Respond to decreasing health budgets:

population coverage, benefit coverage, cost coverage

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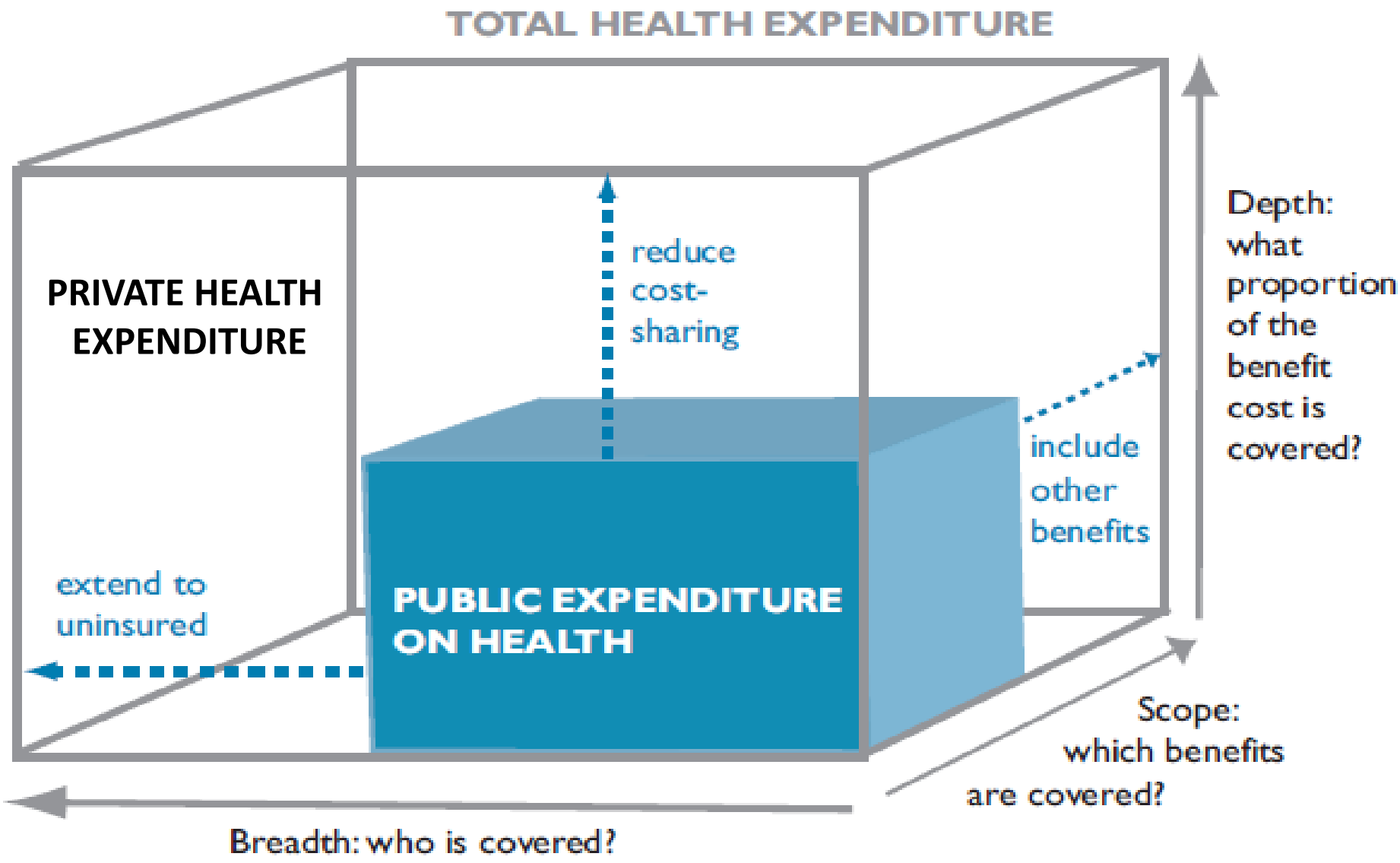
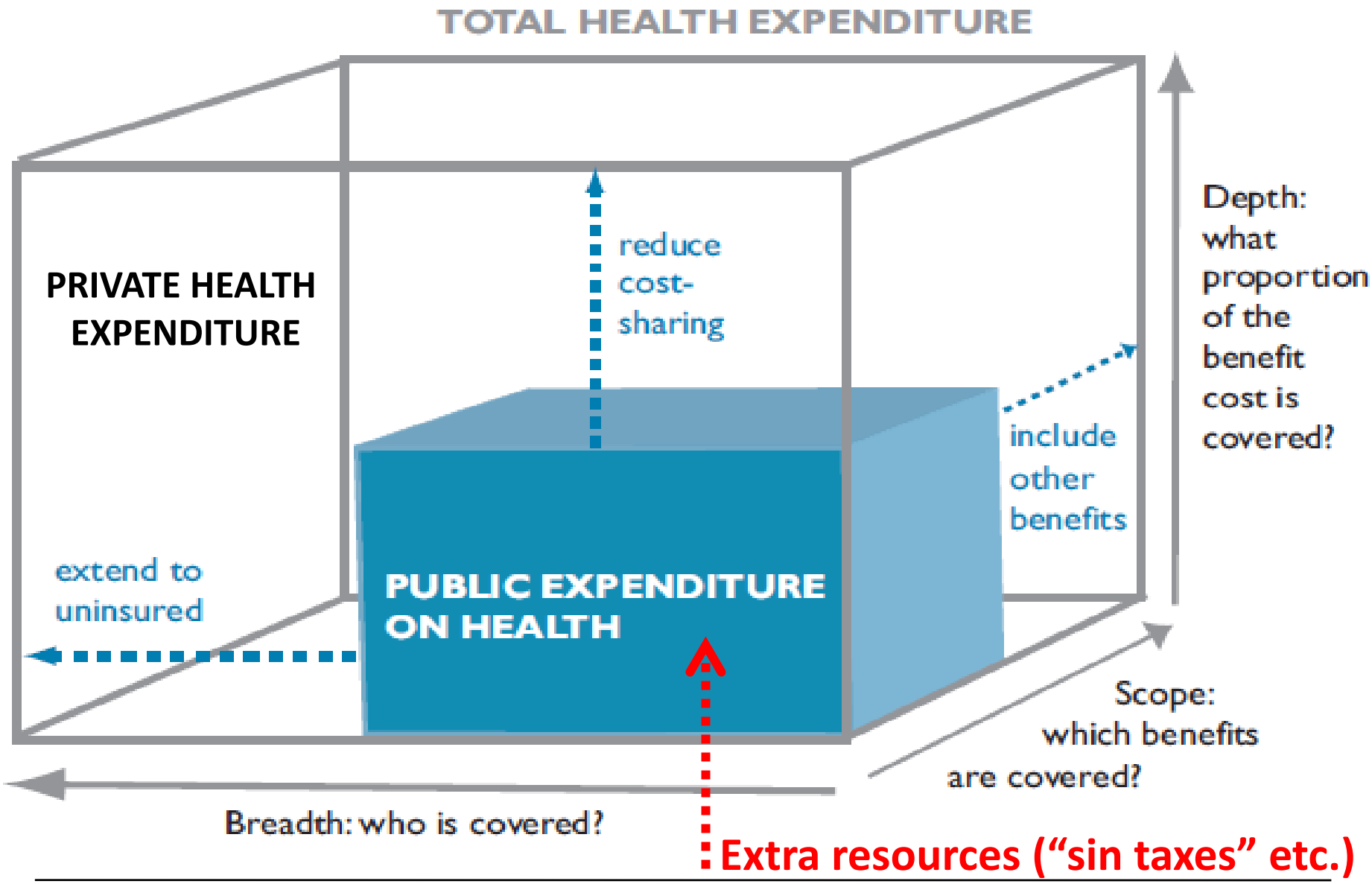

