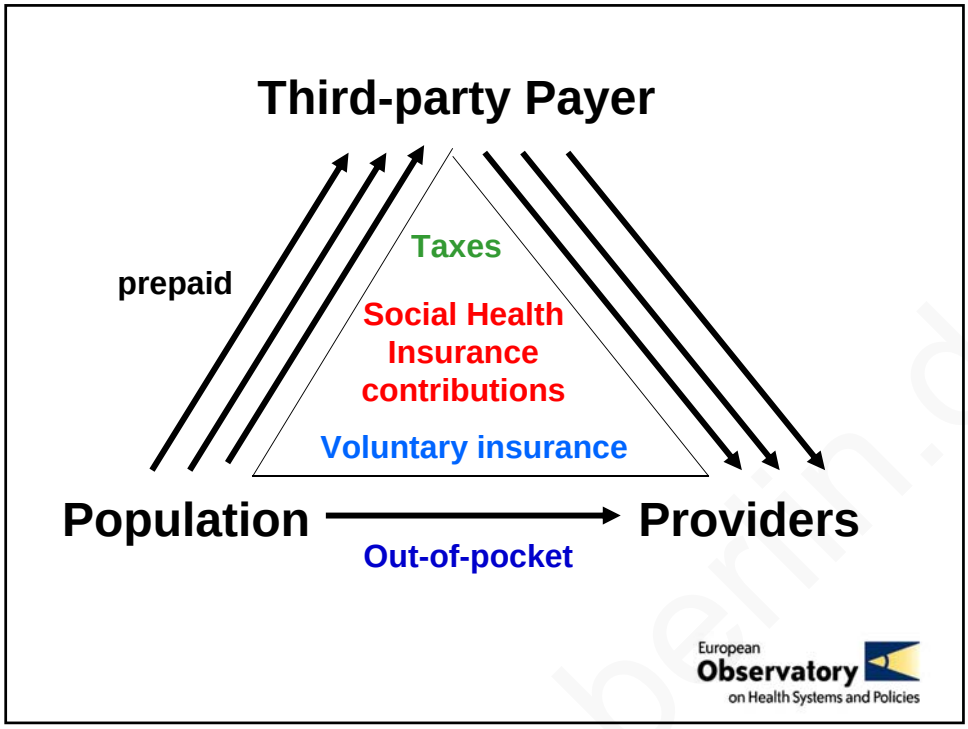
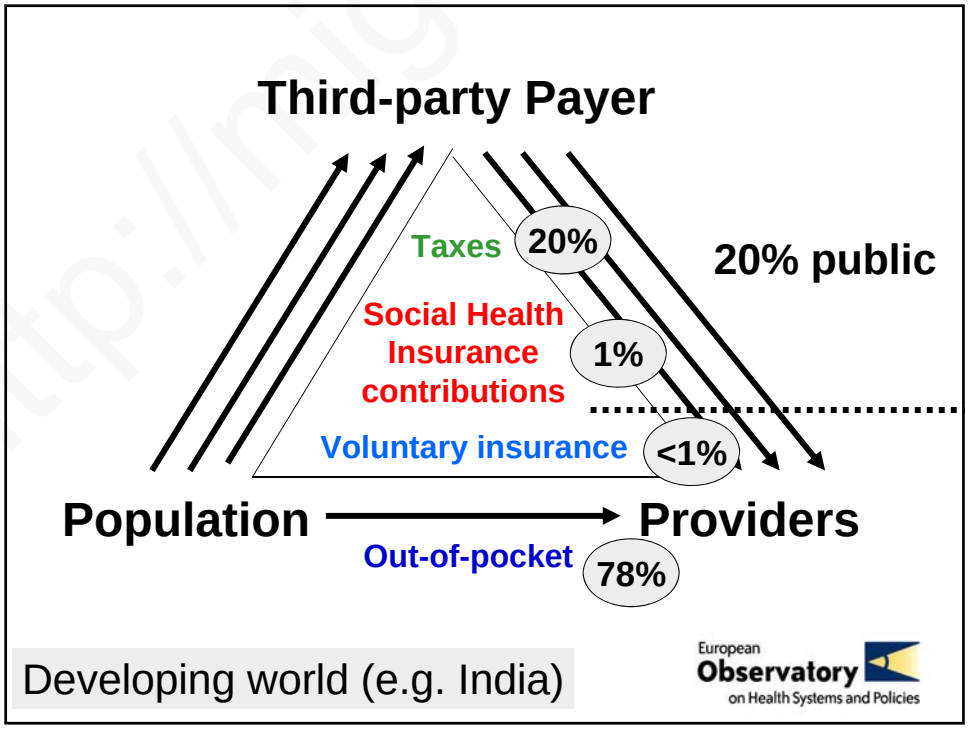
