Technische Universität Berlin

Healthcare financing reforms – the international scene

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&
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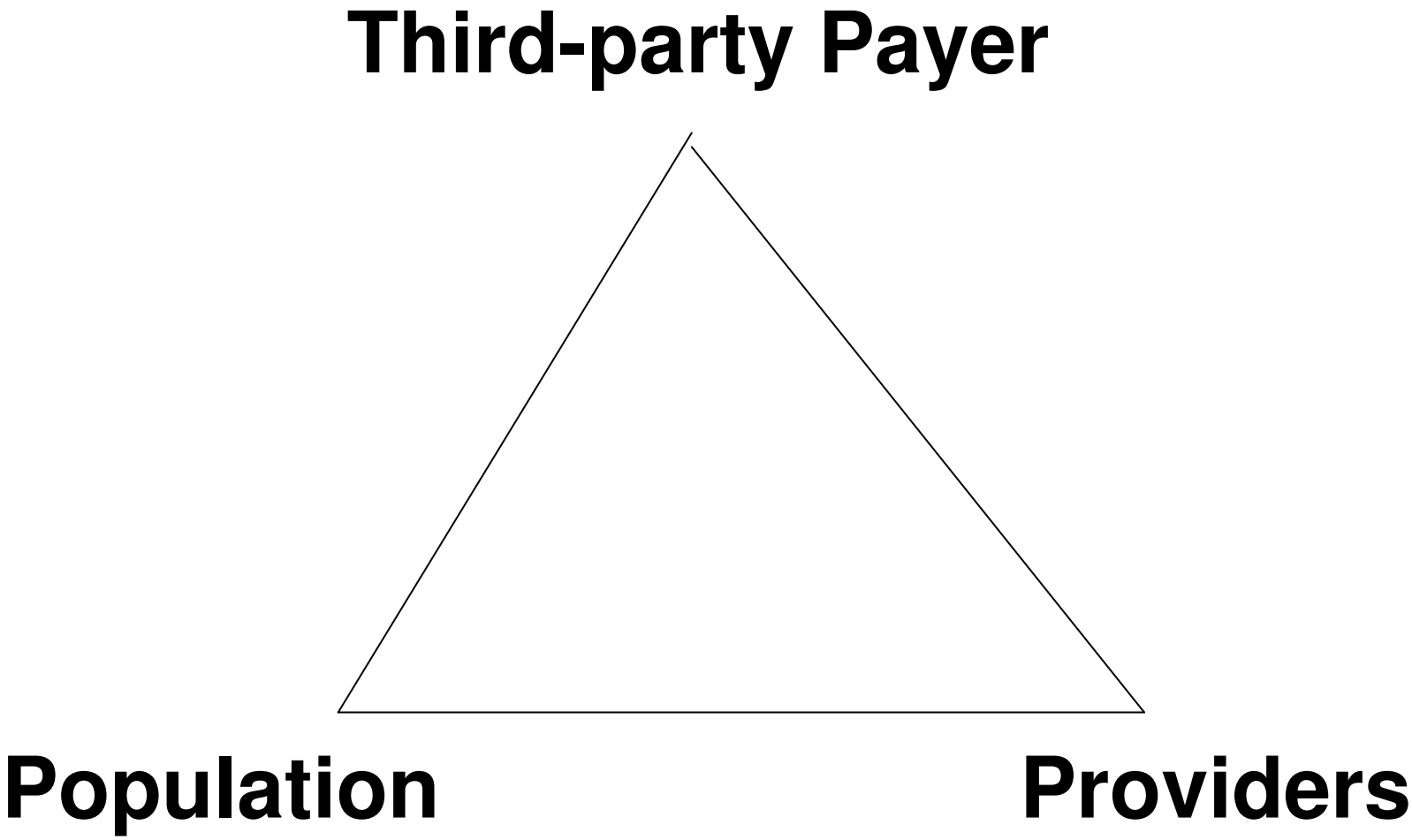

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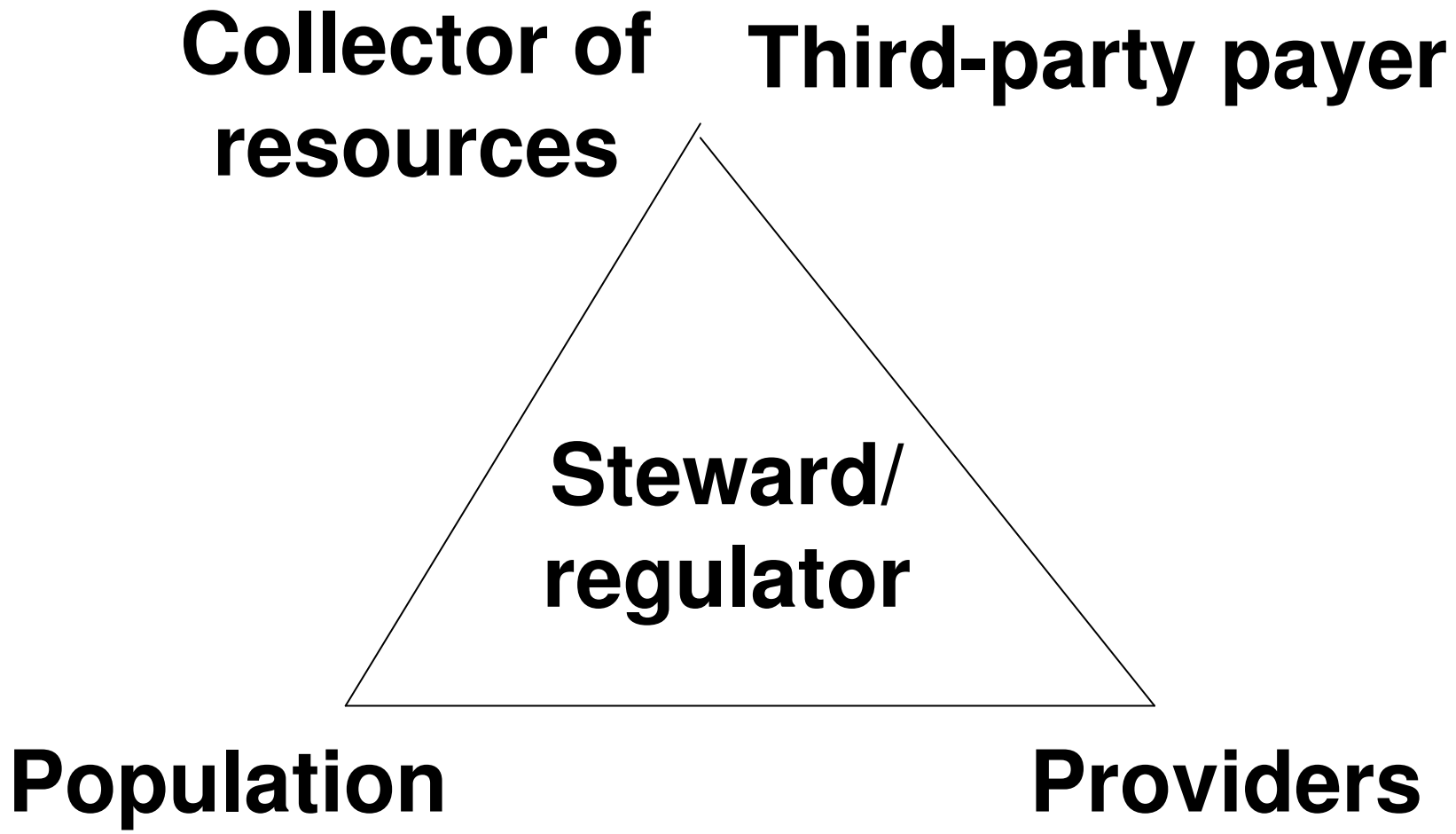

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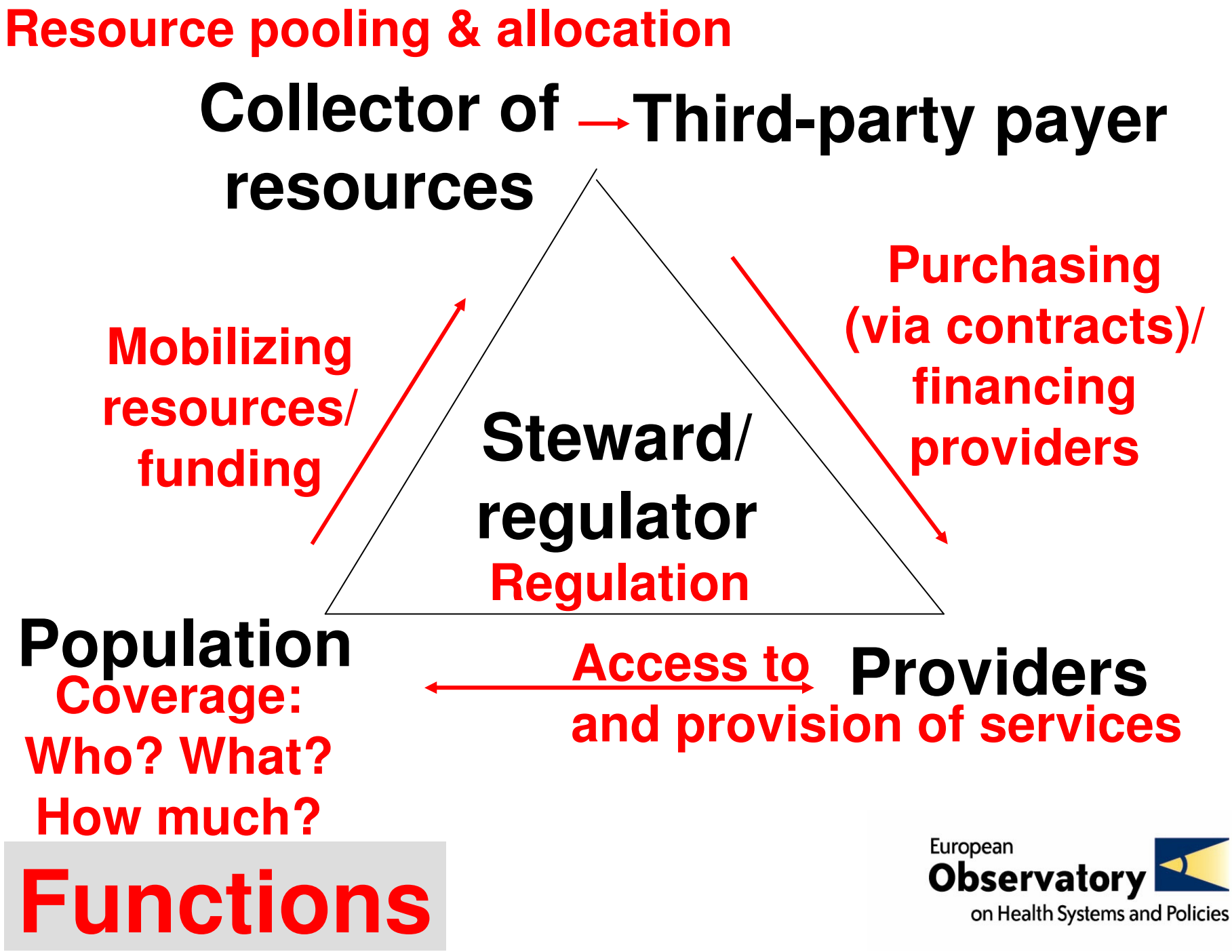

