Technische Universität Berlin

Healthcare financing reforms – the international scene

Reinhard Busse, Prof. Dr. med. MPH FFPH

FG Management im Gesundheitswesen, Technische Universität Berlin
(WHO Collaborating Centre for Health Systems Research and Management)
&
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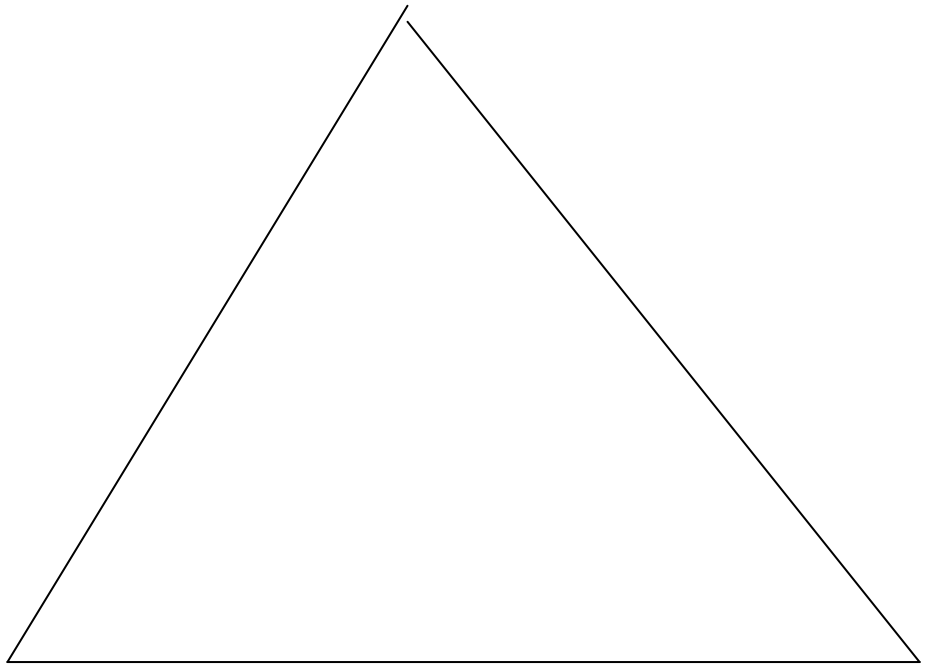
Third-party Payer