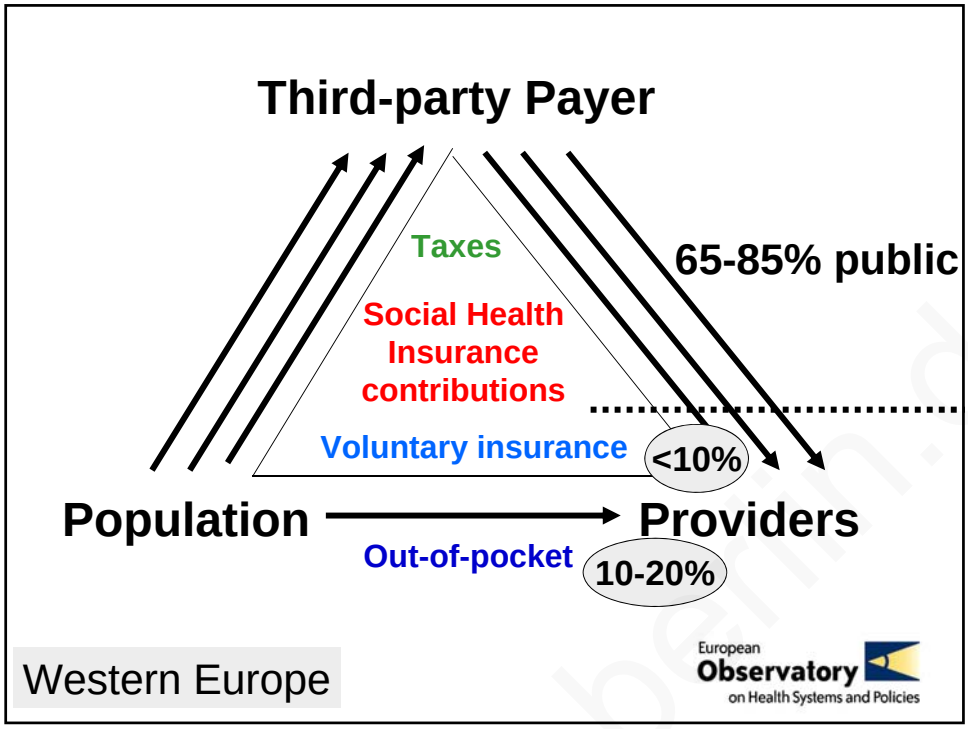
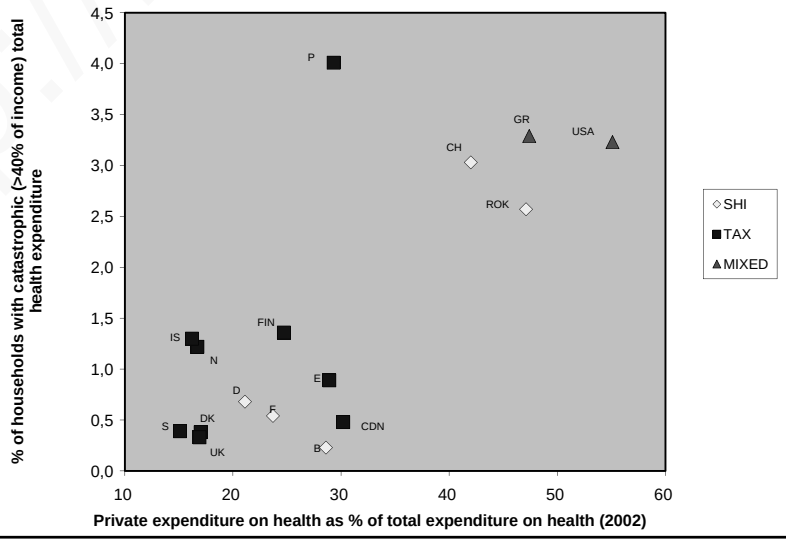