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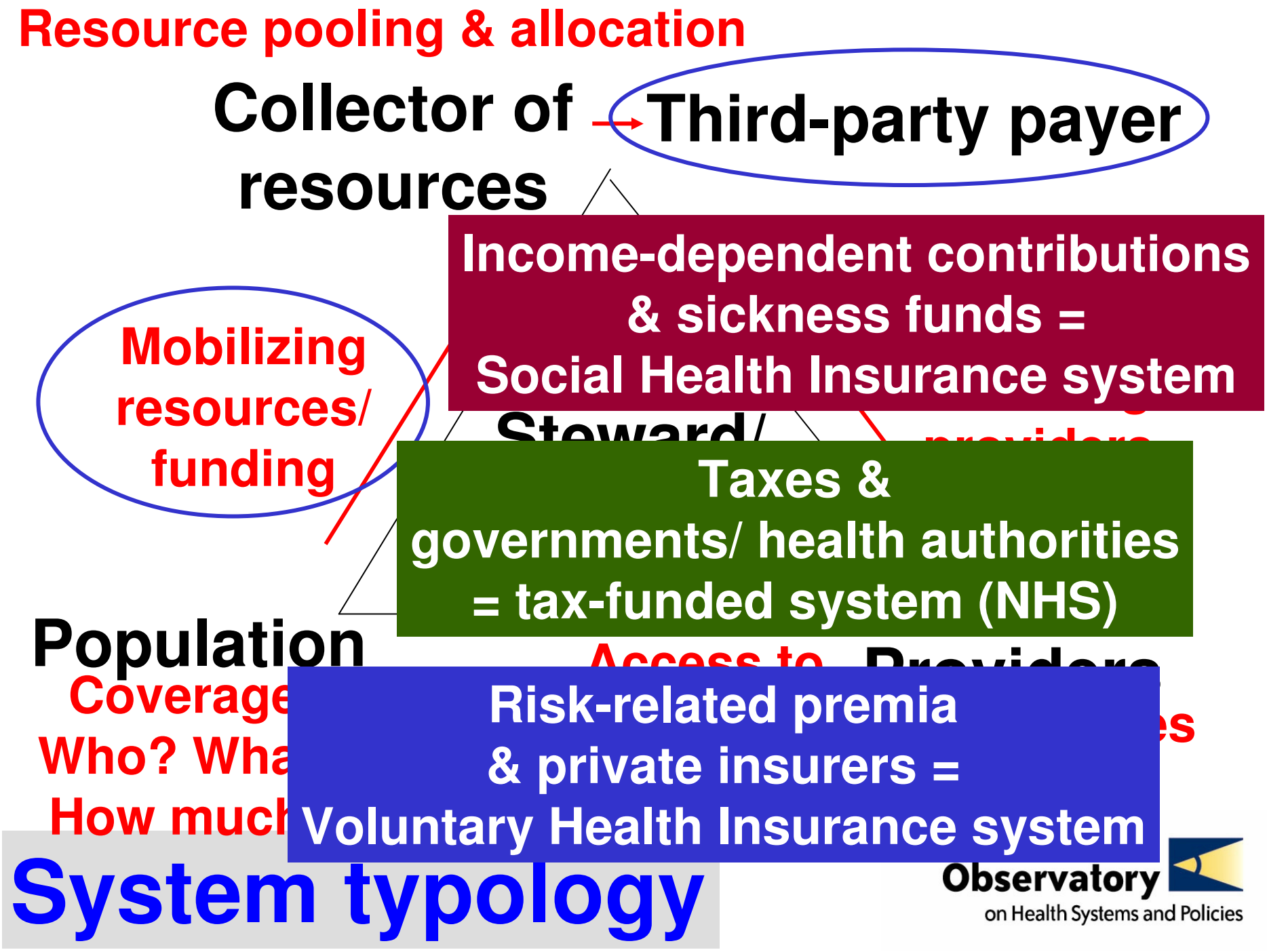
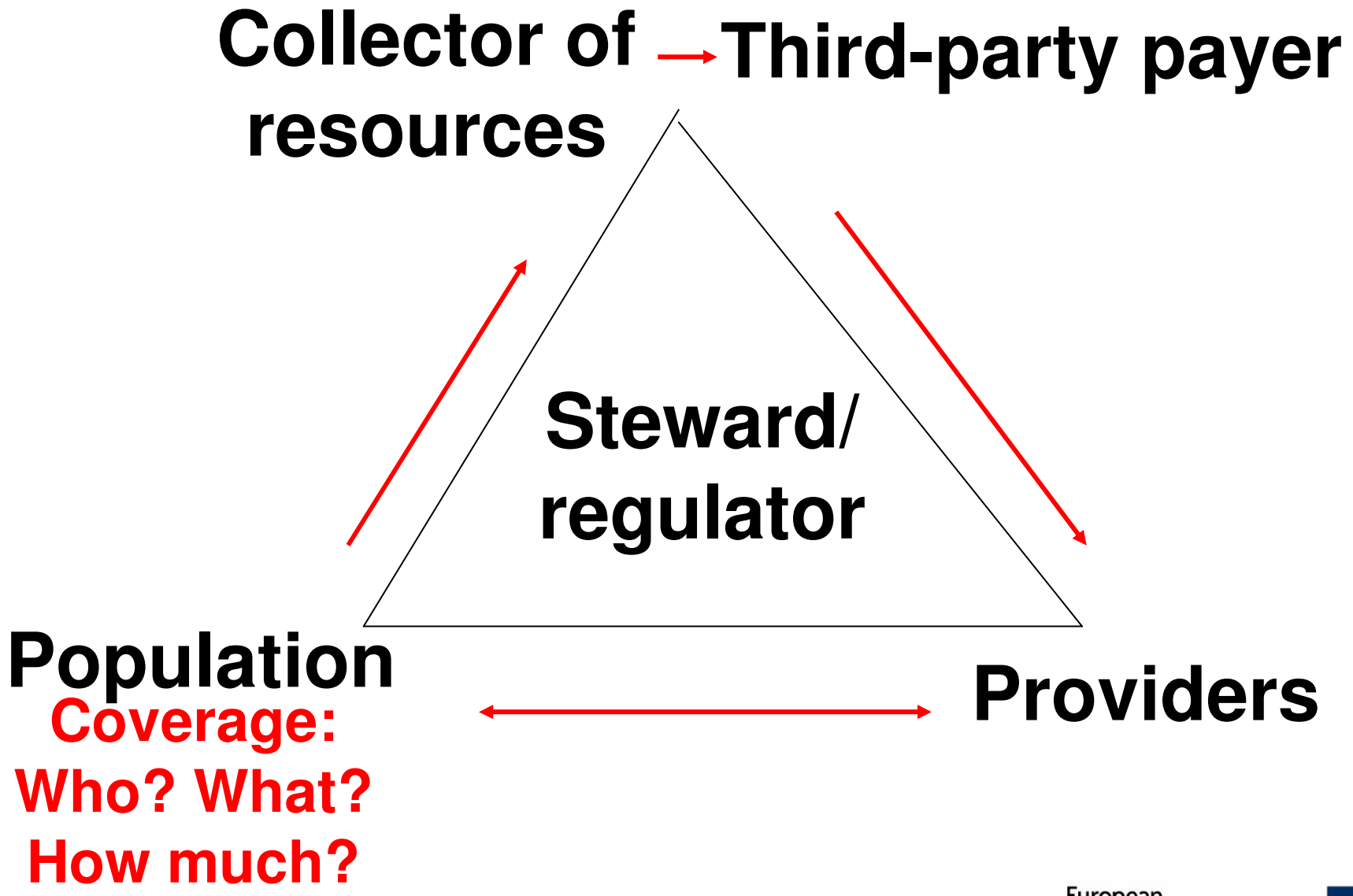

Resource pooling & allocation
Collector of resources
Third-party payer
Income-dependent contributions & sickness funds = Social Health Insurance system
Mobilizing resources/ funding
Taxes & governments/ health authorities = tax-funded system (NHS)
Population
Coverage
Who? Wha
How much
Risk-related premia & private insurers = Voluntary Health Insurance system
System typology
Observatory
on Health Systems and Policies