Population **Providers**

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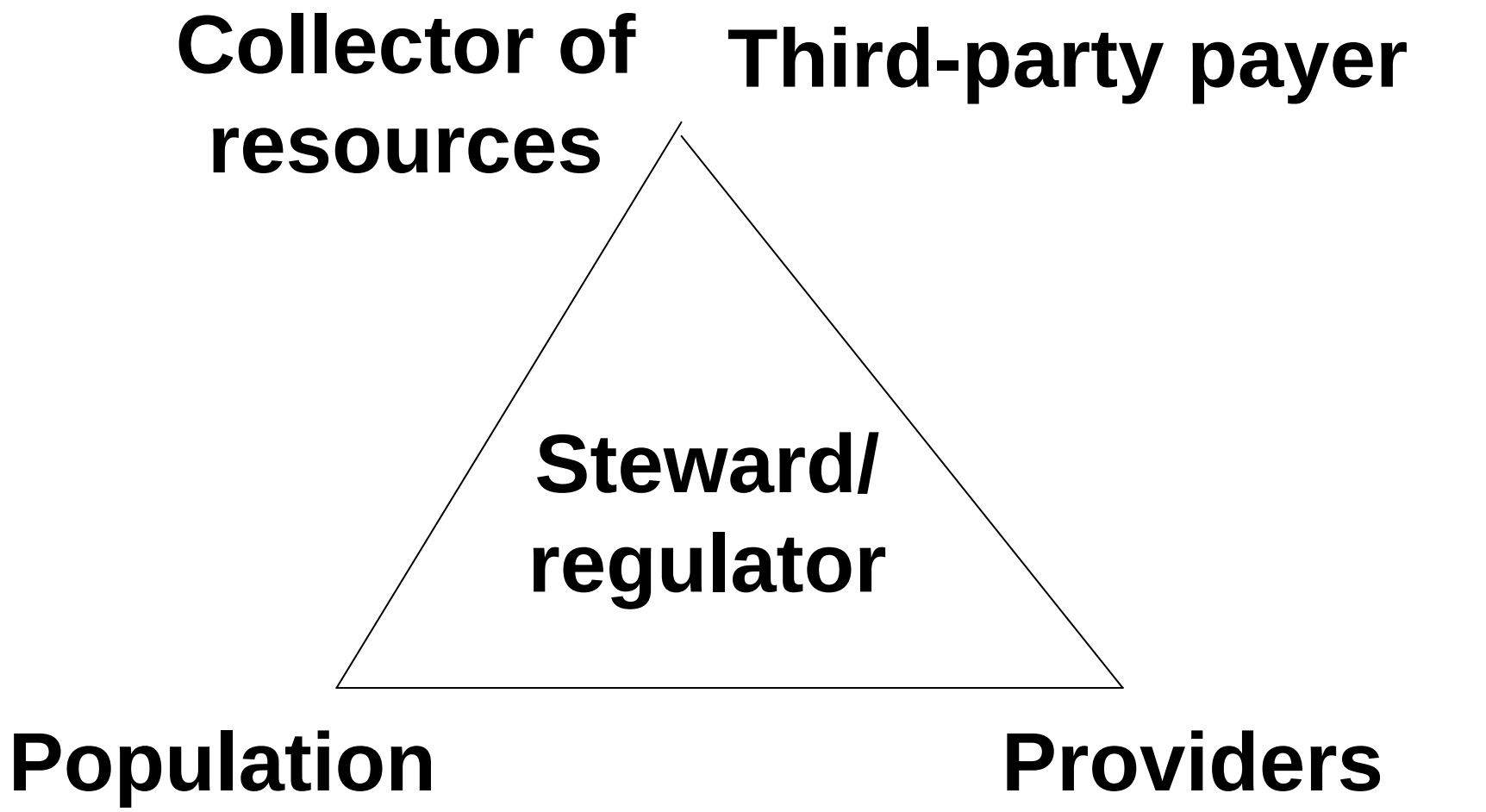

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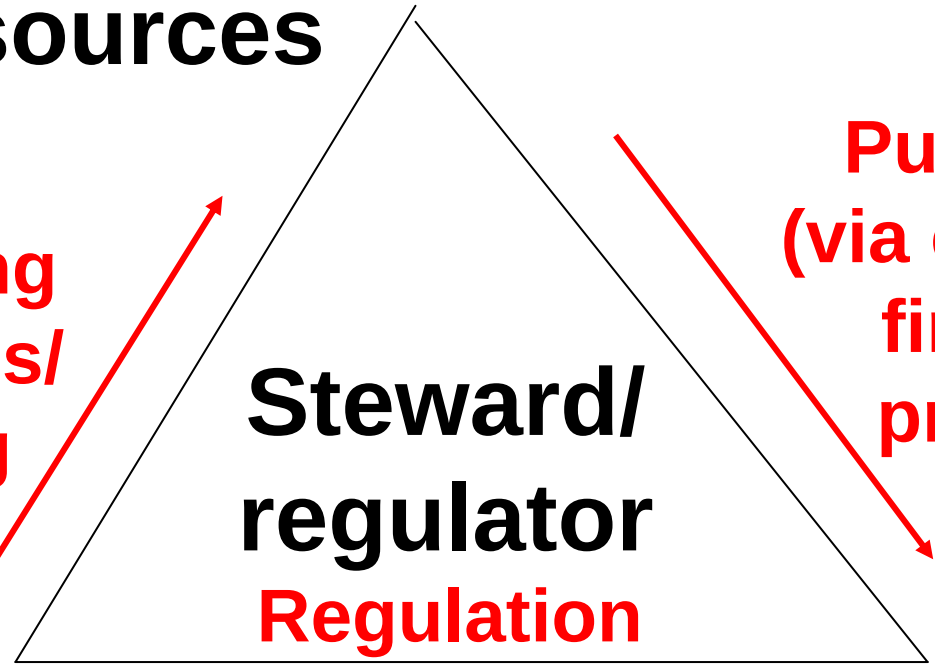
Resource pooling & allocation