TOTAL HEALTH EXPENDITURE
PRIVATE HEALTH EXPENDITURE
reduce cost-sharing
include other benefits
extend to uninsured
PUBLIC EXPENDITURE ON HEALTH
Depth: what proportion of the benefit cost is covered?
Scope: which benefits are covered?
Breadth: who is covered?

How can you respond to shrinking health budgets in times of crisis?

1. Find new money for health care → A GOOD IDEA (BUT WILL PROBABLY NOT BRING IN ENOUGH)
2. Exclude persons from coverage → NOT A GOOD IDEA
3. Exclude certain benefits from basket → NEEDS A CAREFUL EVALUATION OF EFFECTIVENESS ...
4. Increase cost-sharing → NEEDS TO BE DESIGNED CLEVERLY (AND LESS POWERFUL THAN ASSUMED)
5. Increase efficiency of spending → A GOOD IDEA (BUT NOT IMMEDIATELY EFFECTIVE ; *cf. Peter Smith*)

Idea 1: Can we get extra money for health?



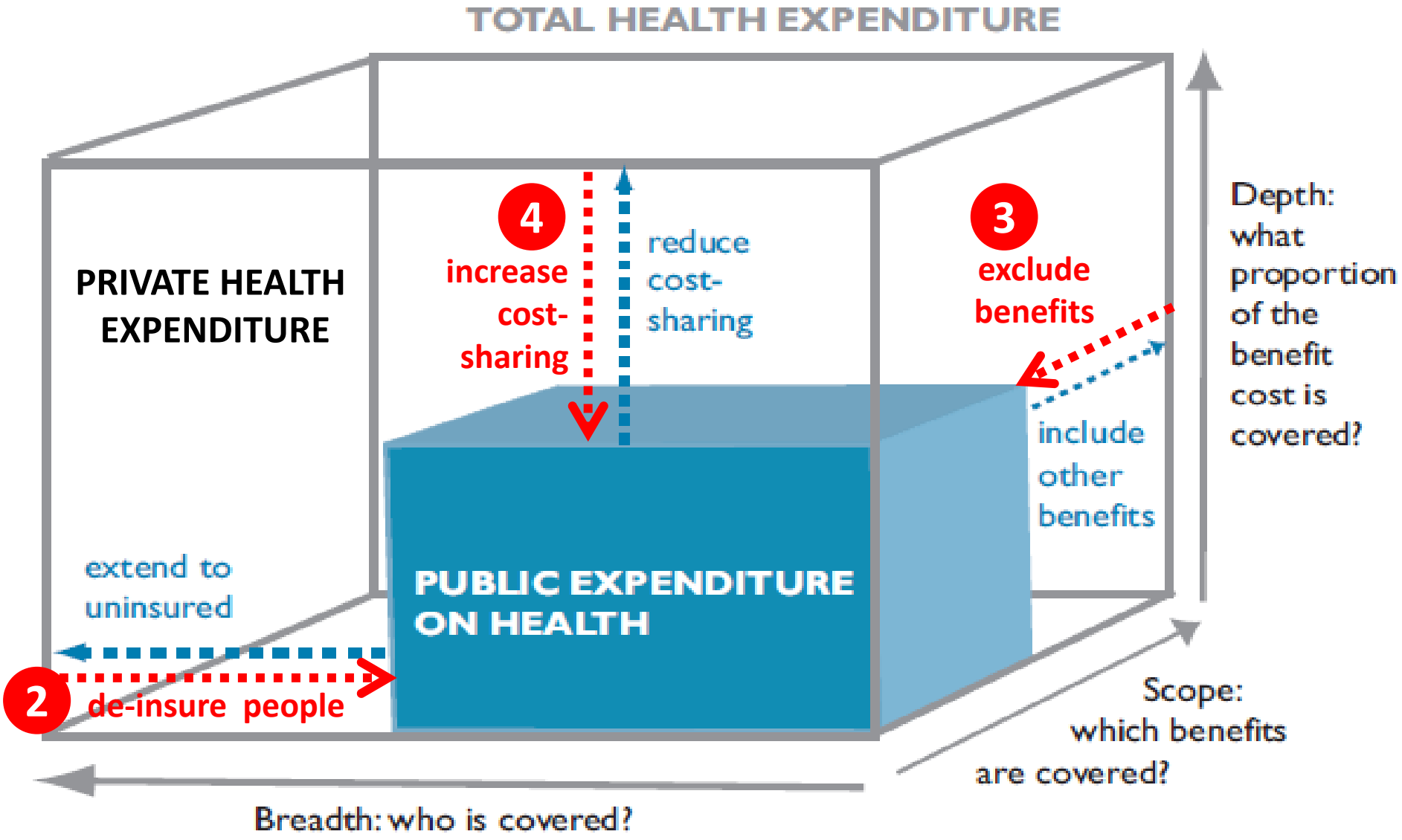
Typical examples of additional financial sources

- on tobacco
- on alcohol
- on fat, sugar …

double effect: less consumption
(→ less health care costs in future)
+ more/ equal money

- on pharmaceutical advertisement
- on car insurance
- on equipment for dangerous sports

Ideas 2, 3 and 4 (if 1 is not enough): Where to reduce public spending?



The Italian NHS basic package

- A first national "list" identifies of the main areas of service to be guaranteed by the NHS (LEAs Essential Levels of care)
  1. Public health services
  2. Community care
  3. Hospital care

- *It is not a precise list. What is included in subject to interpretation according to several laws (summarised in an Annex)!*

1. Public health services

- prophylaxis against infectious diseases
- Public health protection of risks associated with environmental pollution
- public veterinary services
- healthy food surveillance
- prevention services for individuals: obligatory and recommended vaccination; early diagnosis programs
- legal medical services

2. Community care

- primary health care services (ambulatory and domiciliary)
- emergency care
- pharmaceutical services delivered by pharmacies: provision of medicines and Galenical preparations (fully and partially reimbursable); supply of innovative pharmaceuticals
- supplementary services : supply of dietary products to special patient categories
- specialized ambulatory services: treatment, rehabilitation, diagnostic services
- prosthesis services to disabled
- ambulatory and domiciliary community care: ADI (supplementary domiciliary care); health and social services for safeguarding of maternity, responsible reproduction and abortion; health and social services for psychiatric patients and their families; disabled; alcohol and drug addicts; terminally-ill and HIV patients
- residential and semi-residential community care: health and social services for not self-sufficient elderly; rehabilitation services for drug and alcohol addicts, psychiatric patients, disabled, terminally-ill and HIV patients
- thermal treatment for certain pathologies

3. Hospital care

- emergency services
- ordinary recovery
- day hospital
- day surgery
- hospital domiciliary services (based on regional organizational arrangements)
- rehabilitation
- long term recovery
- collection, elaboration, control and distribution of blood components; transfusion services

Where to cut?
What criteria?