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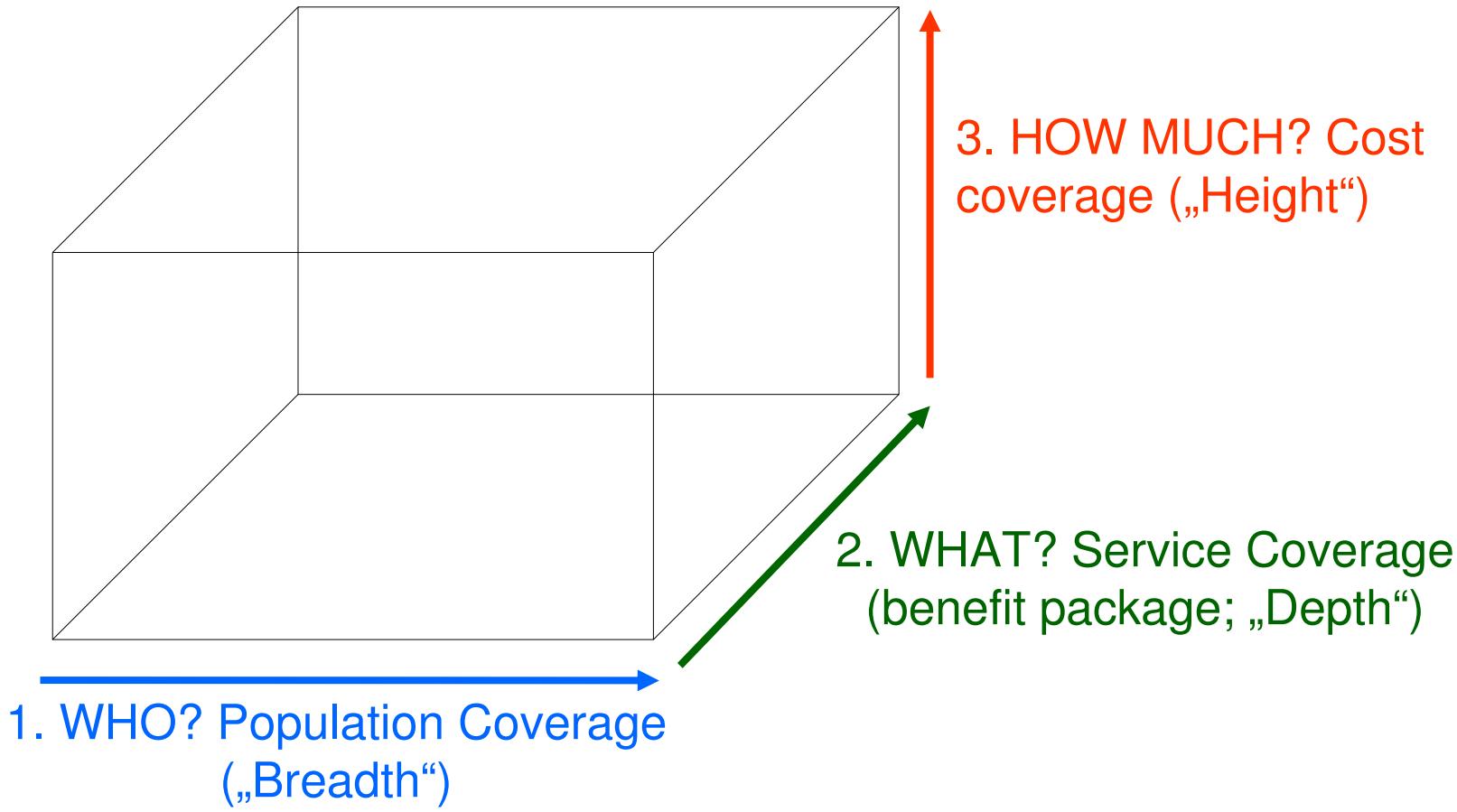
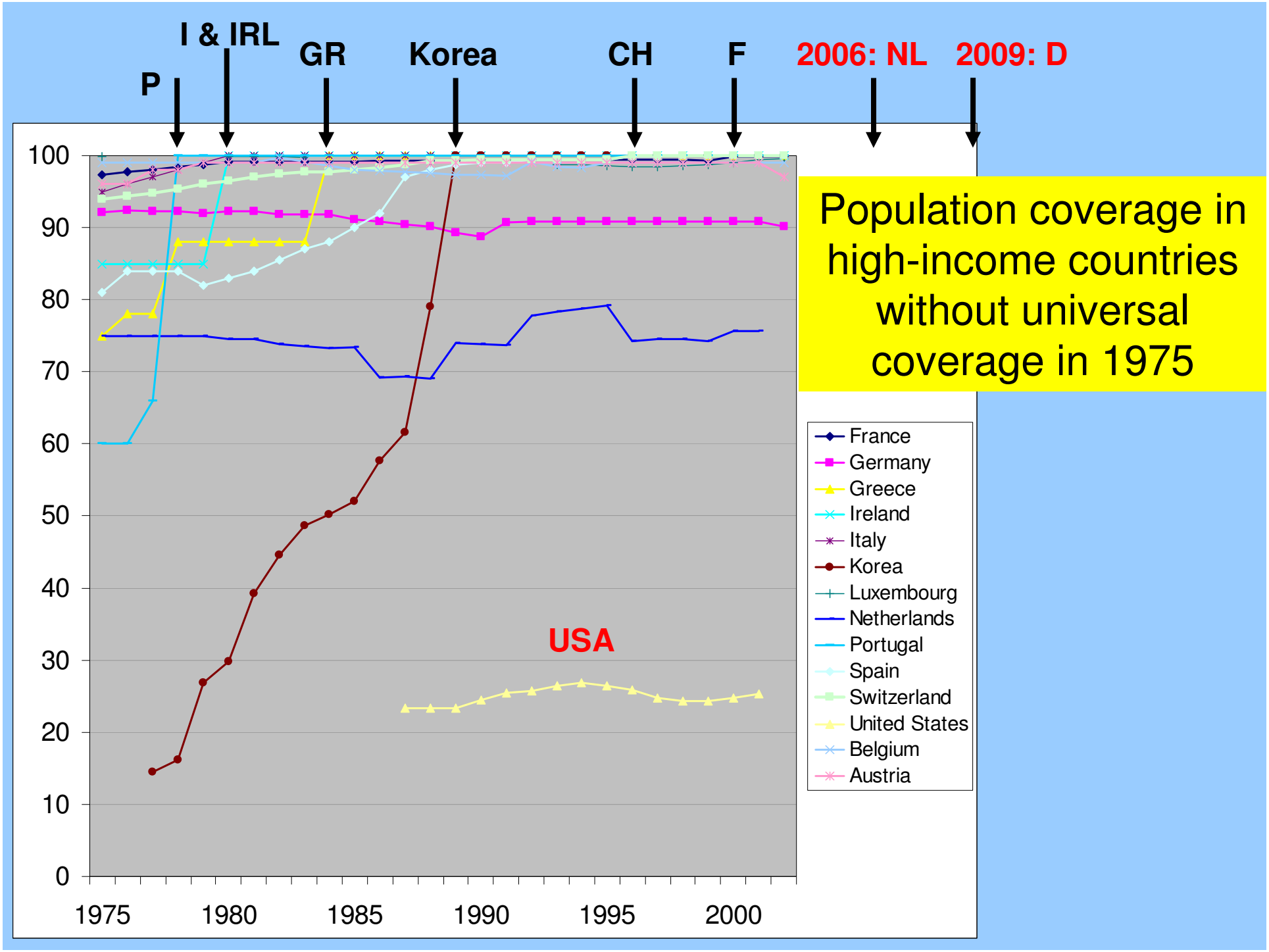
The three dimensions of coverage decisions



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


P
I & IRL
GR
Korea
CH
F
2006: NL
2009: D
Population coverage in high-income countries without universal coverage in 1975
USA
France
Germany
Greece
Ireland
Italy
Korea
Luxembourg
Netherlands
Portugal
Spain
Switzerland
United States
Belgium
Austria
100
90
80
70
60
50
40
30
20
10
0
1975
1980
1985
1990
1995
2000

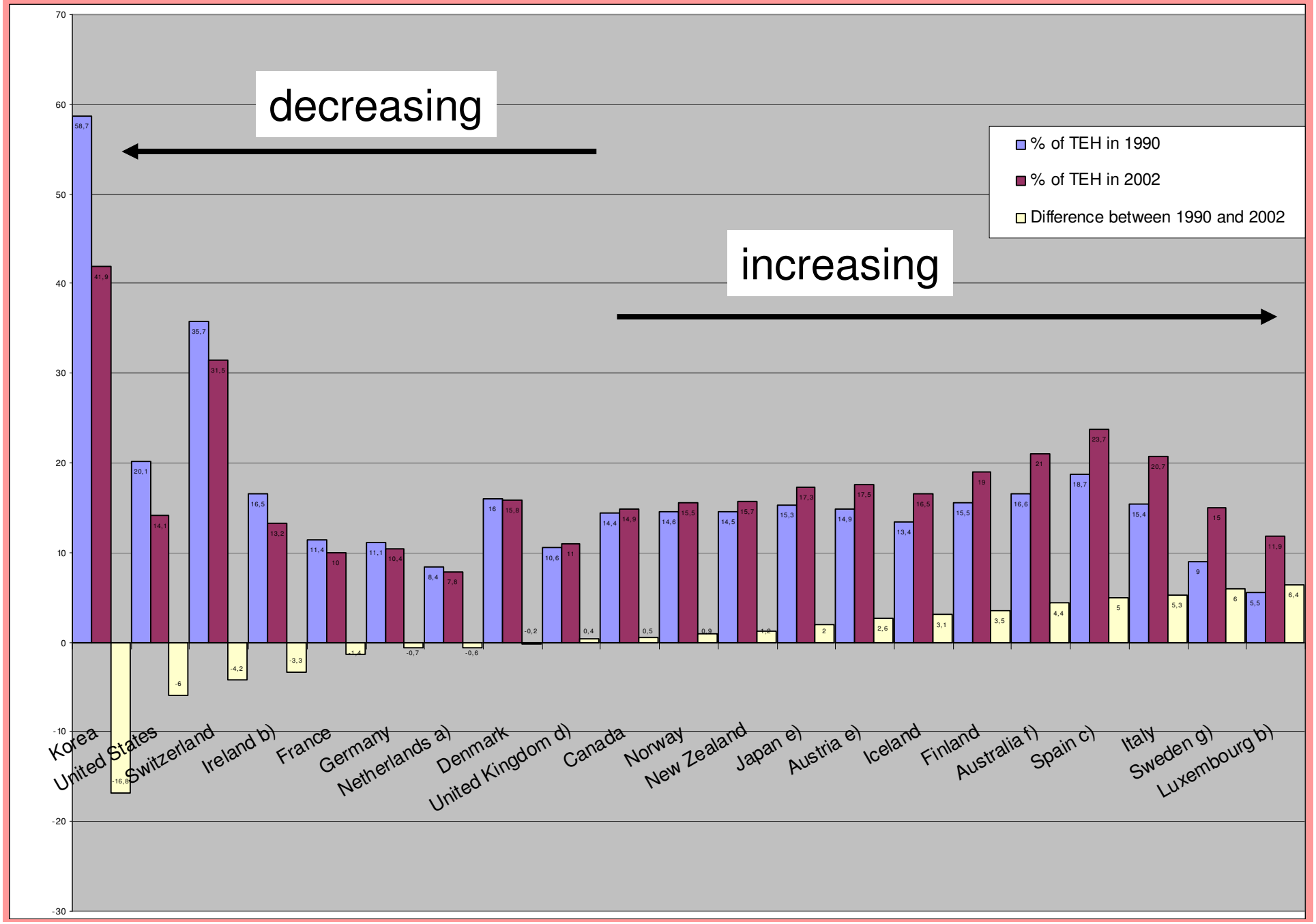
Covered benefits (benefit package)

