Healthcare financing reforms – the international scene

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Third-party Payer

Population

Providers
Third-party payer

Collector of resources

Steward/regulator


Resource pooling & allocation

Mobilizing resources/funding

Purchasing (via contracts)/financing providers

Functions

Regulation

Access to and provision of services

Providers

European Observatory on Health Systems and Policies
Resource pooling & allocation

Collector of resources → Third-party payer

Mobilizing resources/funding

Income-dependent contributions & sickness funds = Social Health Insurance system

Taxes & governments/health authorities = tax-funded system (NHS)

Risk-related premia & private insurers = Voluntary Health Insurance system

Population

Coverage
Who? What?
How much?

System typology
Third-party payer
Collector of resources
Steward/regulator
Providers
Population
The three dimensions of coverage decisions

1. WHO? Population Coverage ("Breadth")

2. WHAT? Service Coverage (benefit package; "Depth")

3. HOW MUCH? Cost coverage ("Height")
NHS-principles: "Universal, comprehensive, free at the point of service"
Population coverage in high-income 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
Out of pocket payments – sometimes referred to as user charges:

1. Full cost charging for, e.g., OTC medicines (second dimension of coverage)
2. Insurance schemes often require part-payments (known as cost sharing) in the form of co-payments, co-insurance and deductibles (third dimension of coverage)
3. Informal (under the counter) payments are commonplace in Eastern Europe and LMIC
Reduced rates or exemptions commonly relate to one or more of the following:

- **clinical condition** – diabetics in Sweden, pregnant women in the UK and people with specified chronic illnesses in Ireland, Finland, Spain and the UK
- **level of income** – all those with low incomes in Austria, Belgium, Germany, Ireland and the UK and older people with low income in Greece
- **age** – older people in Belgium, Ireland, Korea, Japan, Spain and the UK and children and adolescents in many countries, e.g. in Germany, Japan and the UK
- **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 I

Increasing co-payments
(but effects on total
OOP often compensated)

More new benefits
than exclusions

Universal coverage
Third-party payer

Collector of resources

Mobilizing resources/funding

Population

Steward/regulator

Providers

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Third-party Payer

- Taxes: 17%
- Social Health Insurance contributions: 1%
- Voluntary insurance: <1%
- Out-of-pocket: 77%

Population

Providers

India 2005
Third-party Payer

Social Health Insurance contributions

Voluntary insurance

Taxes

17%

22%

3%

Out-of-pocket

Providers

Population

39% public

China 2005

European Observatory on Health Systems and Policies
Third-party Payer

Population

Providers

Taxes
Social Health Insurance contributions
Voluntary insurance

Out-of-pocket

Western Europe

65-85% public

10-20%
GDP per capita and public expenditure on health, by country income group

Source: Schieber and Maeda 1997 and OECD 2004
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure
Reform trends II

• development of clear role for public funding (taxes and/or Social Health Insurance contributions)
• limited role for Voluntary Health Insurance
• attempt to limit Out-of-pocket payments (use it only to steer consumption)
Resource pooling & allocation

Collector of Third-party payer resources

Steward/regulator

Population Provides
Contribution collector

Independent of risk, need and utilisation, i.e. income-related or community-rated

Third-party payer

Dependent on volume, appropriateness (service = need) and quality, steered by priorities and incentives

Pooling allocation

Population

Providers
Expenditure is highly skewed: 5% of population account for >50% of expenditure
(example Germany 2001)

5% of population account for >50% of expenditure,
(example Germany 2001)
Reform trends III

• SHI: larger risk pools (country-wide instead of individual sickness funds)
NHS: regionalisation often leads to smaller/fragmented risk pools

• -> development of allocation formulae
Allocation of resources from pooling to purchasing organizations

- **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 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
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<th>Country</th>
<th>Year of implementation</th>
<th>Risk-adjusters</th>
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<td>Austria</td>
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<td>Belgium</td>
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<td>- Age, sex, disability pension status, participation in disease management program</td>
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<tr>
<td>Switzerland</td>
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Sources: adapted from Busse et al. (2004) and updated with data from Risk Adjustment Network (HAN)
Reform trends IV

• NHS: development of purchasers through purchaser/provider split -> purchasers = regions, health authorities, primary care trusts … providers = autonomous institutions

• SHI: transformation of sickness funds from payers to active purchasers
The growing role of the purchaser

• 1970s and even the 1980s: role of the purchaser = limited to a passive financial intermediary
• 1980s: several countries tried to integrate market mechanisms -> to increase quality and efficiency of the provided services
• 1990s and 2000s: purchasing organizations increasingly gain more autonomy in management and planning
• Active purchasing can allow contracting as well as care management of purchasing organizations e.g. purchasing disease management programs
Tentative lessons from high-income 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:

Downloadable at: http://mig.tu-berlin.de