1. Public health services

- …phylaxis against infectious
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- pr…
- ambulatory …
  (supplementary do…
  services for safeguarding …
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- thermal treatment for certain pathologies

Problem: most services are beneficial for some but are often used in other patients as well ("inapprorpriate")
→ need to start with this problem

Where to cut?
What criteria?

- A second national list identifies services partially covered by the NHS (services are only available for specified clinical conditions)
  - Dental Services
  - Bone densitometry
  - Physical therapy and ambulatory rehabilitation services
  - Refractory laser therapy
- A third national list identifies services which are excluded by NHS coverage
  - Plastic surgery not following accidents, diseases or genetic malformations
  - Ritual male circumcision
  - Non conventional medicine (acupuncture, phyto-therapy, ayurvedic medicine, homeopathy, chiropractic care, osteopathy and all other non conventional care not specified above)
  - Non obligatory vaccination for traveling purposes
  - Medical certificates (except for scholars)
  - Some rehabilitation/ physical therapy services

What to add?

Health Technology Assessment

International Journal of Technology Assessment in Health Care, 18:2 (2002), 361–422.

BEST PRACTICE IN UNDERTAKING AND REPORTING HEALTH TECHNOLOGY ASSESSMENTS

Working Group 4 Report

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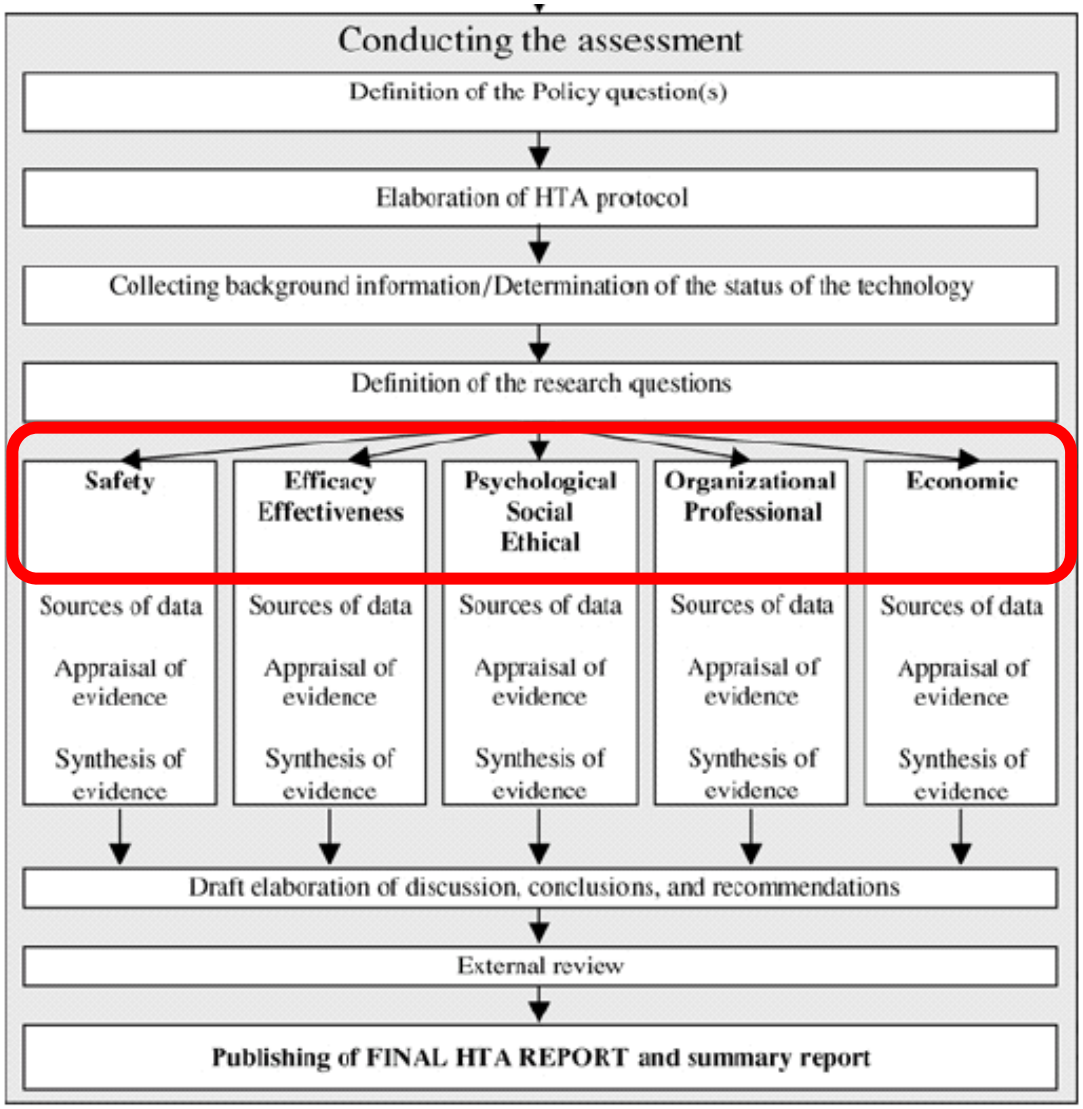
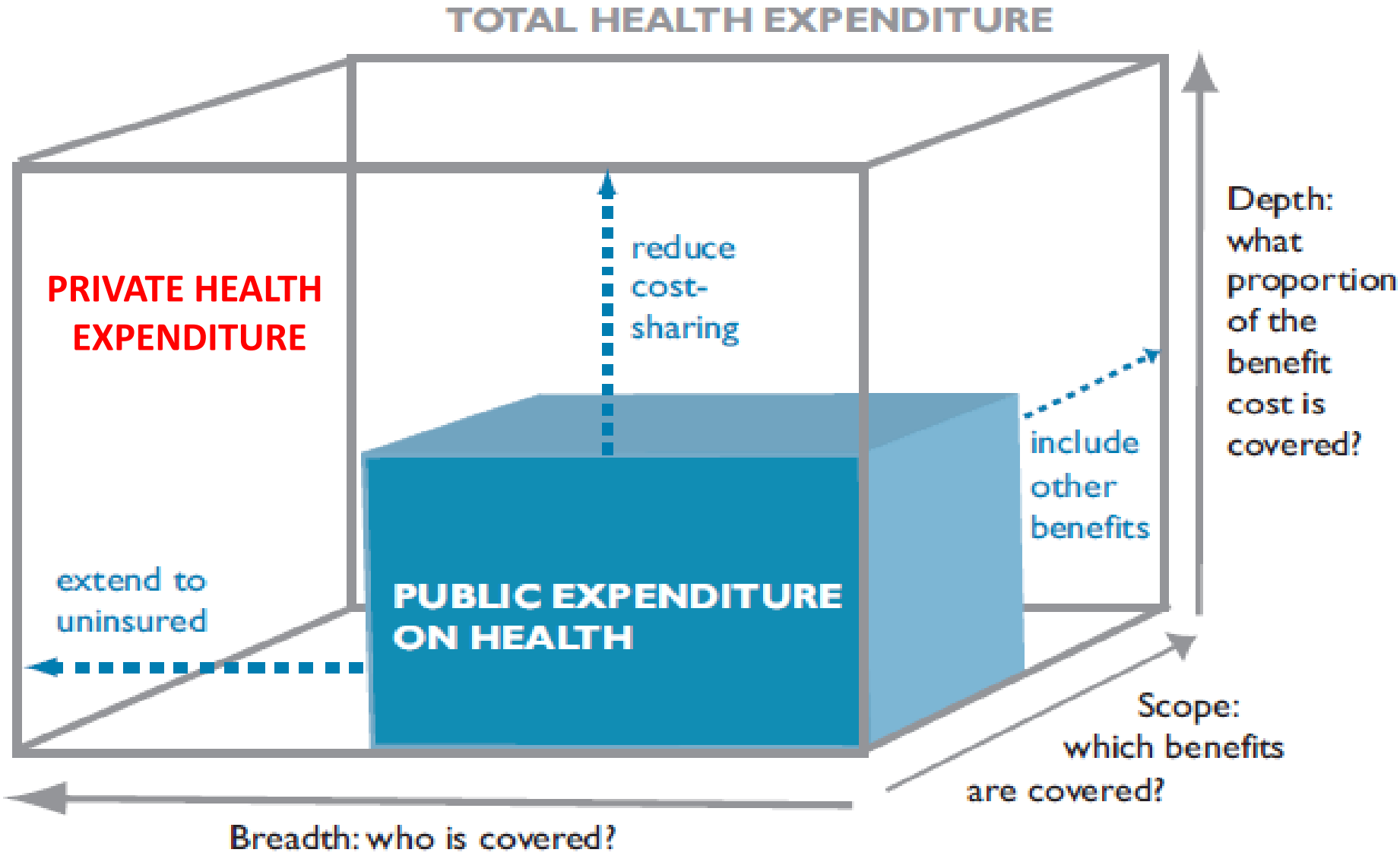
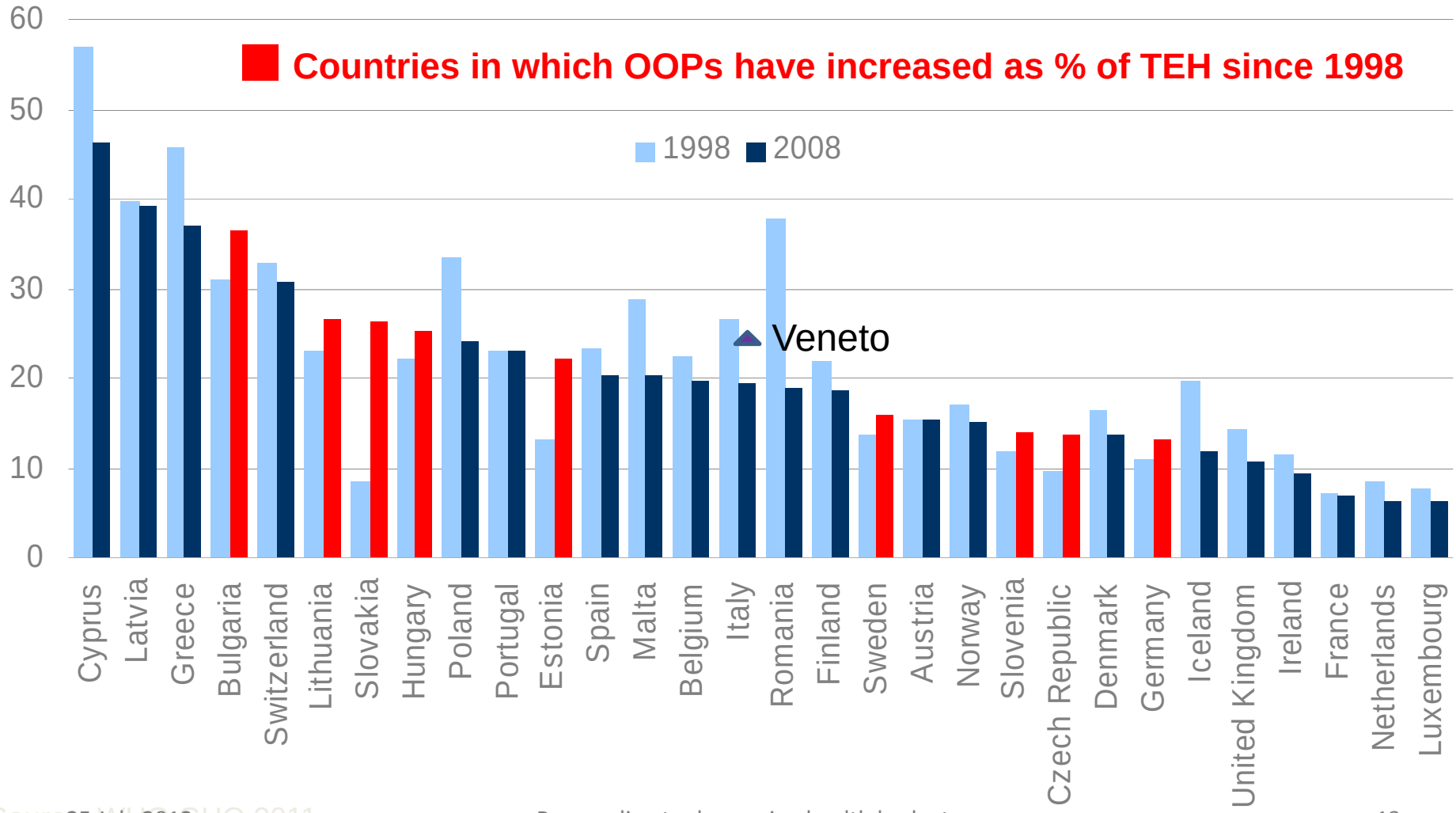


If we do 3 and 4:
Where should the private money come from?



Where are you now?