- 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

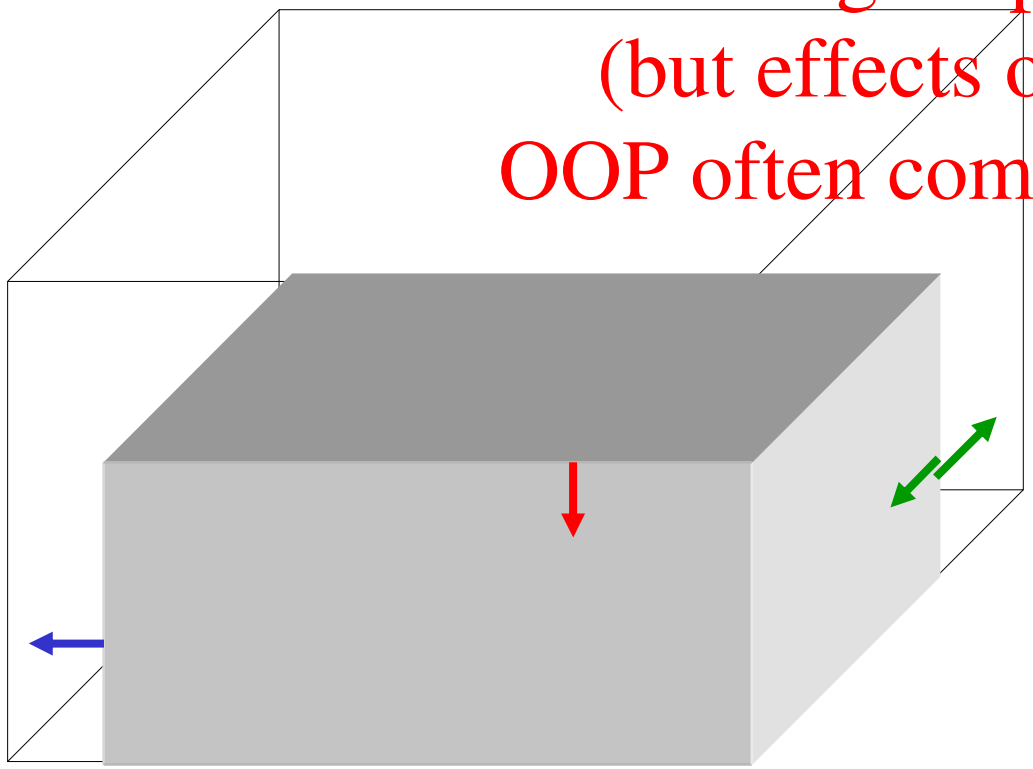
Out-of-pocket: a mixed picture



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

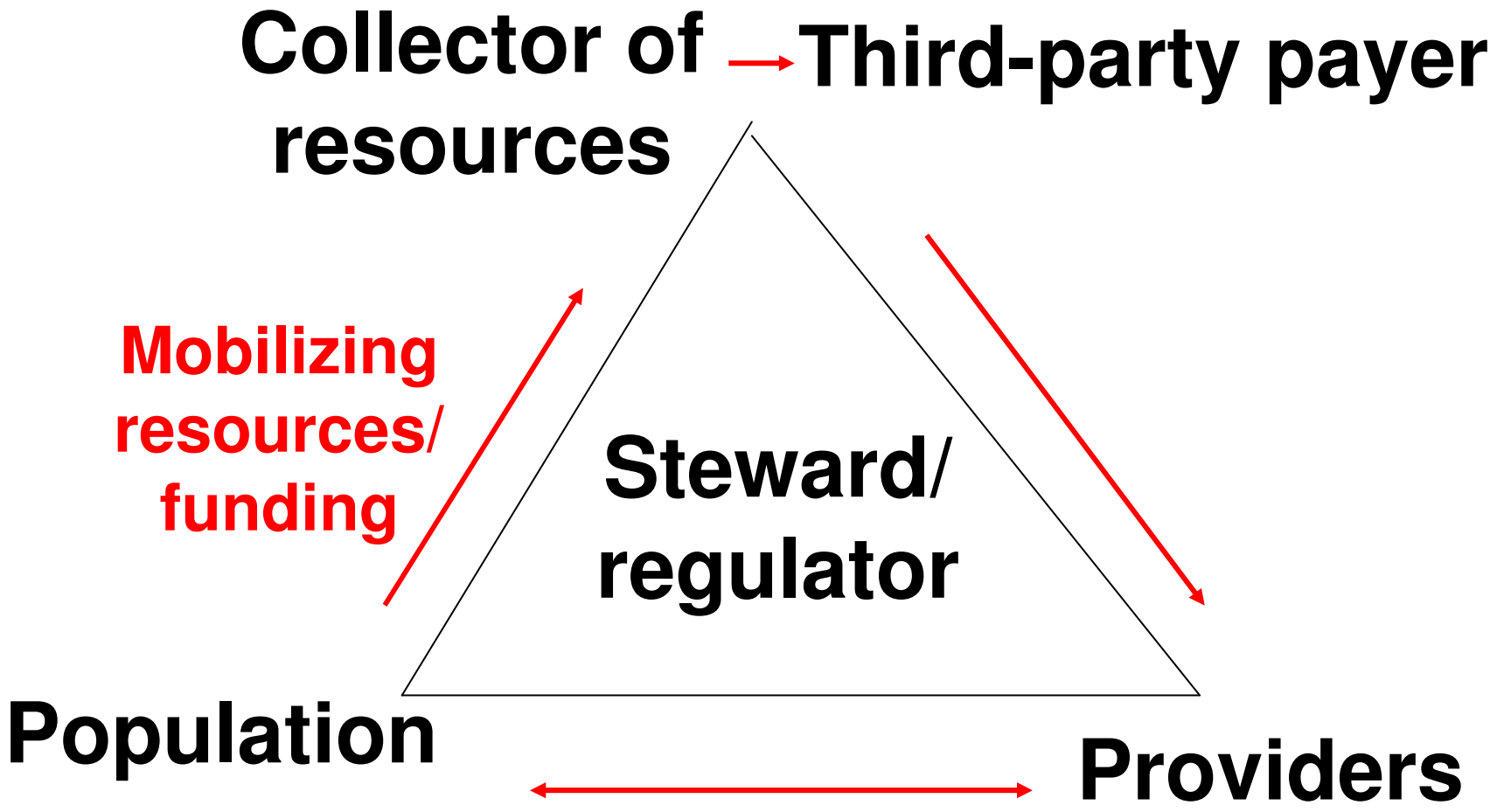
Reform trends I



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

More new benefits
than exclusions

Universal
coverage



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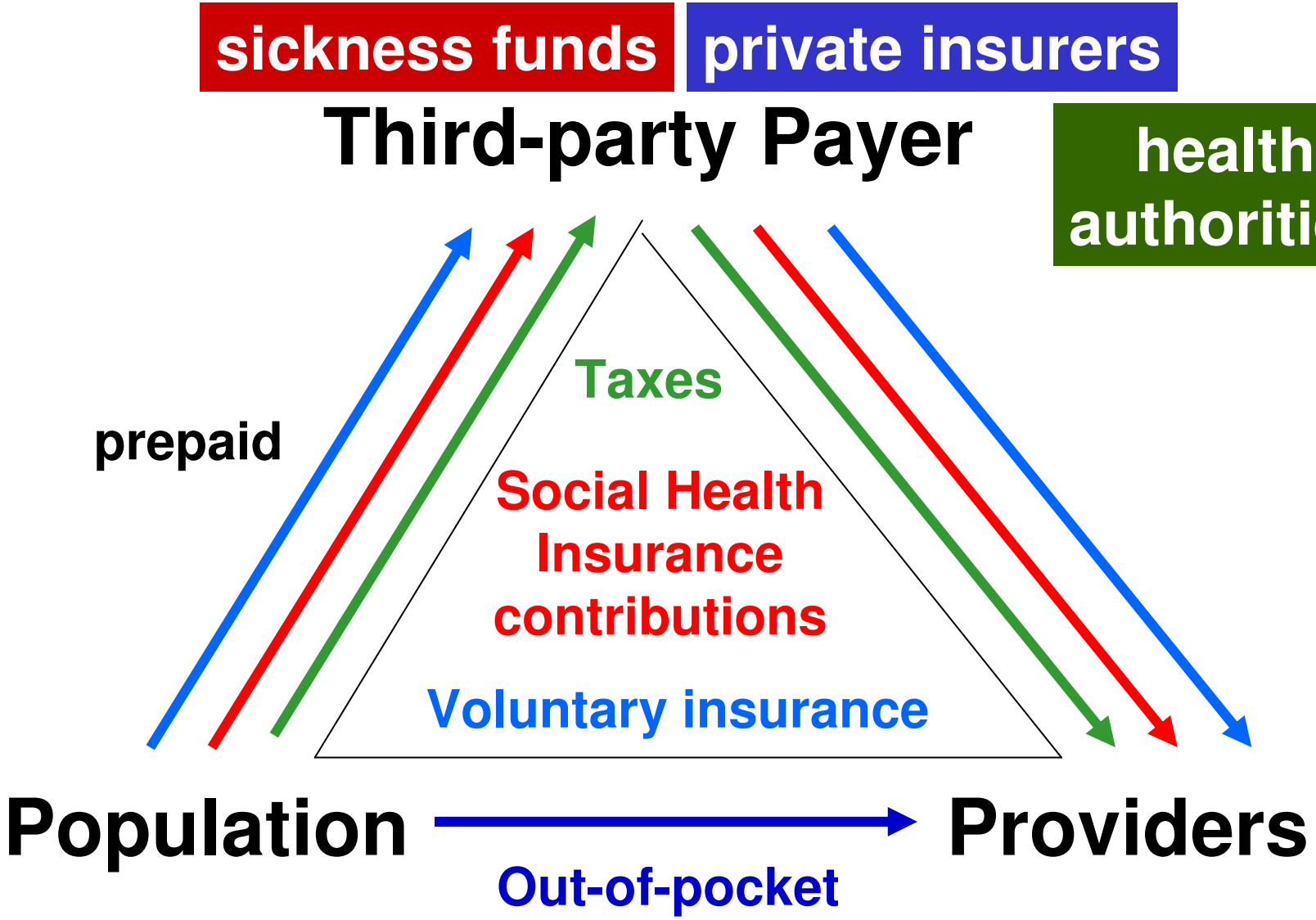