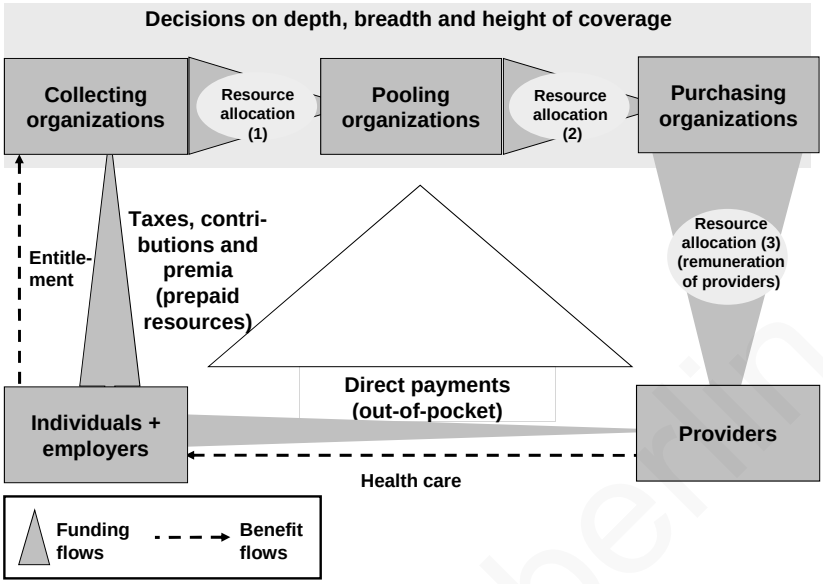




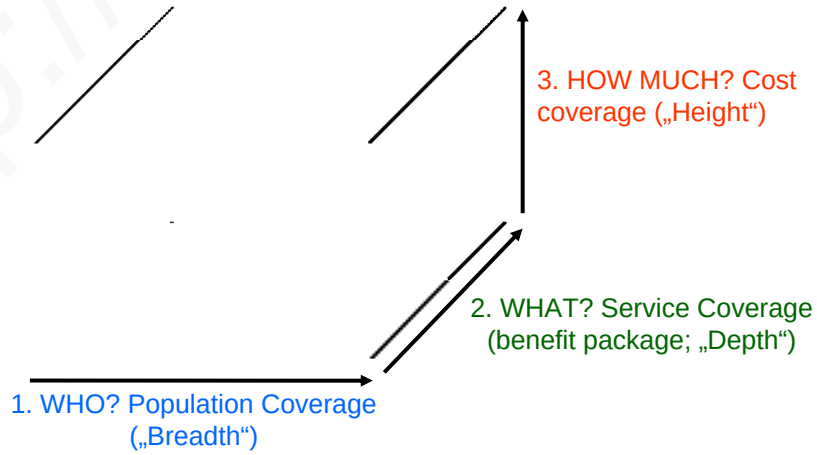
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure

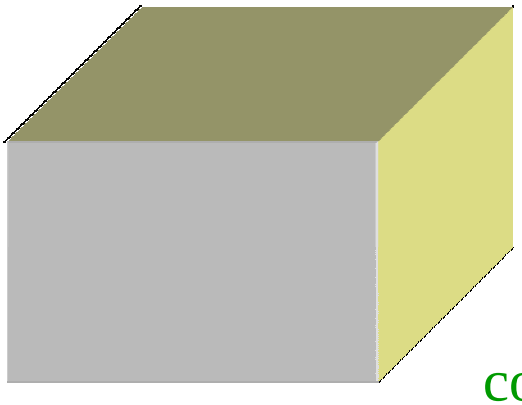


Conceptual Framework for analysing health financing systems

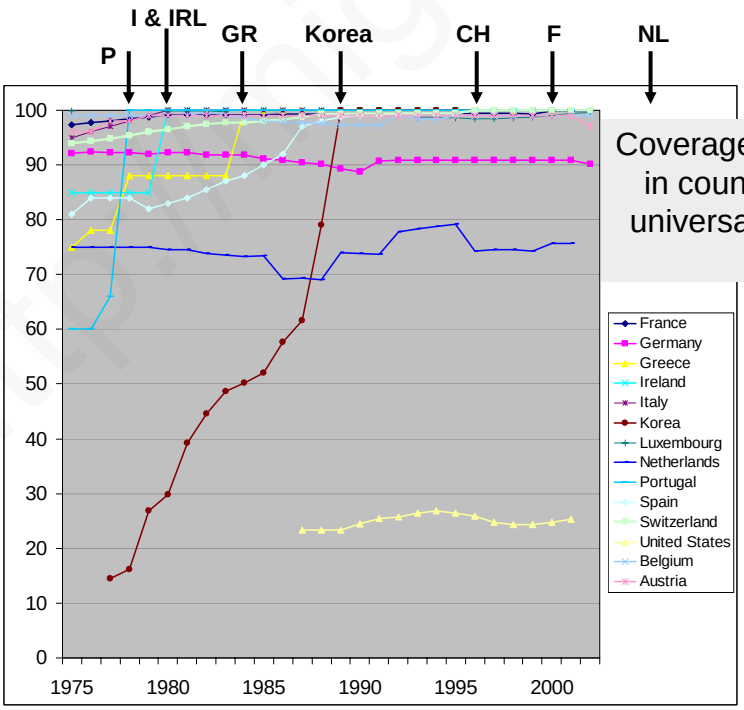


The three dimensions of coverage decisions





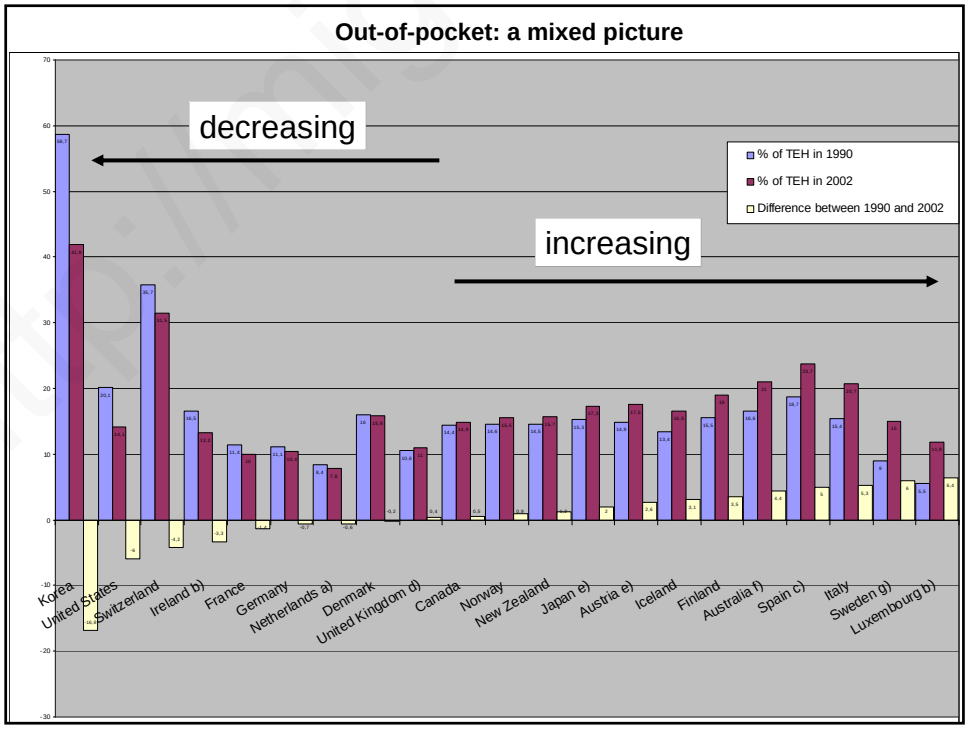
NHS-principles: „Universal, comprehensive, free at the point of service“