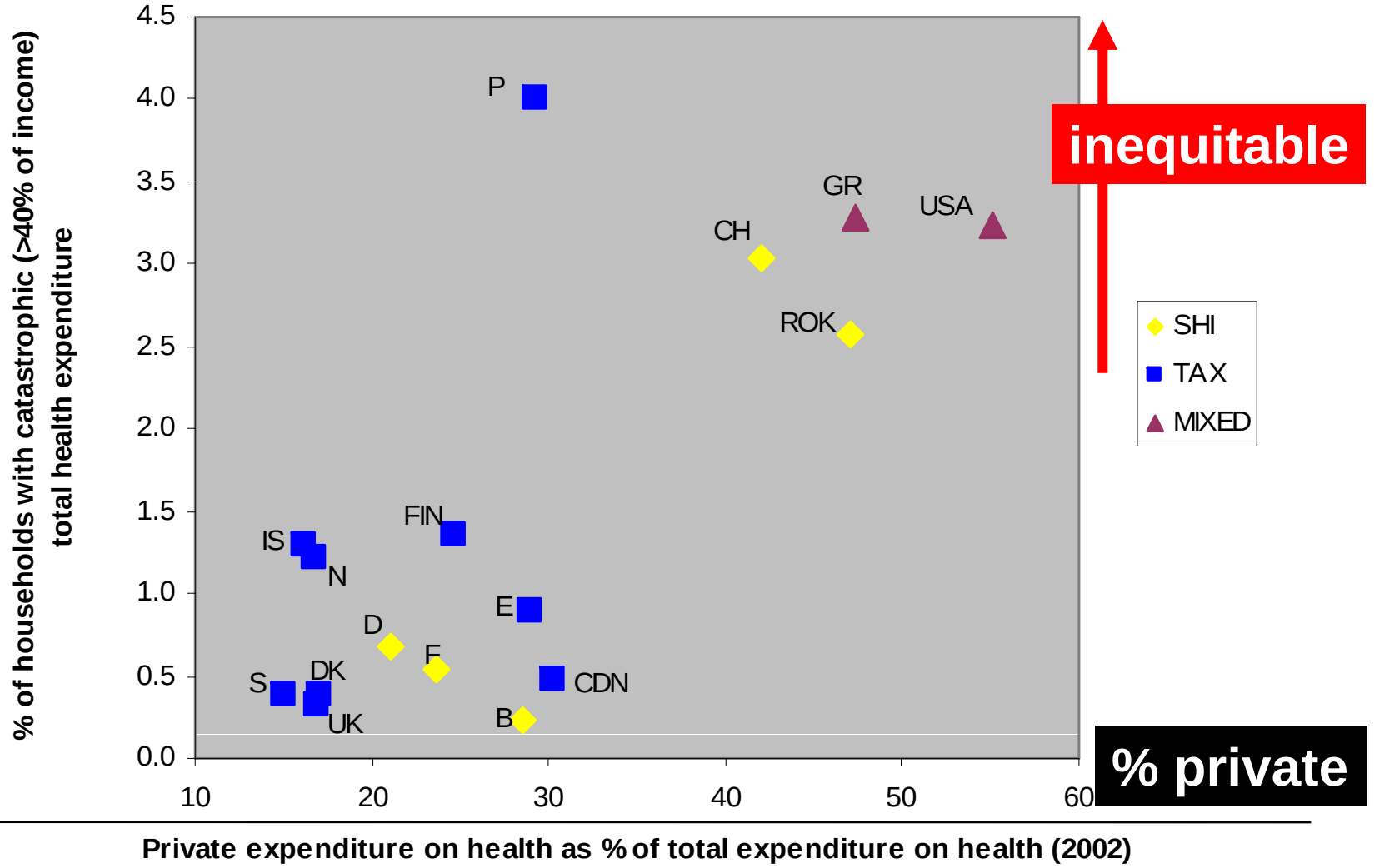
Out-of-pocket payment as % of total health spending