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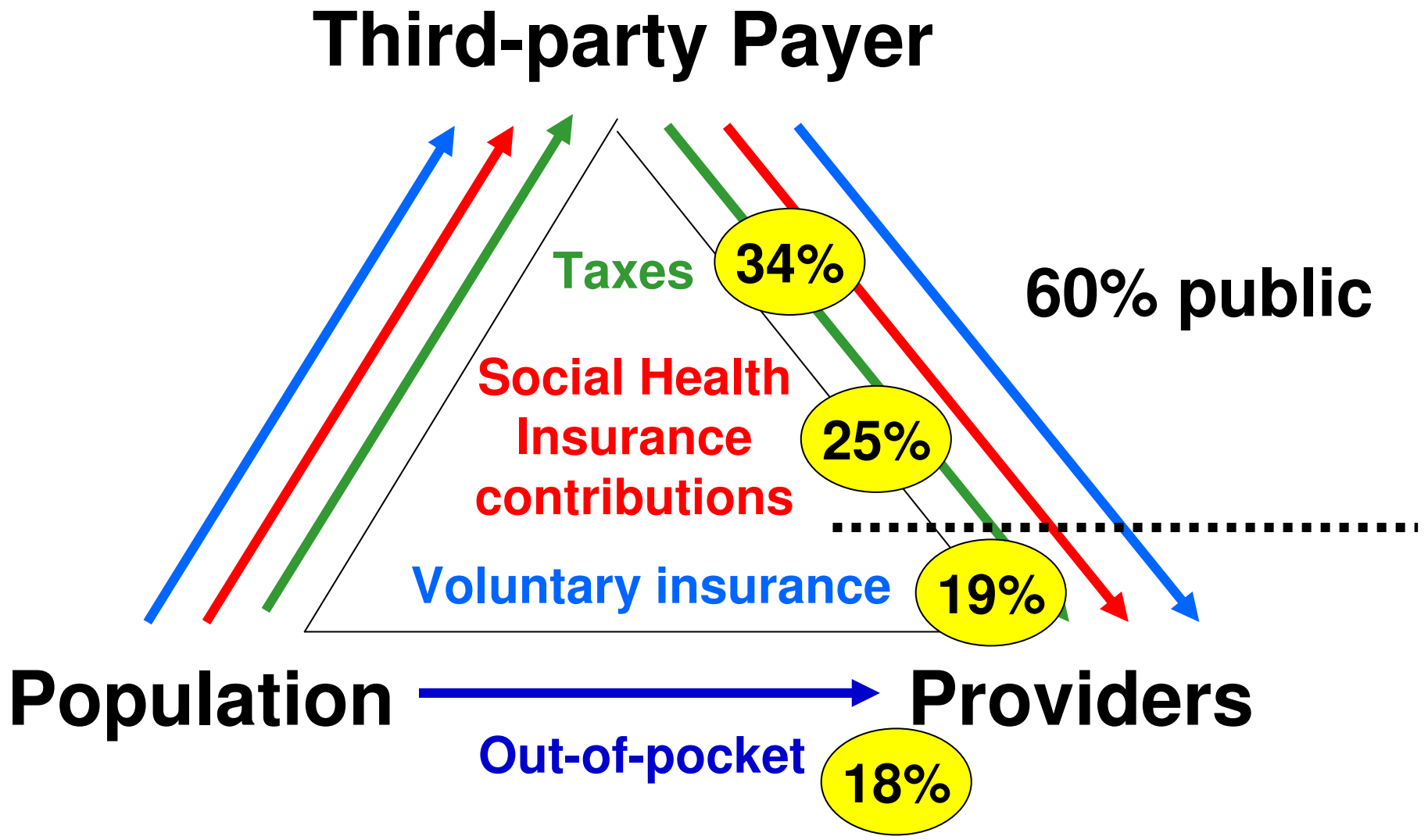

World-wide 2004 *(large US market!)*

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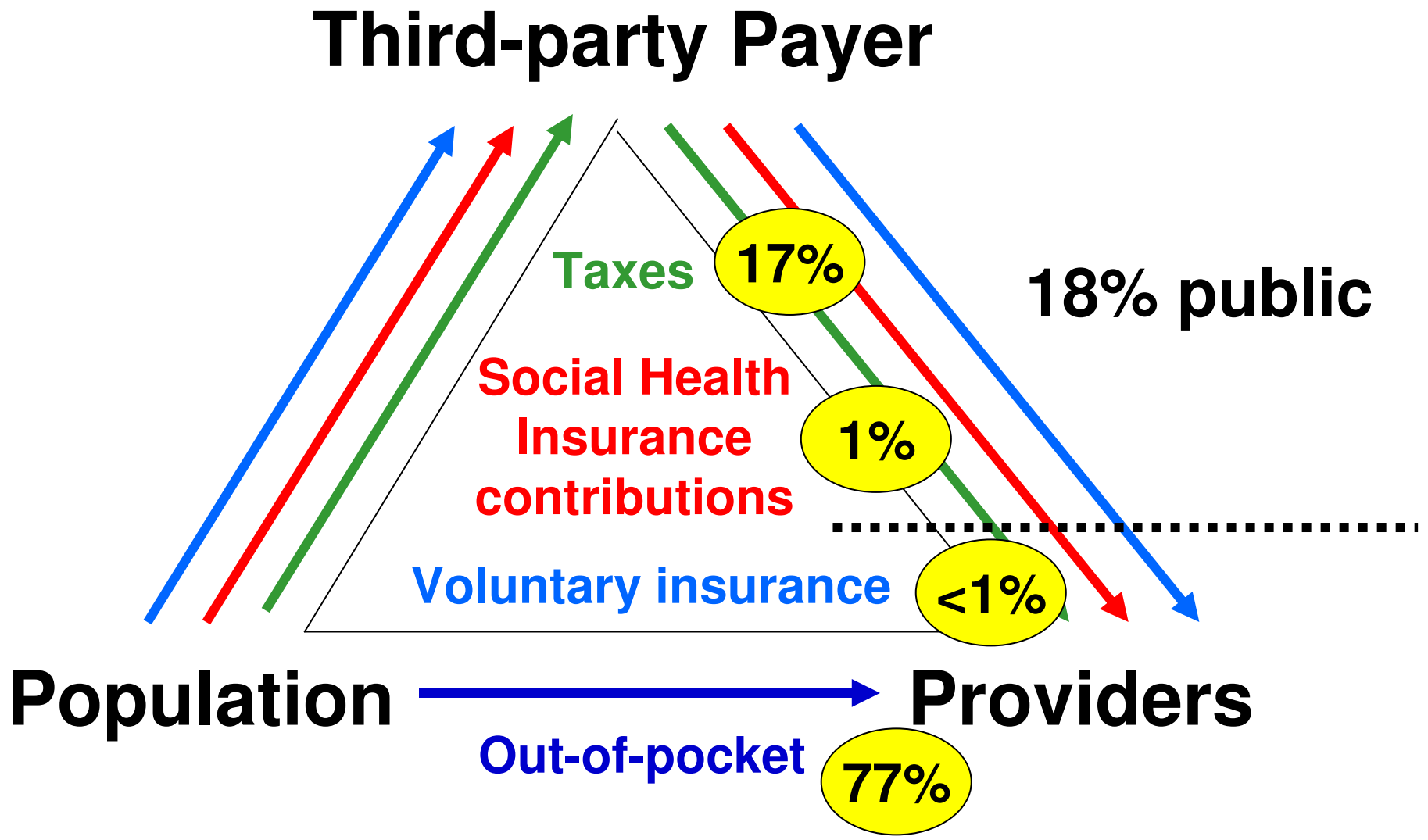