Coverage of population in countries without universal coverage in 1975

Covered benefits (benefit package)

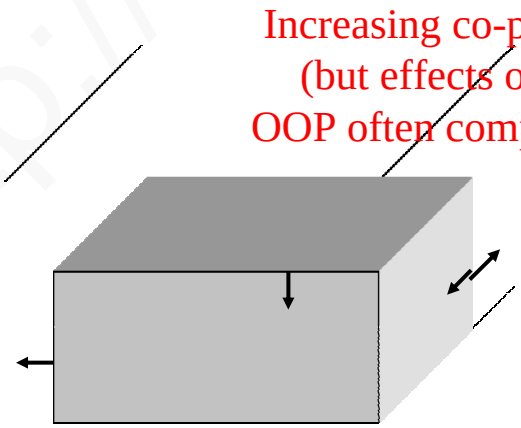
- implicit expansion (new technologies)
- explicit expansion (long-term care in Austria, Germany, Japan …; dental care in Spanish regions …; ambulatory services in Singapore)
- (attempts to) limitations due to exclusion of service categories (dental care, cosmetic surgery …) and, more importantly, introduction of Health Technology Assessment



Reduced rates or exemptions commonly relate to one or more of the following:

- clinical condition – diabetics in Sweden, pregnant women in the United Kingdom and people with specified chronic illnesses in Ireland, Finland, Spain and the United Kingdom (Thomson et al. 2003).
- level of income – all those with low incomes in Austria, Belgium, Germany, Ireland and the United Kingdom and older people with low income in Greece
- age – older people in Belgium, Ireland, Korea, Japan, Spain and the United Kingdom and children and adolescents in many countries, e.g. in Germany, Japan and the United Kingdom
- type of drug – drugs for chronic illnesses in Portugal, drugs for life-threatening illnesses in Belgium, both types of drug in Greece and effective drugs in France

Reform trends

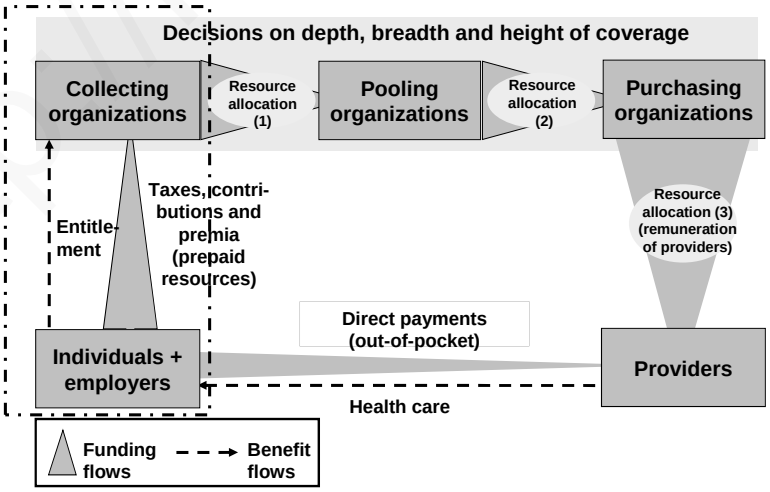


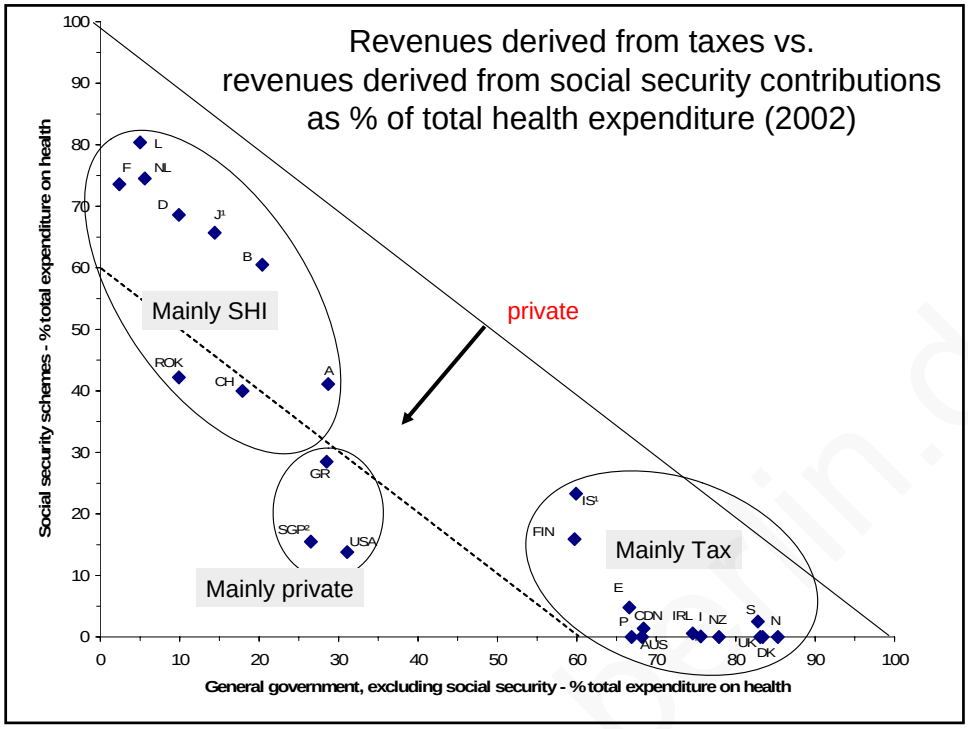
With respect to “the extent” benefits are covered (benefit coverage)