Functions

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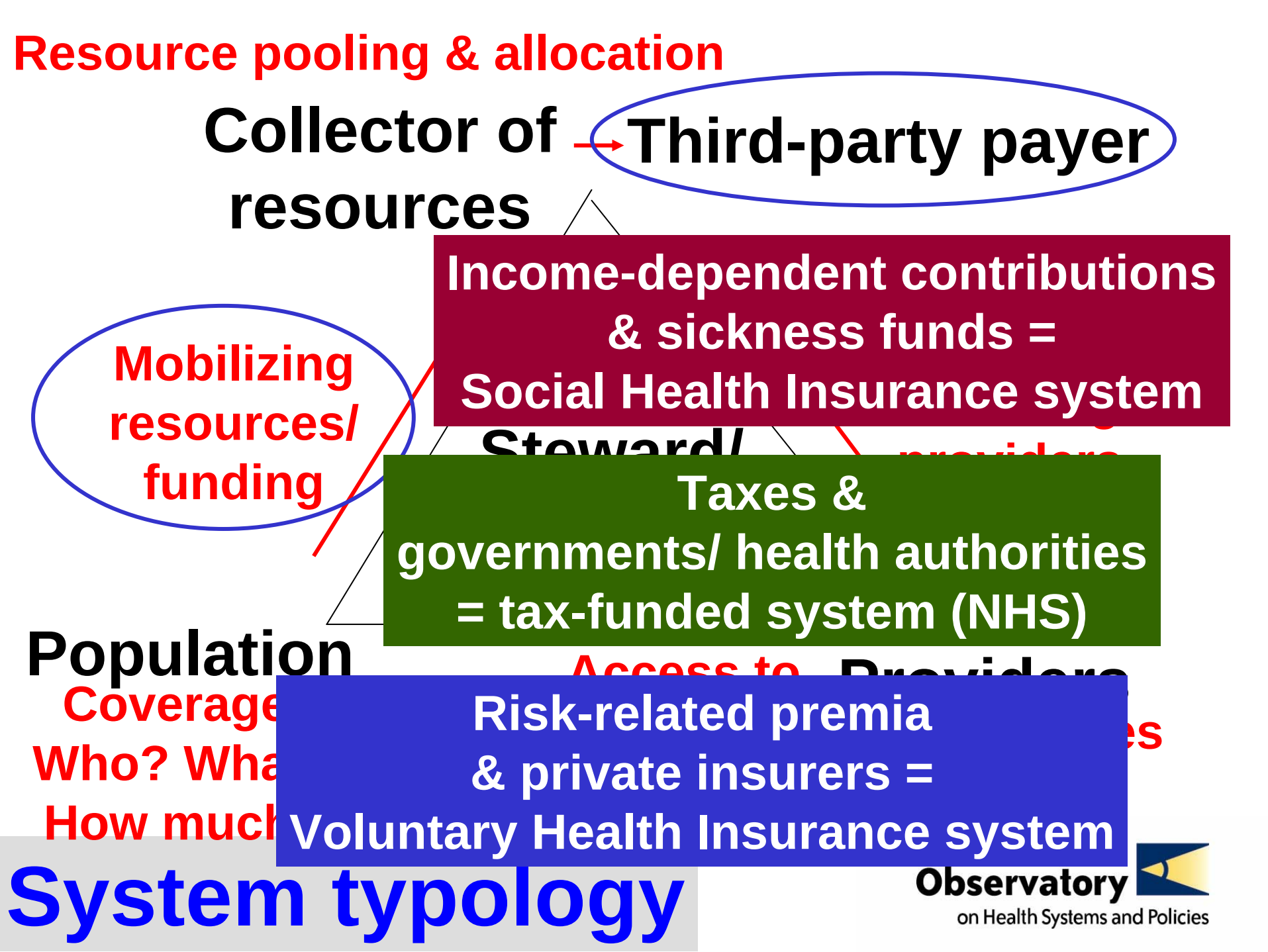
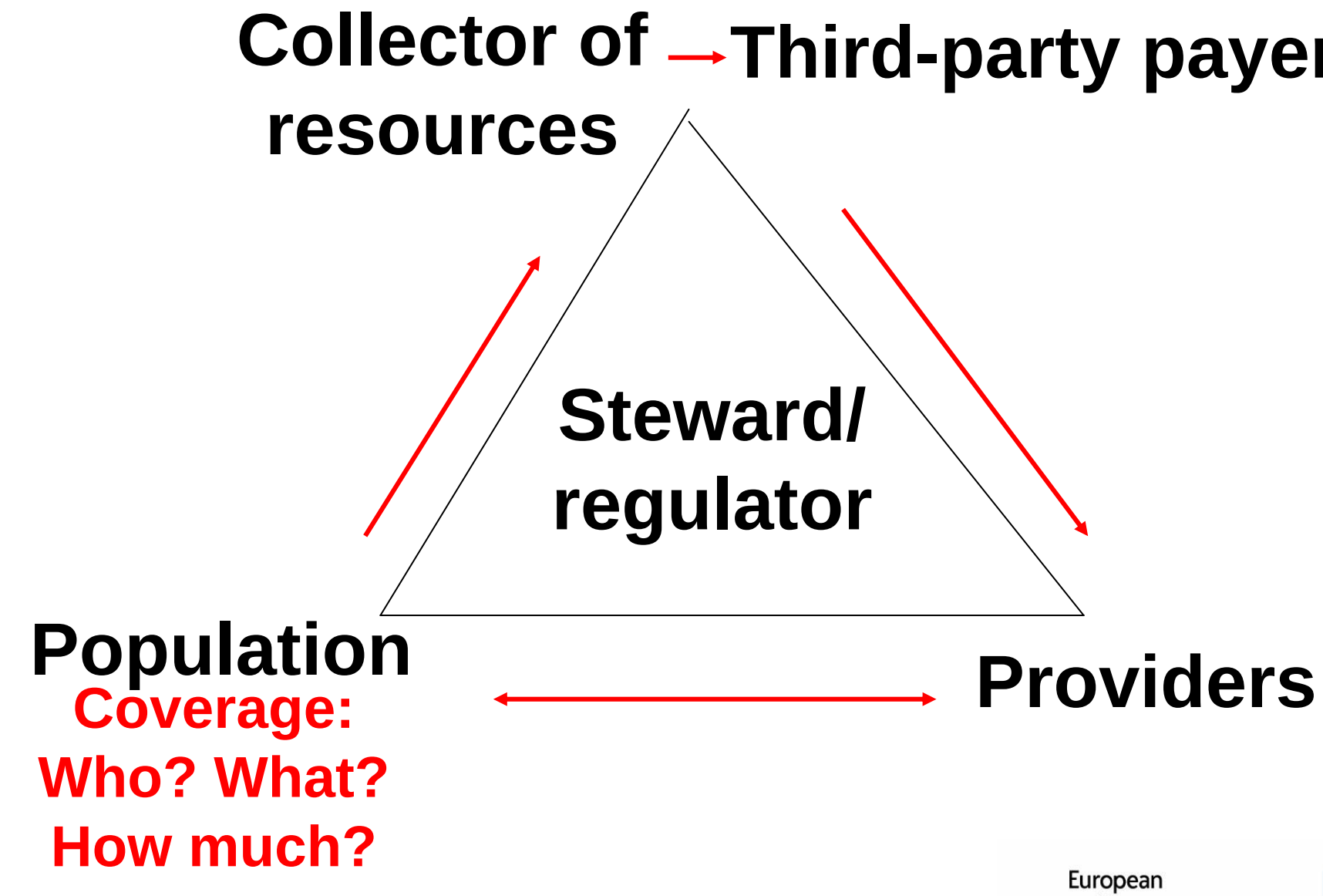