Source: WHO 2011

Is there a maximum on private expenditure? Yes, at around 30-35%

% households bankrupt due to health expenditure

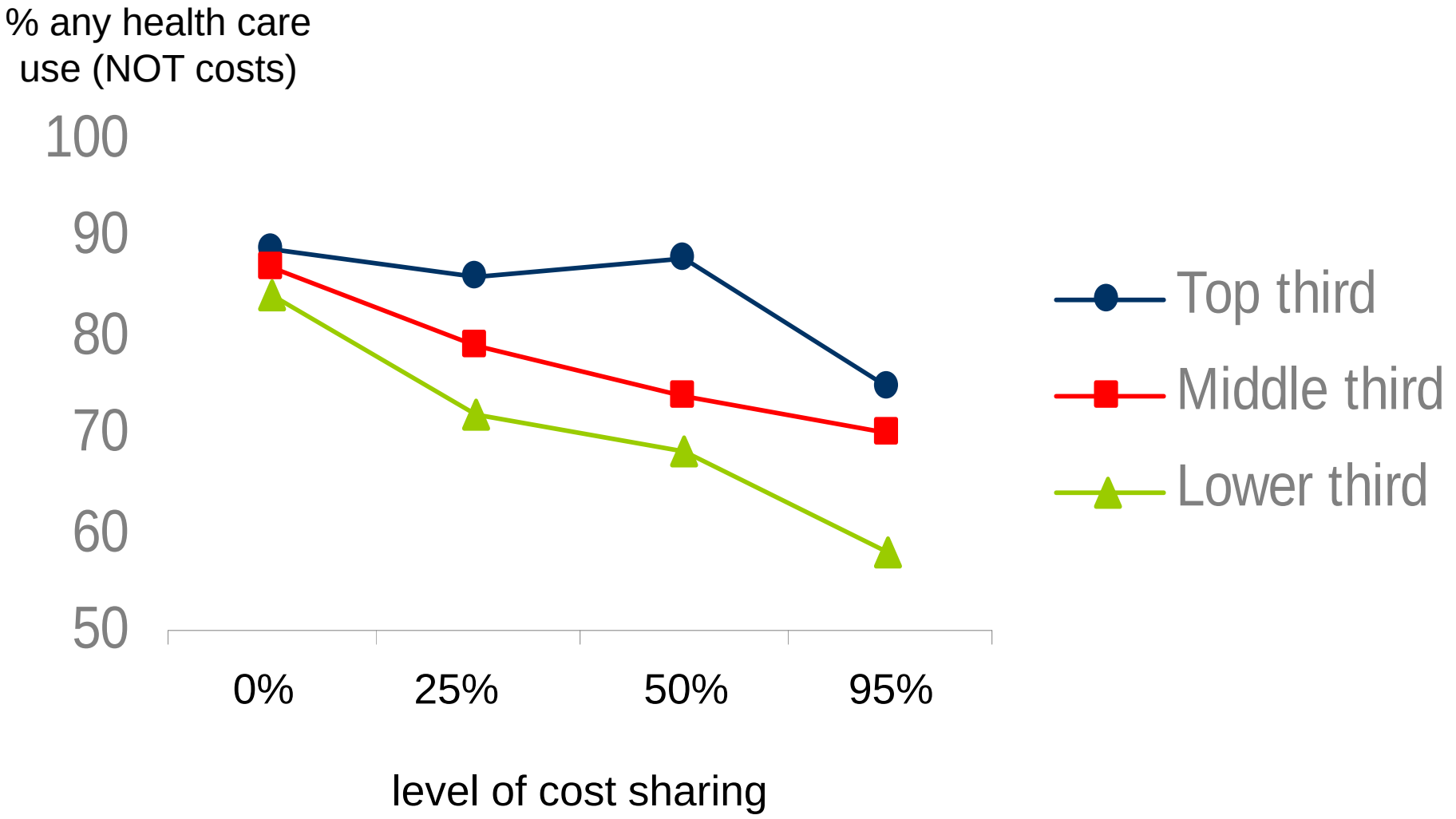


Arguments and evidence

Cost-sharing

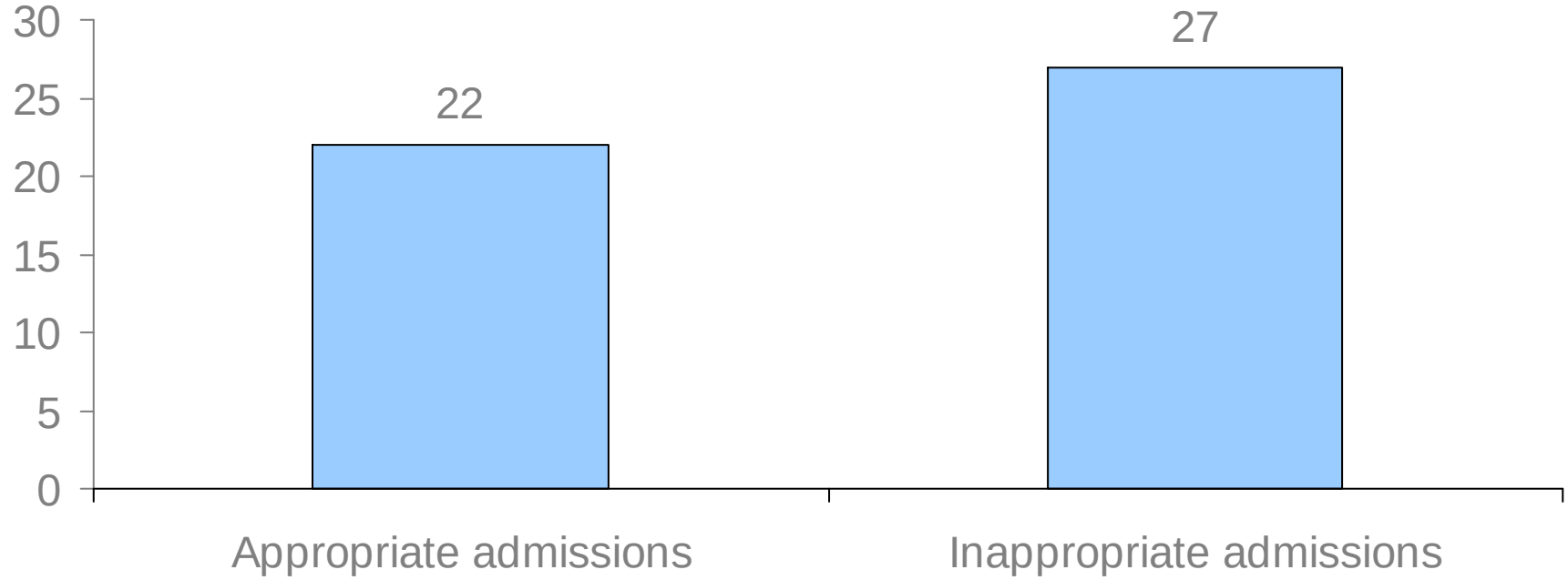
- reduces excess demand caused by full insurance (moral hazard)
  YES, BUT MORE IN POOR → INEQUITY
- contains costs A BIT
- directs people to more cost-effective use NOT BY THEMSELVES → DIFFERENT RATES NEEDED
- raises revenue YES, BUT LESS THAN EXPECTED

Cost-sharing reduces use – for poorer much more than for richer persons



Source: Manning et al 1987 (RAND study)

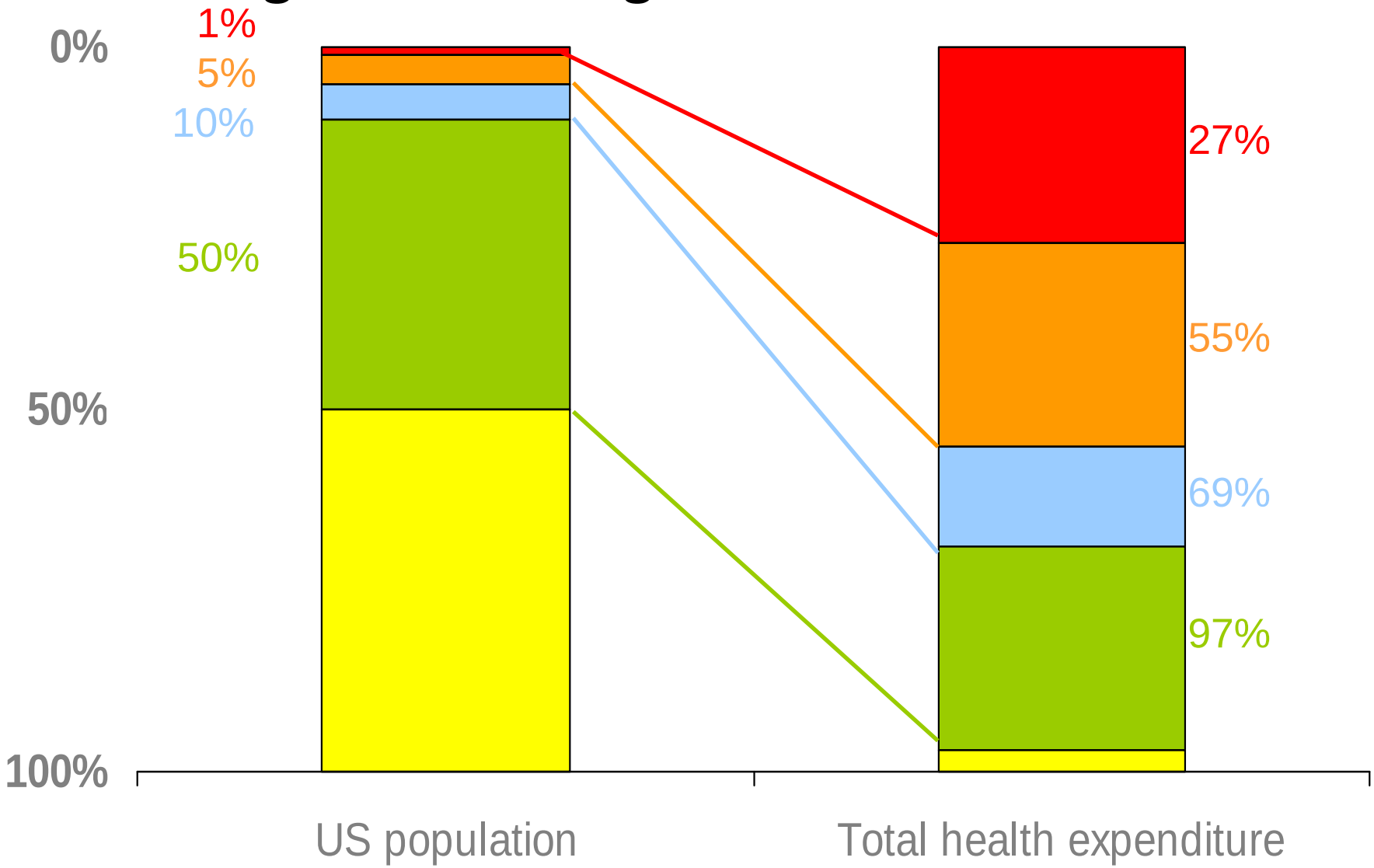
People cannot differentiate between appropriate and inappropriate services → different cost-sharing rates for effective/ necessary and less effective/ less appropriate services needed



% reduction in hospital admissions among those who had to pay (compared to free care)

Source: Siu et al (1986) New Engl J Med, RAND study

How much can you realistically save through cost-sharing?