- Not all benefits are covered at 100% by public schemes
- Three different forms of cost-sharing are most commonly used

Form	Definition
Co-payment	User pays a fixed fee (flat rate) per item or service
Co-insurance	User pays a fixed proportion of the total cost, with the insurer paying the remaining proportion
Deductible	User bears a fixed quantity of the costs, with any excess borne by the insurer; deductibles can apply to specific cases or a period of time

Collection of resources

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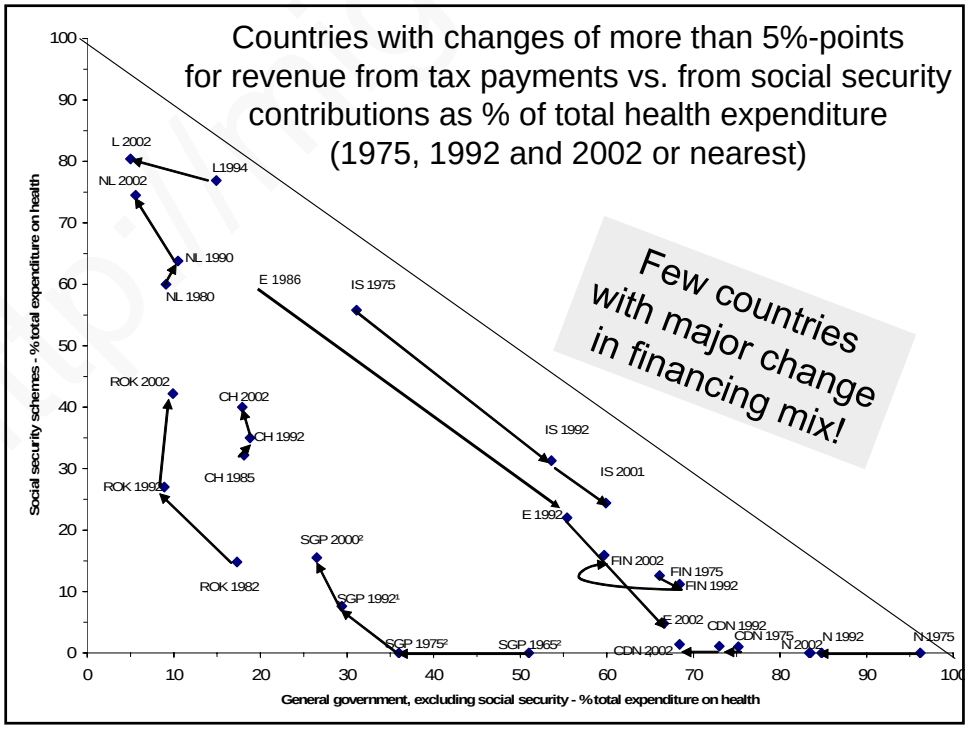
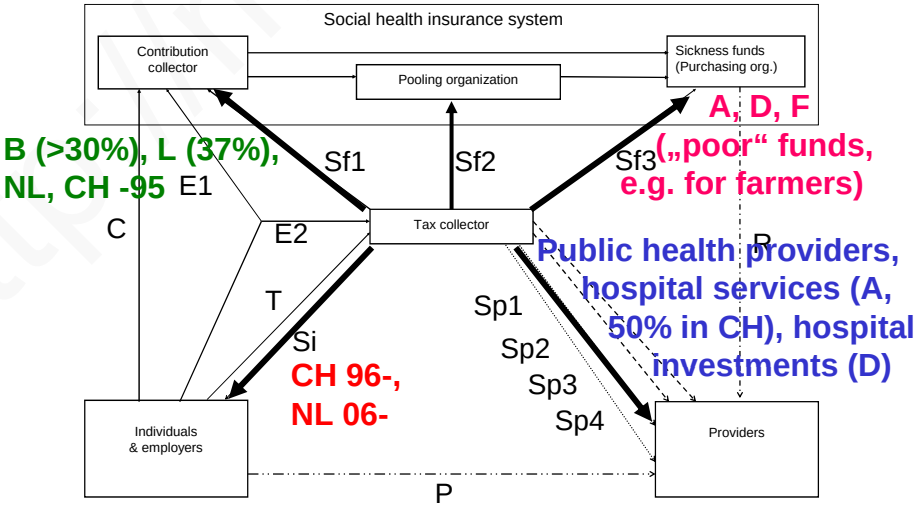