India 2005

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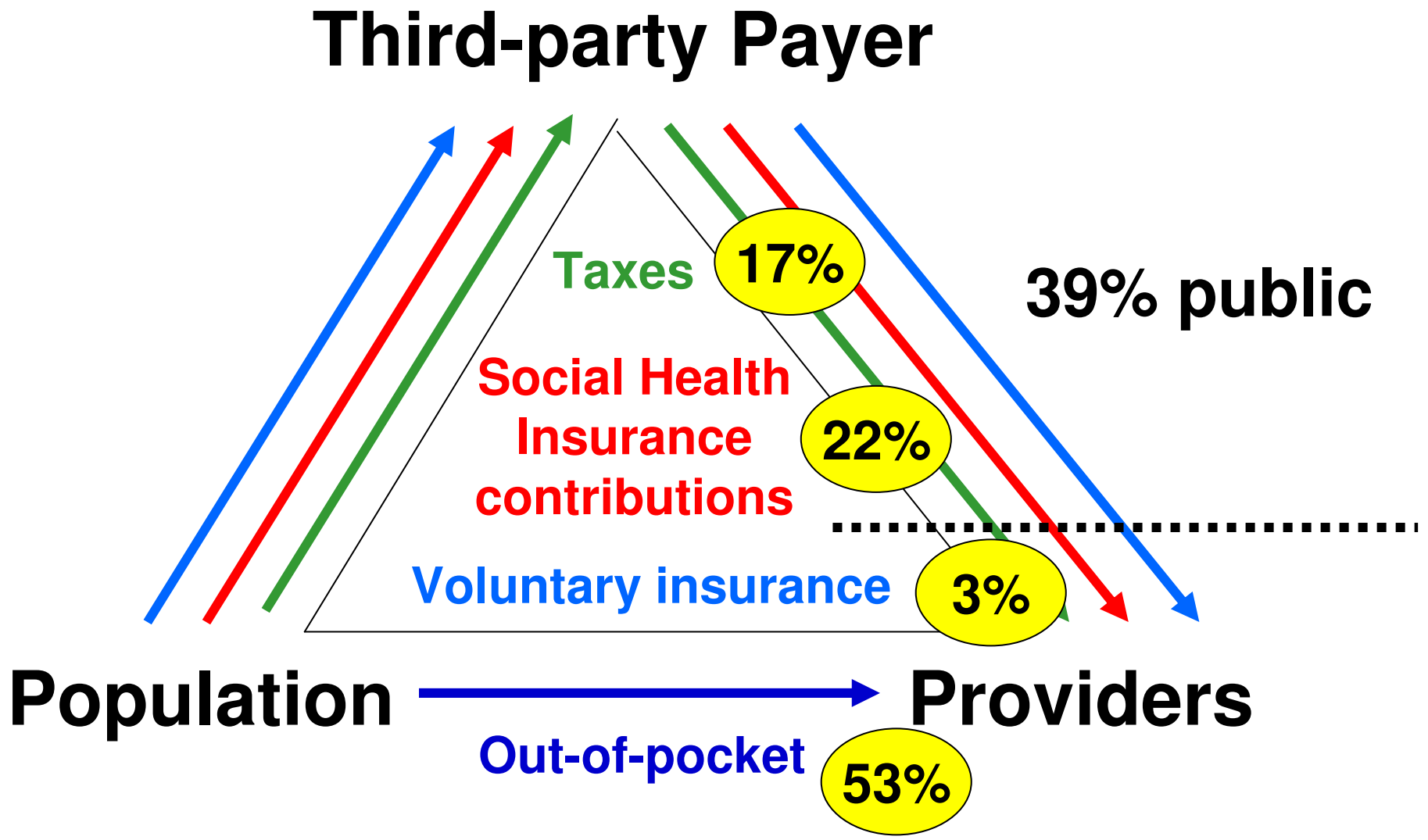

China 2005

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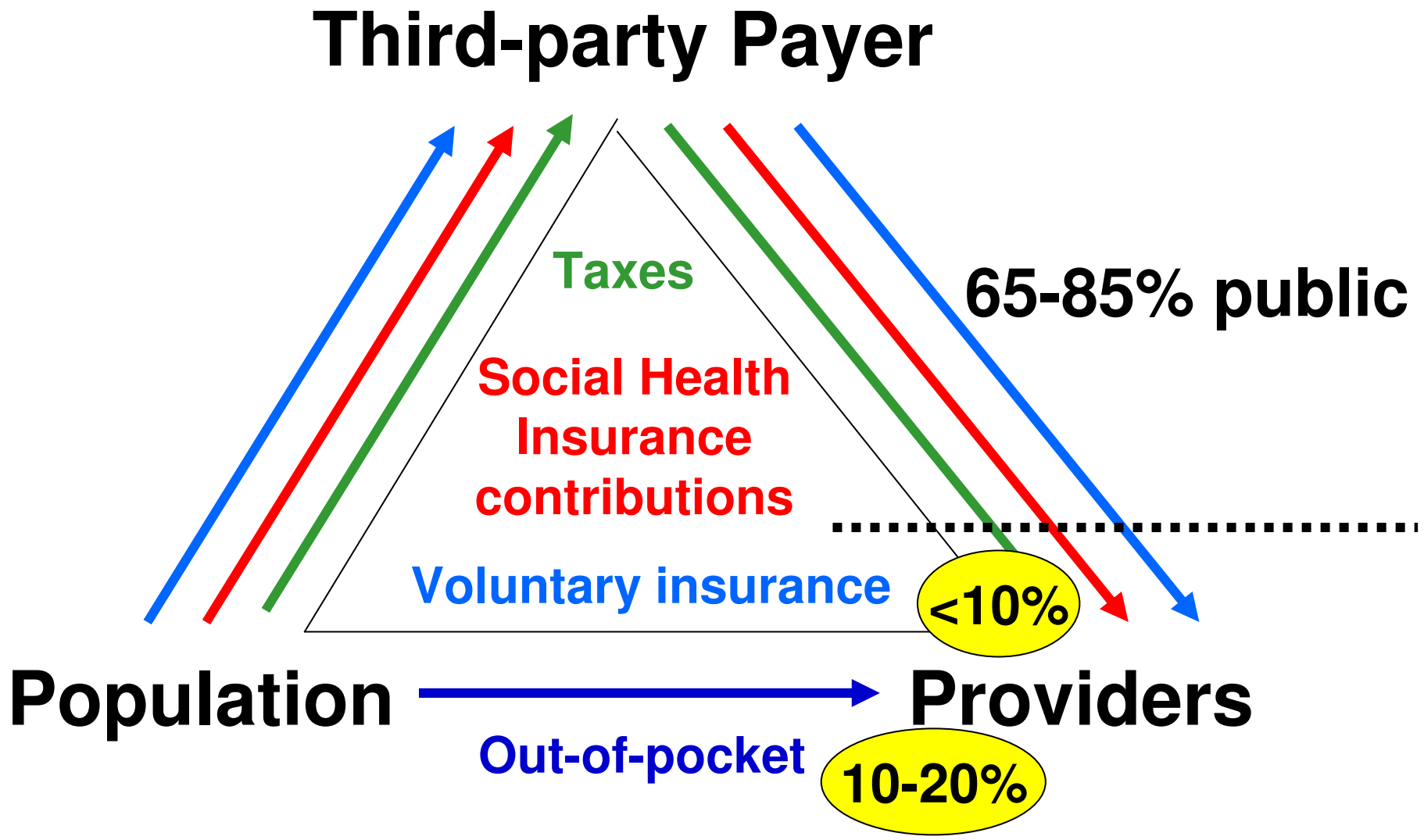