Source: Monheit 2003 and Berk and Monheit 2001

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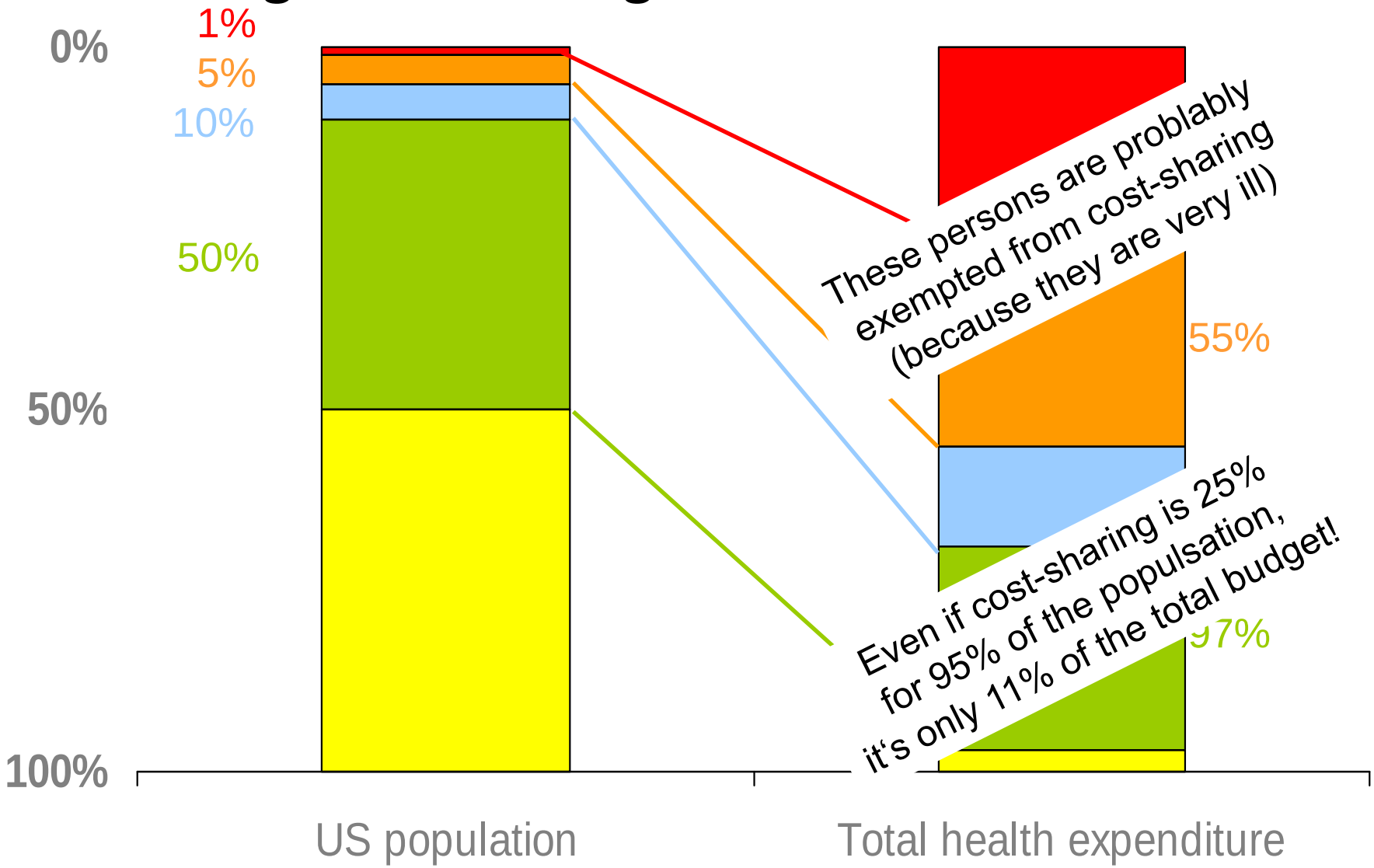

Source: Monheit 2003 and Berk and Monheit 2001

	GP visits			Specialist visits			Outpatient prescriptions				Dental care				Inpatient care		
	D	CP	CI	D	CP	CI	D	CP	CI	RP	D	CP	CI	RP	D	CP	CI
AT																	
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Grey indicates the presence of a user charge; D = deductible; CP = co-payment; CI = co-insurance