Countries with changes of more than 5%-points
for revenue from tax payments vs. from social security
contributions as % of total health expenditure
(1975, 1992 and 2002 or nearest)
Few countries
with major change
in financing mix!
Social security schemes - % total expenditure on health
General government, excluding social security - % total expenditure on health
L 2002
L1994
NL 2002
NL 1990
NL 1980
E 1986
IS 1975
ROK 2002
CH 2002
CH 1992
CH 1985
ROK 1992
ROK 1982
IS 1992
IS 2001
E 1992
SGP 2000²
FIN 2002
FIN 1975
FIN 1992
SGP 1992¹
E 2002
CDN 1992
CDN 1975
N 2002
N 1992
N 1975
SGP 1975²
SGP 1965²
CDN 2002

The case of Spain: shift from SHI- to tax-financed system

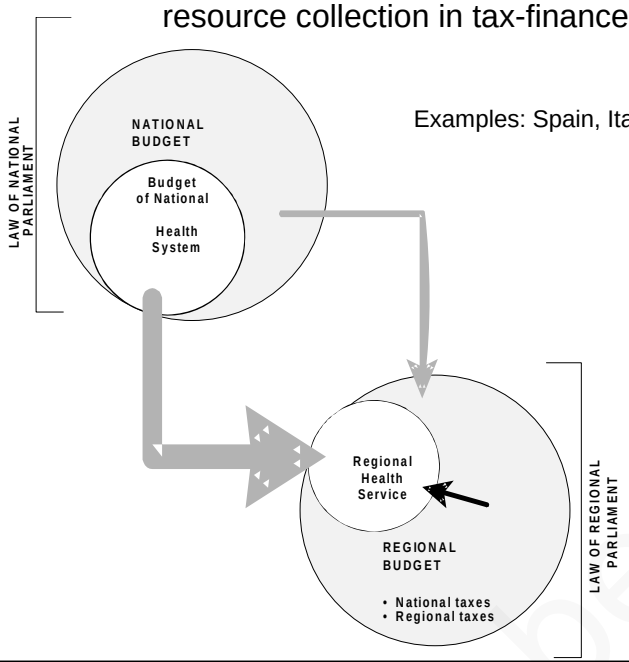
- Spain also mainly relied on social health insurance contributions
- In the mid-1970s, 2/3 SHI contributions and 1/3 taxes of total health care expenditure
- In 1986 with the introduction of a National Health Service a major shift towards tax funding was initiated
- By 1989, the previous pattern was reversed for the first time, 70% taxes and 30% SHI contributions

-> Main reason for change: perceived higher progressivity of tax-financing mechanism (although SHI-system could have achieved the same progressivity)

SHI countries: role of taxes increasing, but target varies



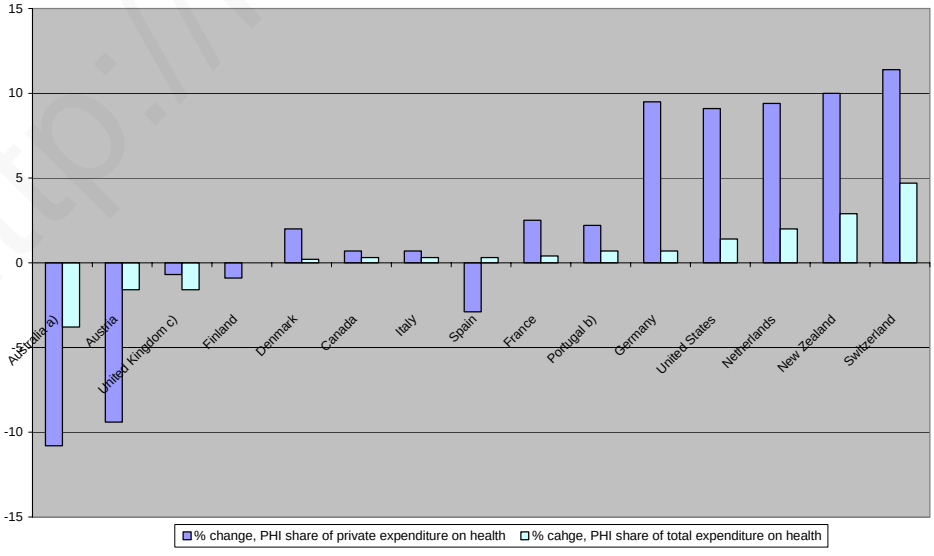
Decentralization of responsibilities for resource collection in tax-financed systems