Western Europe

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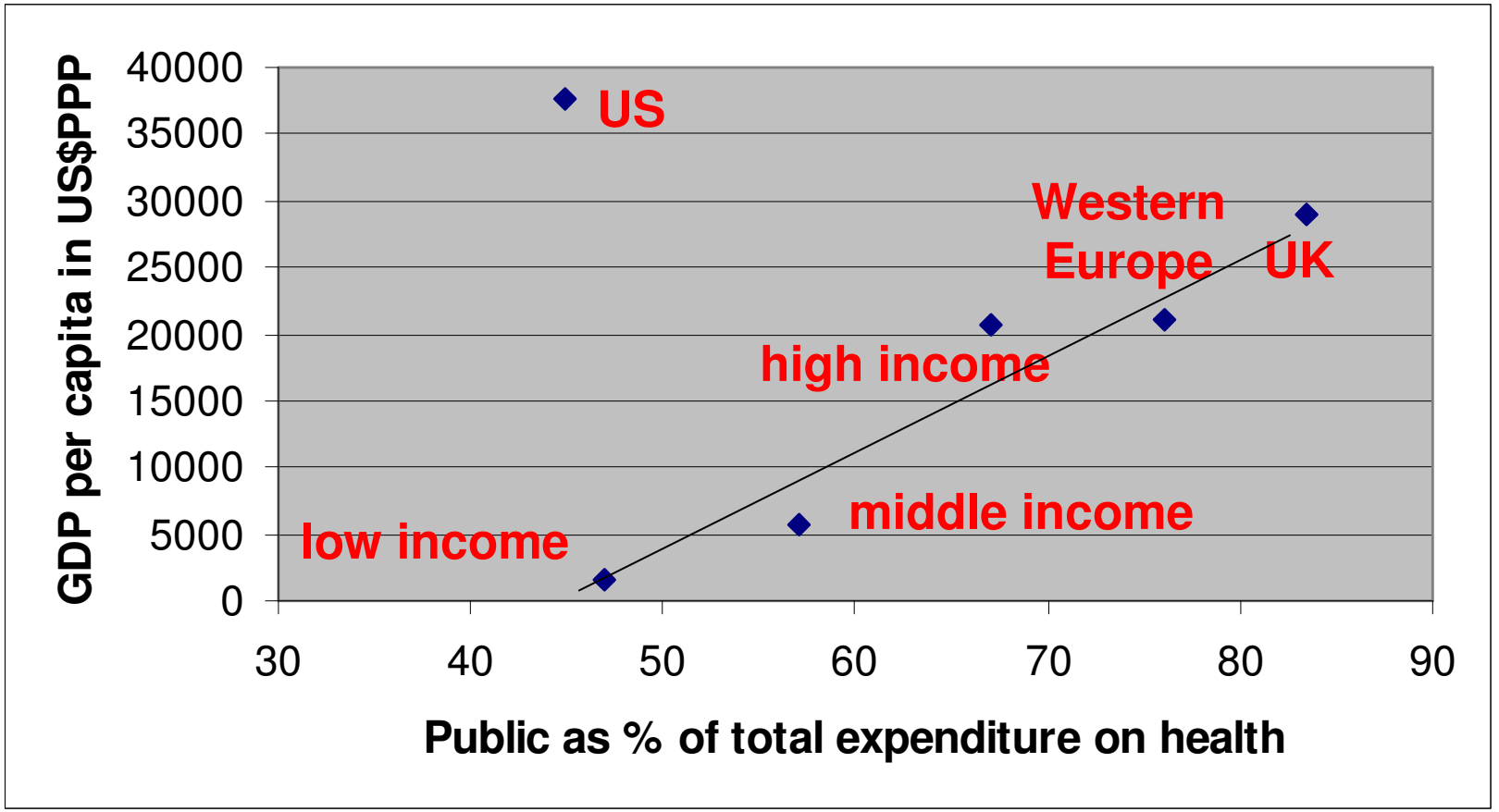
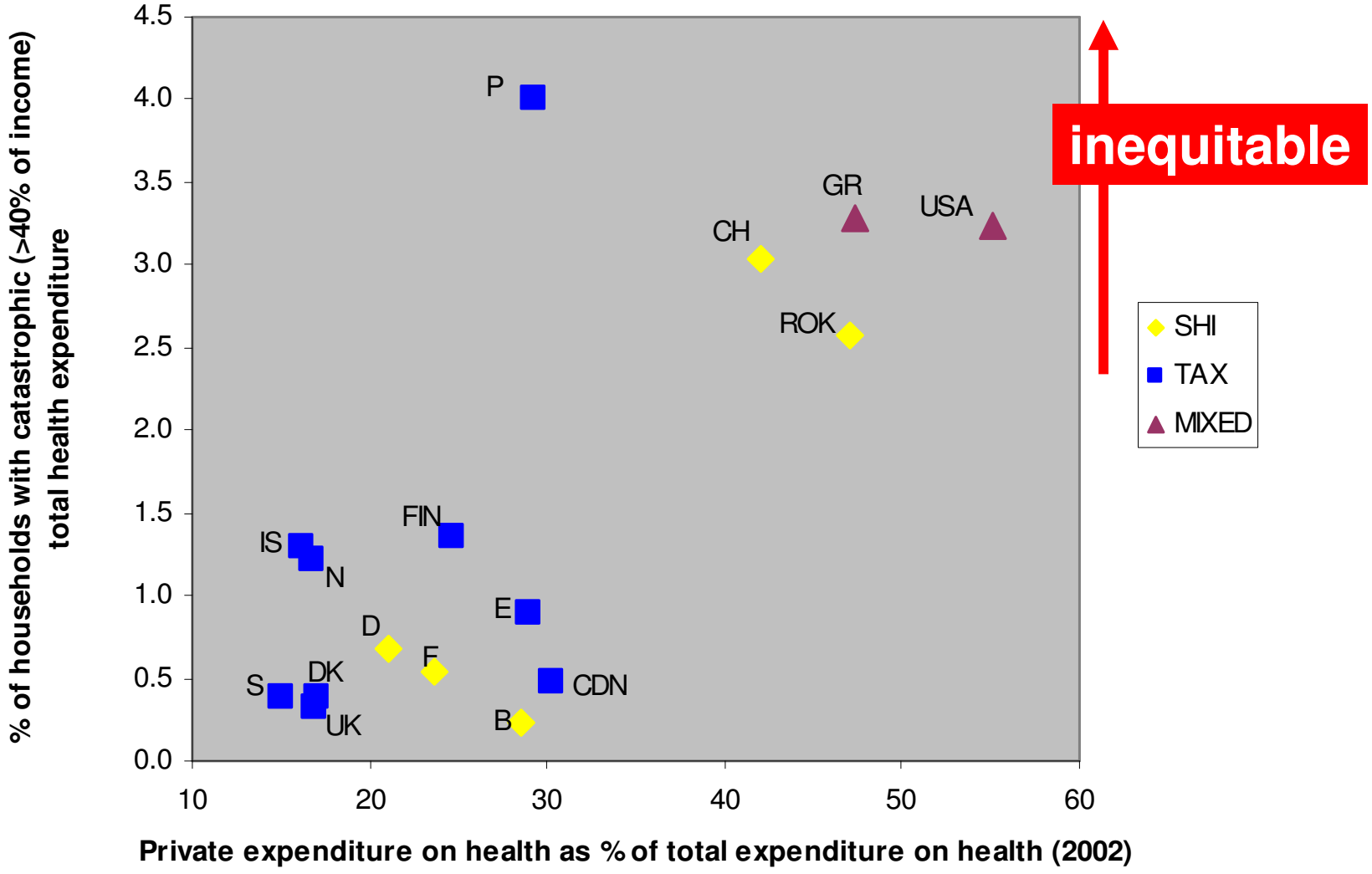
GDP per capita and public expenditure on health, by country income group



Source: Schieber and Maeda 1997 and OECD 2004

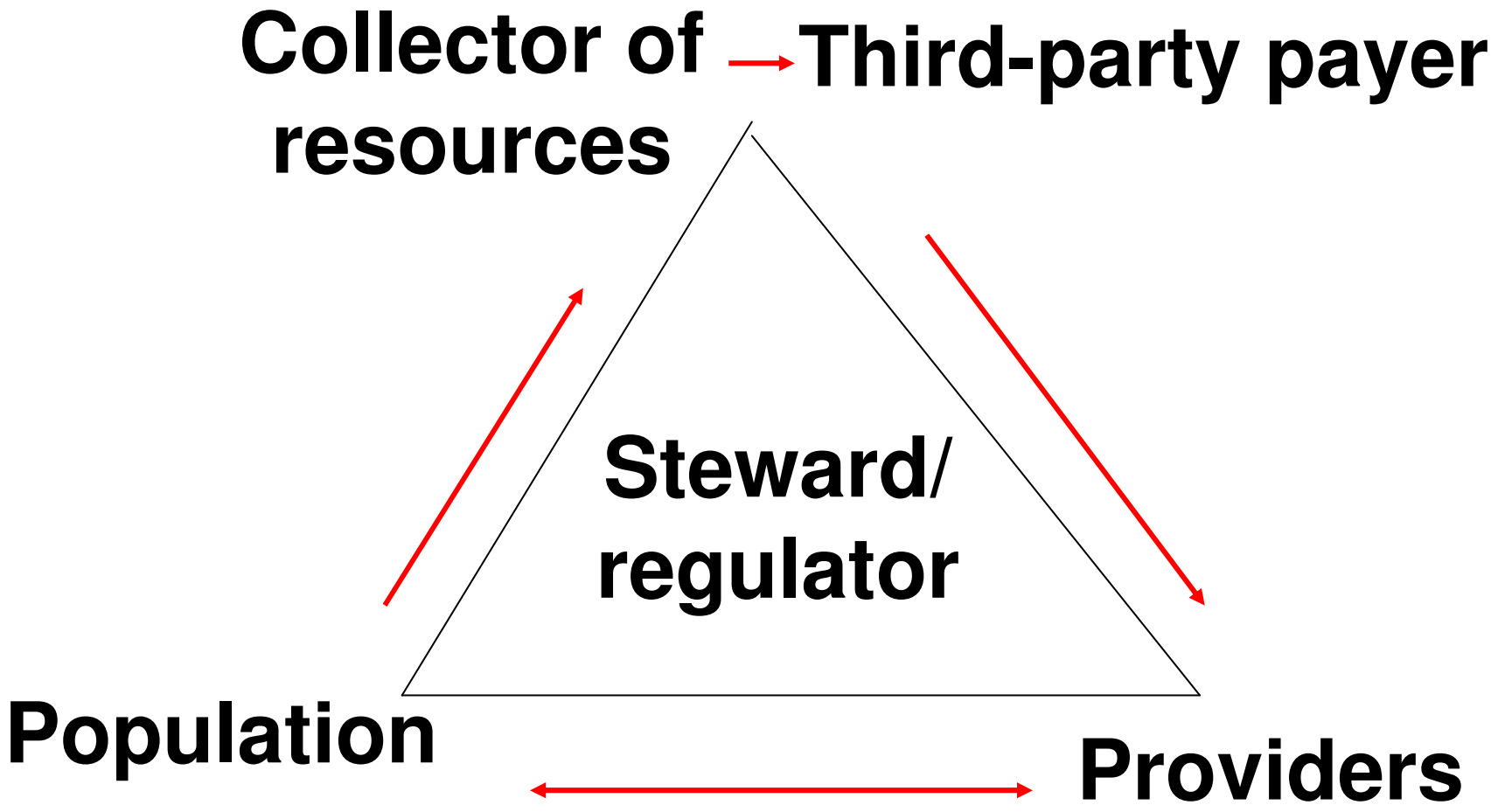
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure



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



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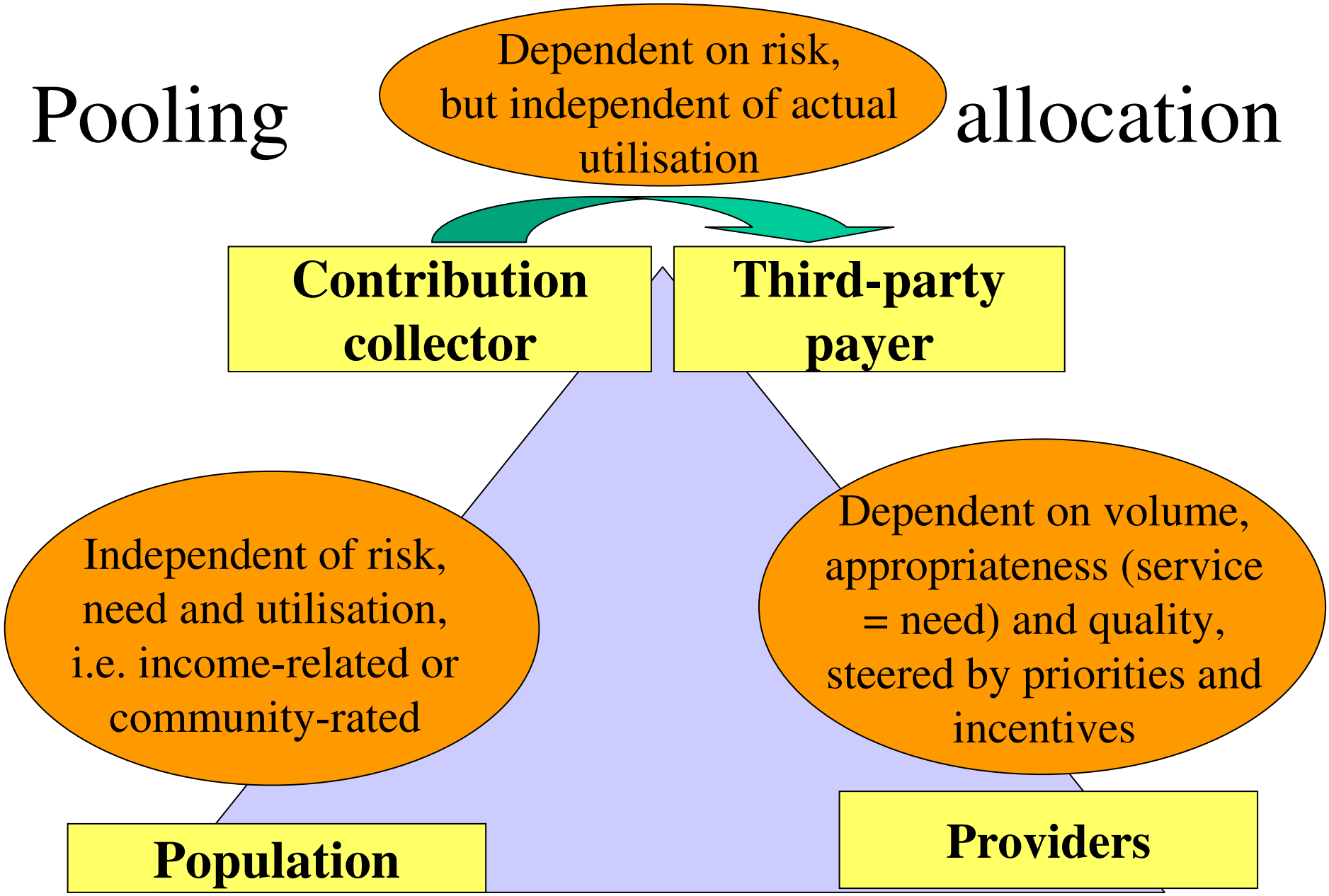
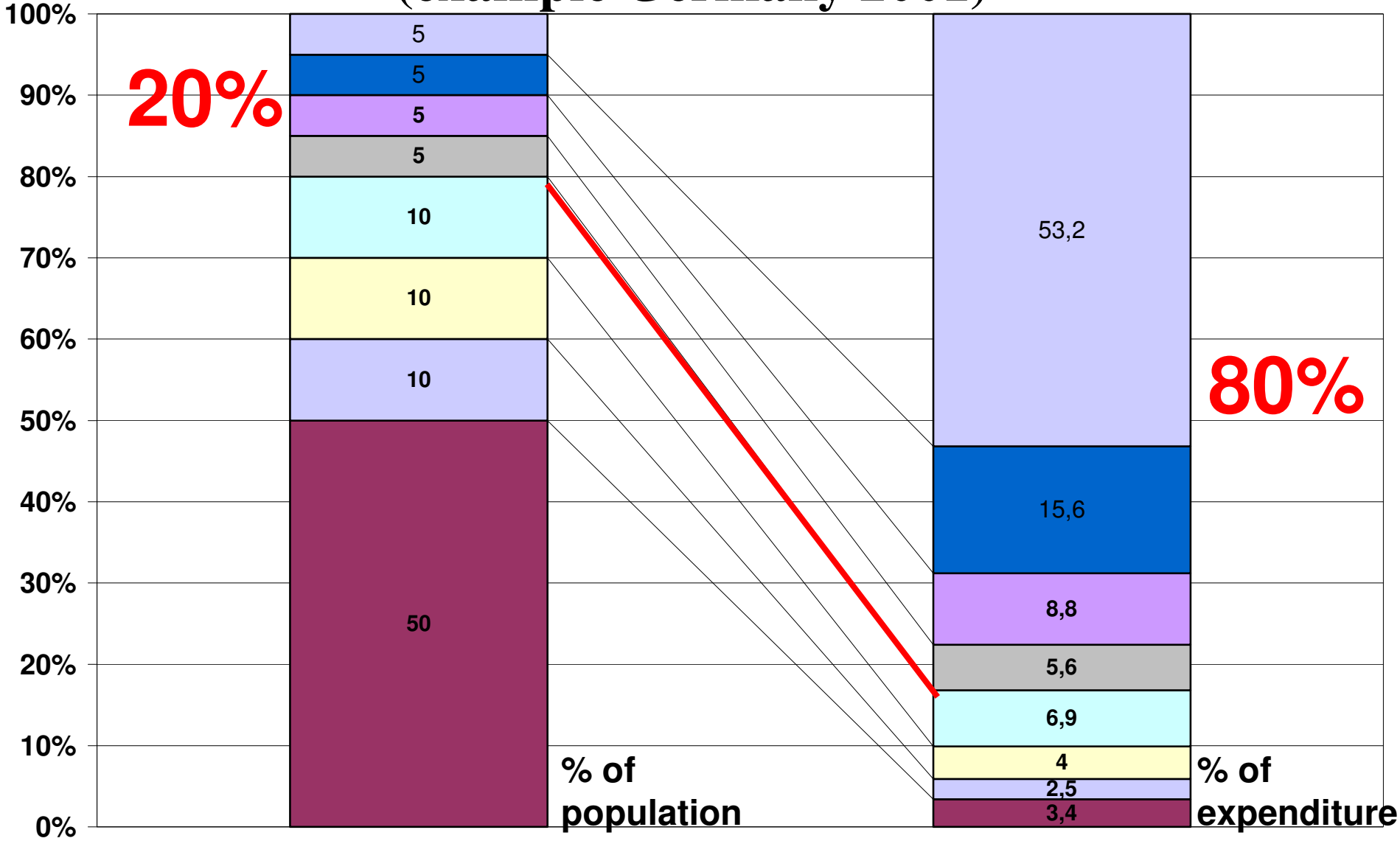

Pooling
Dependent on risk, but independent of actual utilisation
allocation
Contribution collector
Third-party payer
Independent of risk, need and utilisation, i.e. income-related or community-rated
Dependent on volume, appropriateness (service = need) and quality, steered by priorities and incentives
Population
Providers

Expenditure is highly skewed: 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

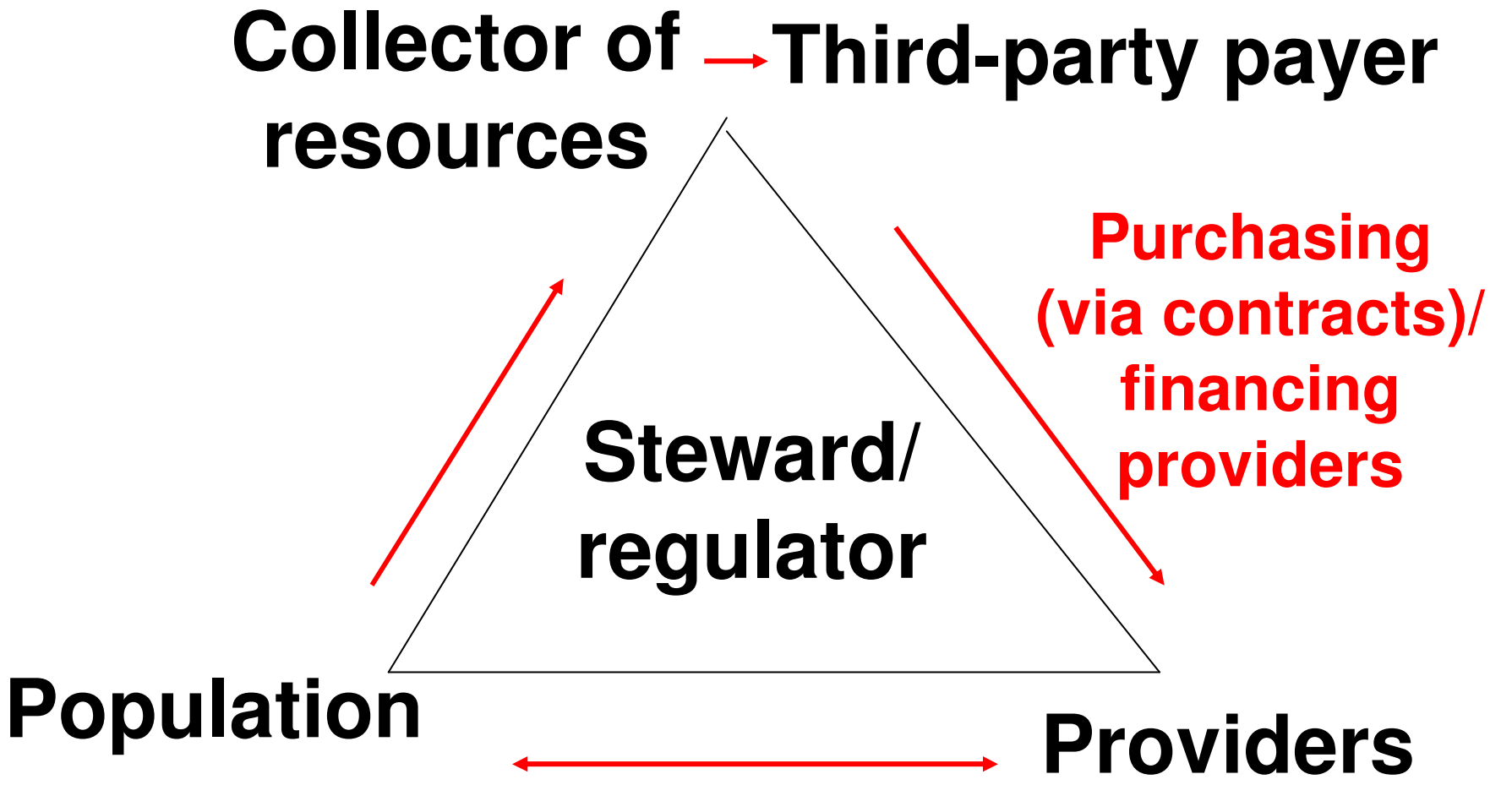
Capitation methods

- 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

Risk adjusters in the capitation formulas for resource allocation (SHI 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)



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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:

Busse, R., Schreyögg, J. and Gericke, C. (2007), Analyzing Changes in Health Financing Arrangements in High-Income Countries – A Comprehensive Framework Approach. Health, Nutrition and Population Discussion Paper. Washington, DC: World Bank (free www download)

Short version as chapter 9 in: „Health Financing Revisited“, Washington: The World Bank.

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http://mig.tu-berlin.de