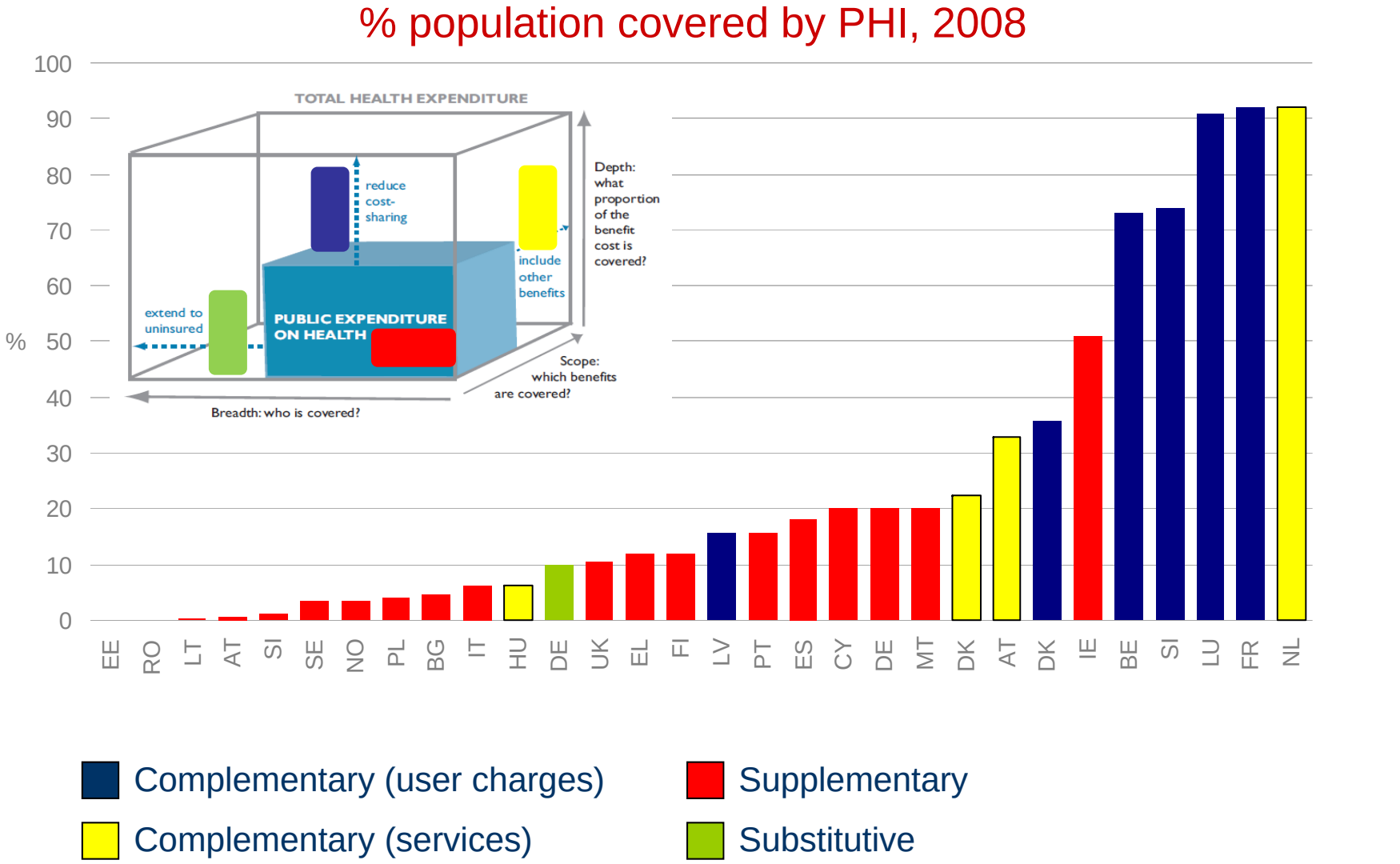
Black indicates the absence of any health coverage (ie the user pays full cost)

Green indicates free care;

Key messages

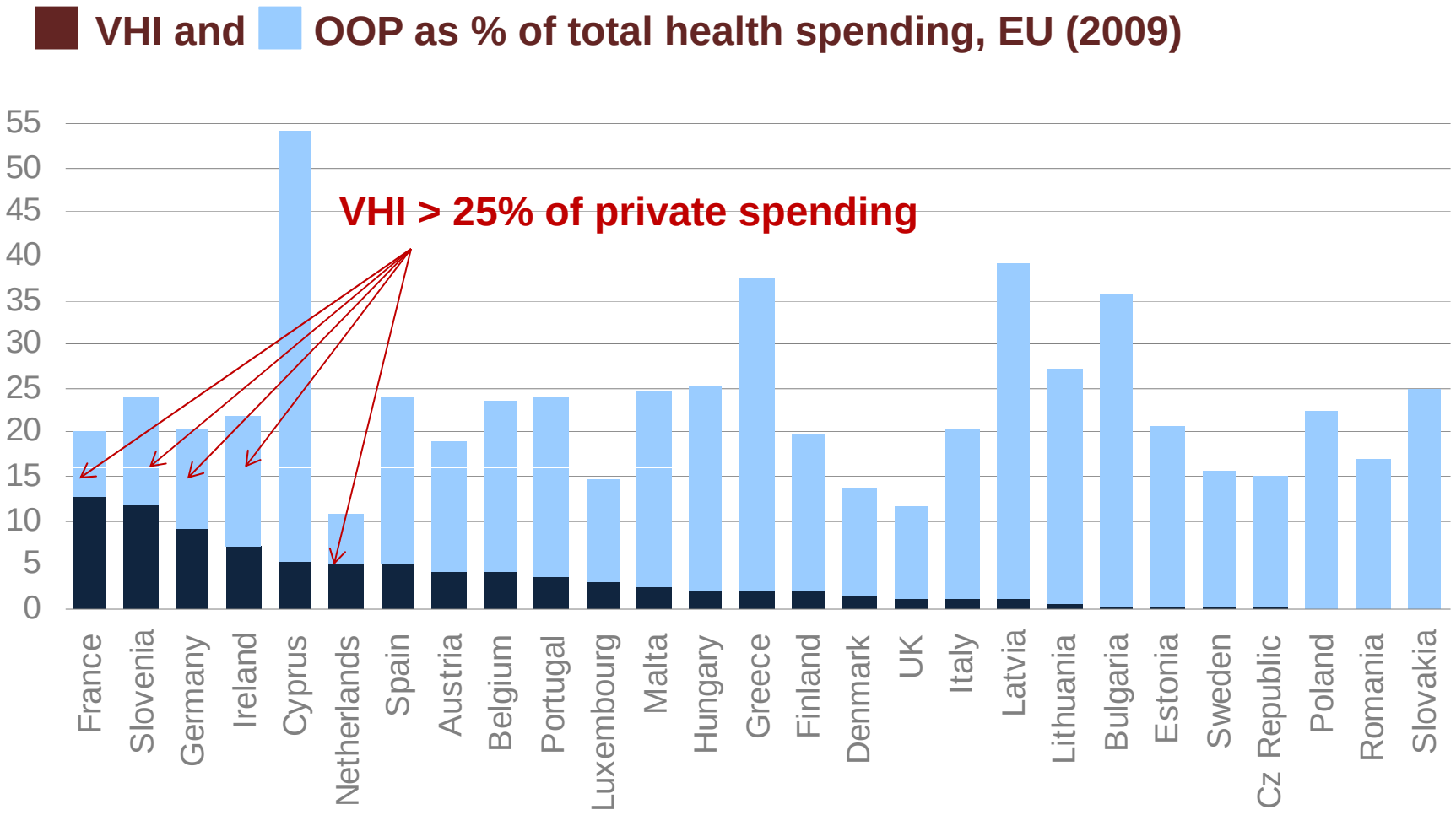
- Cost-sharing may undermine efficiency: patients cannot easily distinguish between cost-effective and non-cost effective care, substitution effects
- policy requires careful design: clarity about goals, clear signals to users, transaction costs, monitor impact on access
- to secure value for money: main policy focus should be on purchasing and supply

What role(s) for Voluntary Health Insurance?



Source: Thomson and Mossialos 2009

Can VHI fill gaps in coverage?



Source: WHO data

Risks associated with VHI

- VHI may not address major problems and may create new challenges
- VHI may exacerbate pressure on public budgets (especially substitutive VHI)
- VHI may undermine value in public spending, especially if public resources subsidise private access to care (eg risk segmentation, tax relief, non-aligned incentives, distortion of public priorities, waiting times etc)
- **the larger the market, the larger the risks**

Key messages

- proceed with caution, clear principles
- **clarity** about goals
- **complementarity**: how best to combine public & private resources to attain health policy goals – requires understanding of how VHI interacts with the health system
- **careful policy design**: anticipate & minimise risks
- **capacity** for regulation & oversight

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