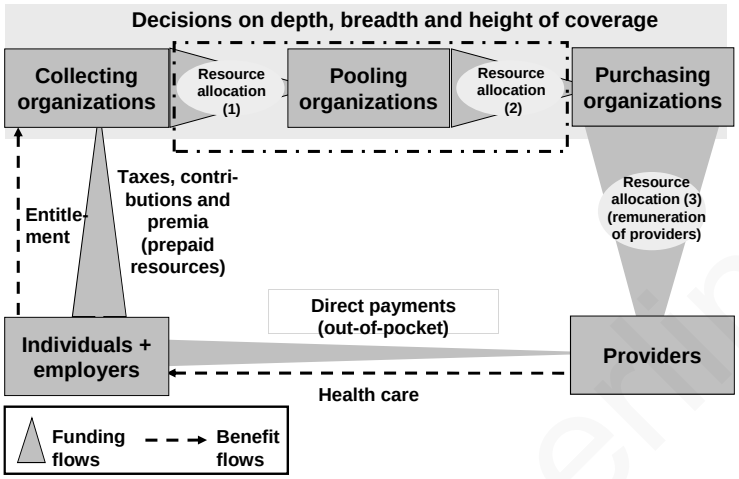
Examples: Spain, Italy, Sweden

No clear trend for private/ voluntary health insurance:

Change of PHI as % of THE and PHE between 1990 and 2002



Pooling of resources



Allocation of resources from collecting to pooling organizations (tax financed systems)

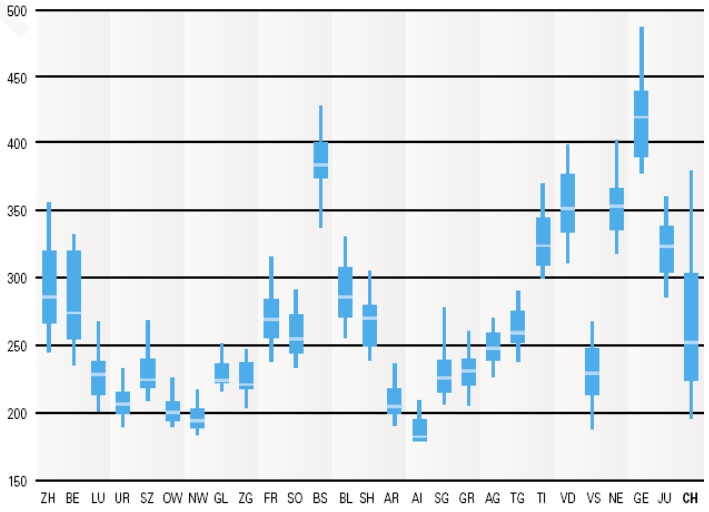
- Pooling and purchasing organizations often the same institution, but sometimes pooling organization = ministry of health e.g. in England, Ireland, Italy and New Zealand
- Allocation between these two bodies is in most cases rather a matter of political agenda setting than of objectively defined allocation
- <u>But:</u> New Zealand has implemented an allocation formula which takes into account the most important pressures on health expenditure
  - projected population changes (in size and age structure with yearly automatic adjustment)
  - predicted price increases (estimated each year)
  - the net effect of technological changes and efficiency gains (estimated each year)
- Trend towards decentralised pooling organizations e.g. Sweden

Allocation of resources from collecting to pooling organizations (SHI systems)

- Trend towards centralisation of pooling organizations (Germany, the Netherlands, Belgium and Switzerland)
- mostly independent organizations on the federal level as the Federal Insurance Office in Germany or the Health Care Insurance Board in the Netherlands
- Unique case: Switzerland, pooling only on regional (Kanton) level
- In Austria, Korea, and Japan sickness funds have double-function of collecting and pooling, thus making reallocation between different organizations unnecessary
- Belgium, France and the Netherlands have two separate central bodies, one responsible for collecting and one responsible for pooling
- Luxemburg has a central pooling organization (Association of Sickness Funds) which is also acting as collecting organization
- Reallocation only necessary in Germany, the Netherlands and Switzerlands (funds collect, independent association is pooling)

Incomplete pooling – the case of Switzerland: Premia in 2005 by canton (in CHF/ month)

Grafik 3e: Verteilung der kantonalen monatlichen Durchschnittsprämien für Erwachsene (26 Jahre und mehr) in Franken für 2005 (mit ordentlicher Franchise und Unfalldeckung)



Allocation of resources from pooling to purchasing organizations

Allocation mechanisms

- Retrospective allocation (e.g. in Belgium, Luxembourg and the Netherlands before reforms in 1990s)
- Prospective allocation
  - historical precedent (e.g. in *Portugal 84.5% of resources allocated to Regional Health Administrations are based on historical precedent/ subsidies to in Farmers' funds in Germany and Austria*)
  - political negotiations (*e.g. Greece uses a combination of historical precedent and political negotiations for the allocation to the regions*)
  - independent criteria (risk adjusters) of health care needs (capitation: price paid by the pooling organizations for each individual covered by purchasing organizations with the necessary health services)

Allocation of resources from pooling to purchasing organizations

Capitation methods

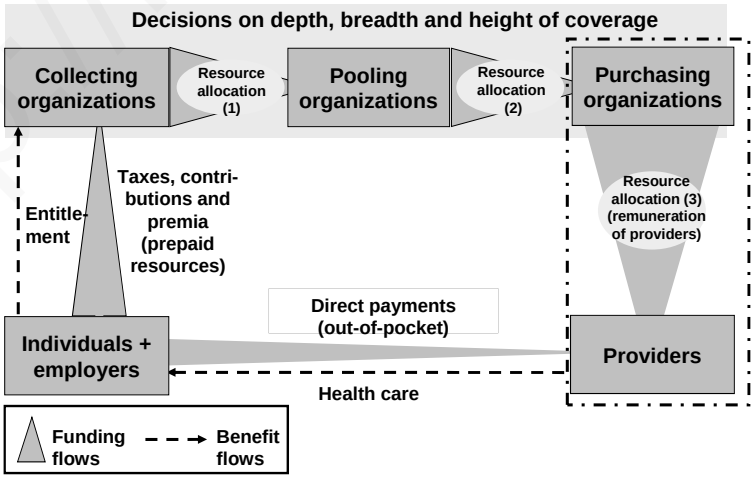
- Matrix approach
  - based on individual-level data
  - E.g. individual utilization of drugs
  - enables higher predictive value for the actual health expenditure
  - Problem: data is often not available
- Index approach
  - based on aggregate data
  - E.g. urbanisation of regions
  - Most commonly used

Risk adjusters in the capitation formulas for resource allocation (social health insurance systems)

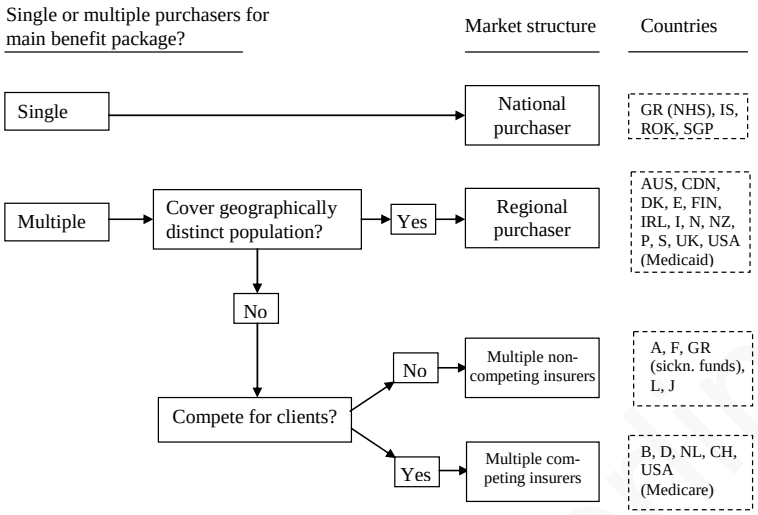
Country	Year of implementation	Risk-adjusters
Austria	None	
Belgium	1995 2006	-Age, sex, social insurance status, employment status, mortality, urbanization, income -Age, sex, social insurance status, employment status, mortality urbanization, income, diagnostic and pharmaceutical cost groups
France	None	
Germany	1994/1995 2002	-Age, sex, disability pension status -Age, sex, disability pension status, participation in disease management program
Japan	None	
Korea	None	
Luxembourg	None	
Netherlands	1993 1996 1999 2002	-Age, sex -Age, sex, region, disability status -Age, sex, social security/ employment status, region of residence -Age, sex, social security/ employment status, region of residence, diagnostic and pharmaceutical cost groups
Switzerland (within canton)	1994	-Age, sex

Sources: adapted from Busse et al. (2004) and updated with data from Risk Adjustment Network (HAN)

Purchasing (and remuneration of providers)



Different market structures for purchasing organizations



Source: adapted from Kutzin (2001)

Number of sickness funds from 1990-2002

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Change 1990-2002
Austria	26	26	26	26	26	26	26	26	26	26	26	25	24	-7.7%
Belgium	119	127	127	121	121	114	116	111	109	107	103	95	94	-21.0%
France	18	17	17	17	17	17	17	17	17	17	17	17	17	-5.6%
Germany[1]	-	1209	1223	1221	1152	960	642	554	482	455	420	396	355	-70.6%
Japan	5247	5247	5244	5243	5236	5233	5235	5230	5229	5210	5192	5159	5124	-2.3%
Korea	409	n.a.	n.a.	n.a.	n.a.	384	n.a.	373	143	141	1	1	1	-99.8%
Luxembourg	9	9	9	9	9	9	9	9	9	9	9	9	9	0%
Netherlands	37	31	27	26	26	27	29	30	28	28	27	25	24	-35.1%
Switzerland	220	203	191	207	178	166	145	129	118	109	101	99	93	-57.7%

The role of the purchaser

- 1970s and even the 1980s role of the purchaser was traditionally limited to a passive financial intermediary
- 1980s several countries tried to integrate market mechanisms in order to increase quality and efficiency of the provided services
- During the 1990s purchasing organizations increasingly gained more autonomy in management and planning
- Active purchasing can allow contracting as well as care management of purchasing organizations (not necessarily managed care in a narrow sense) e.g. purchasing disease management programs

Tentative lessons for low- and middle-income countries

1. *Facilitate steady economic growth*
2. *Initiate pilots for health insurance schemes*
3. *Foster ability to administrate*
4. *Ensure political commitment to expand population coverage*
5. *Combine expansion of population coverage with risk-pooling*
6. *Ensure evaluation of covered/provided goods and services at each stage*

Content based on Study commissioned by the World Bank:

Busse, R., Schreyögg, J. and Gericke, C. (2006), Challenges of health financing in high income countries. Short version as chapter 9 in: „Health Financing Revisited“, Washington: The World Bank.

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