Resource pooling & allocation
Collector of resources
Third-party payer
Income-dependent contributions & sickness funds = Social Health Insurance system
Mobilizing resources/ funding
Taxes & governments/ health authorities = tax-funded system (NHS)
Population
Risk-related premia & private insurers = Voluntary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



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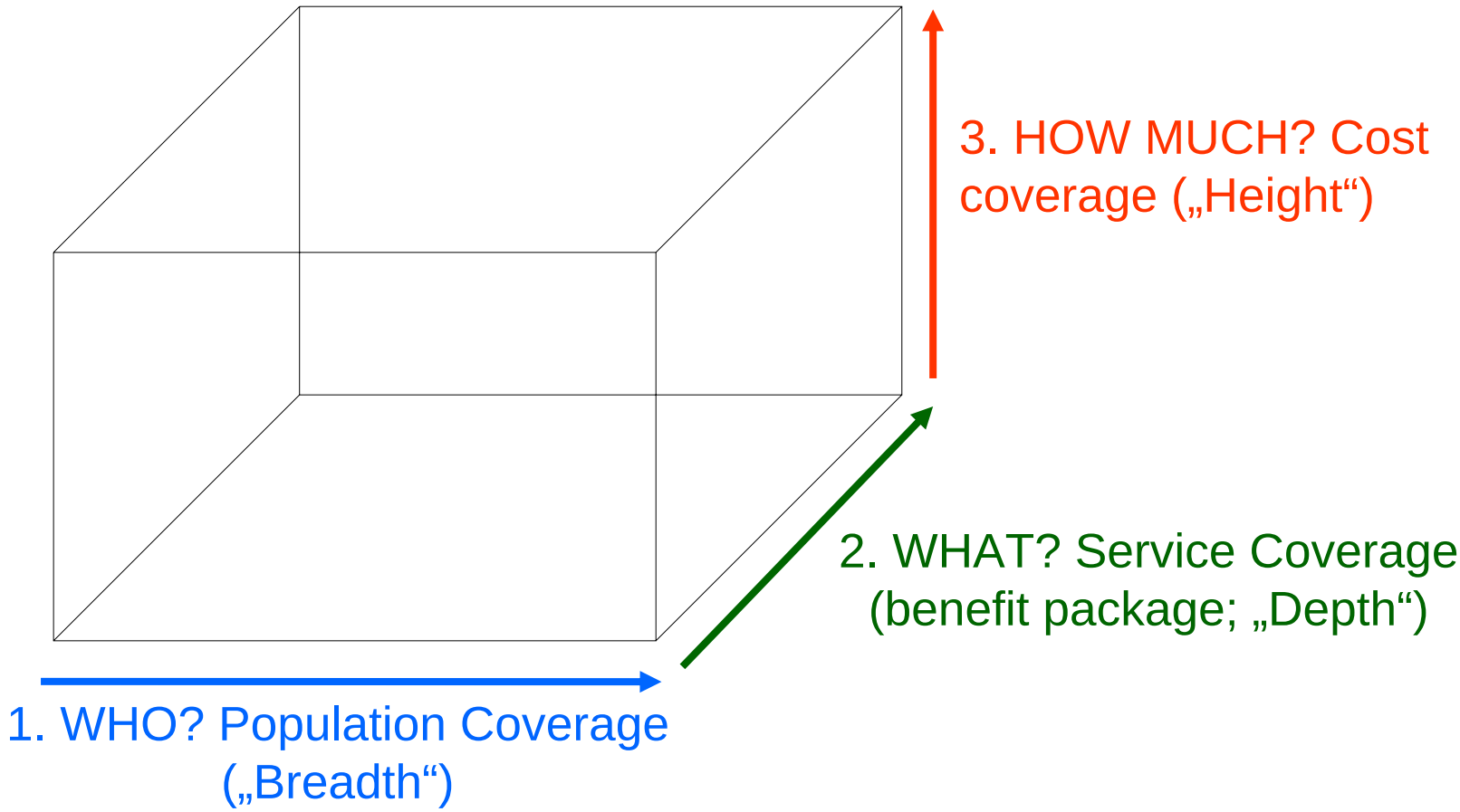
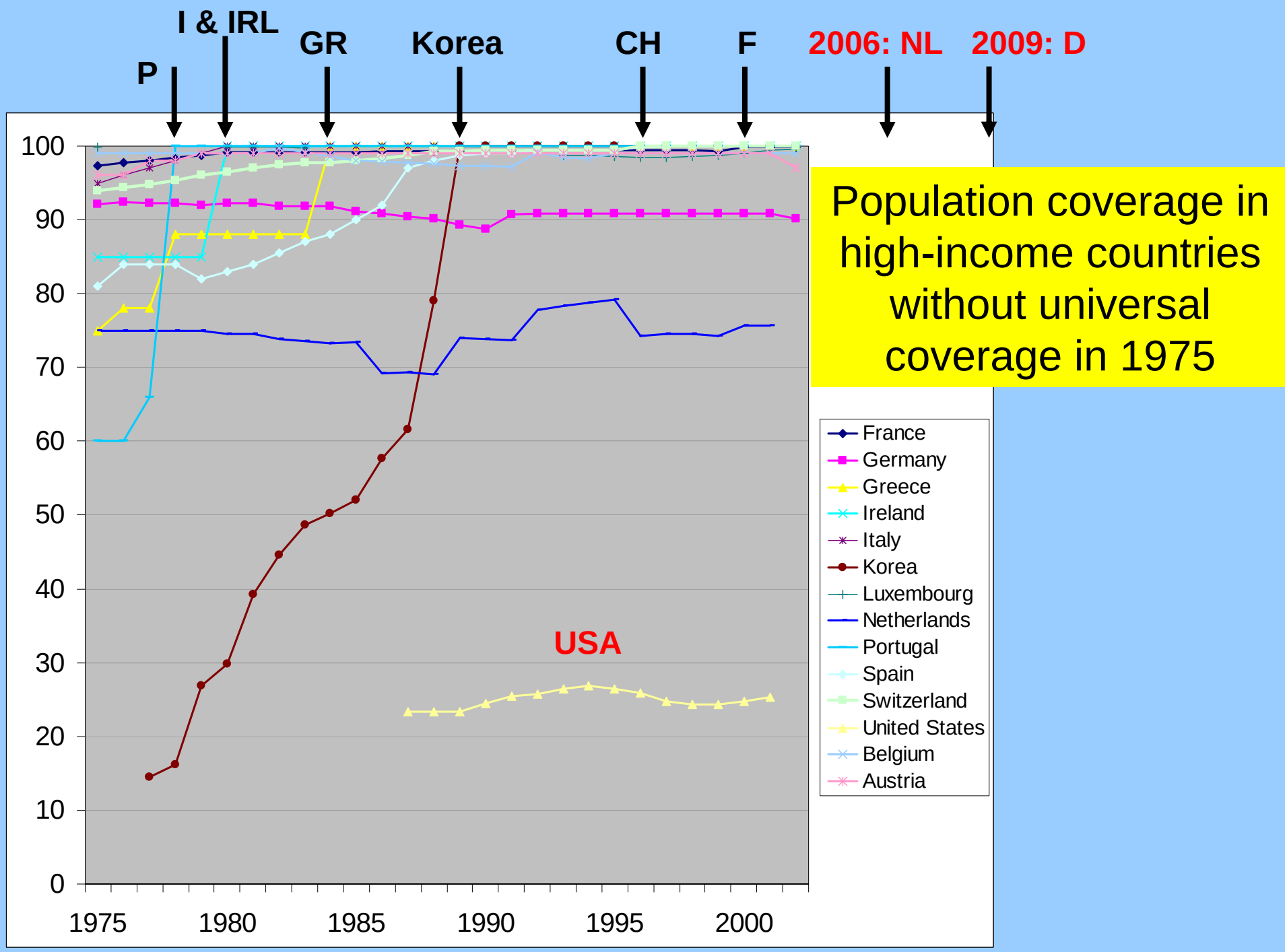
The three dimensions of coverage decisions



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



Population coverage in high-income countries without universal coverage in 1975

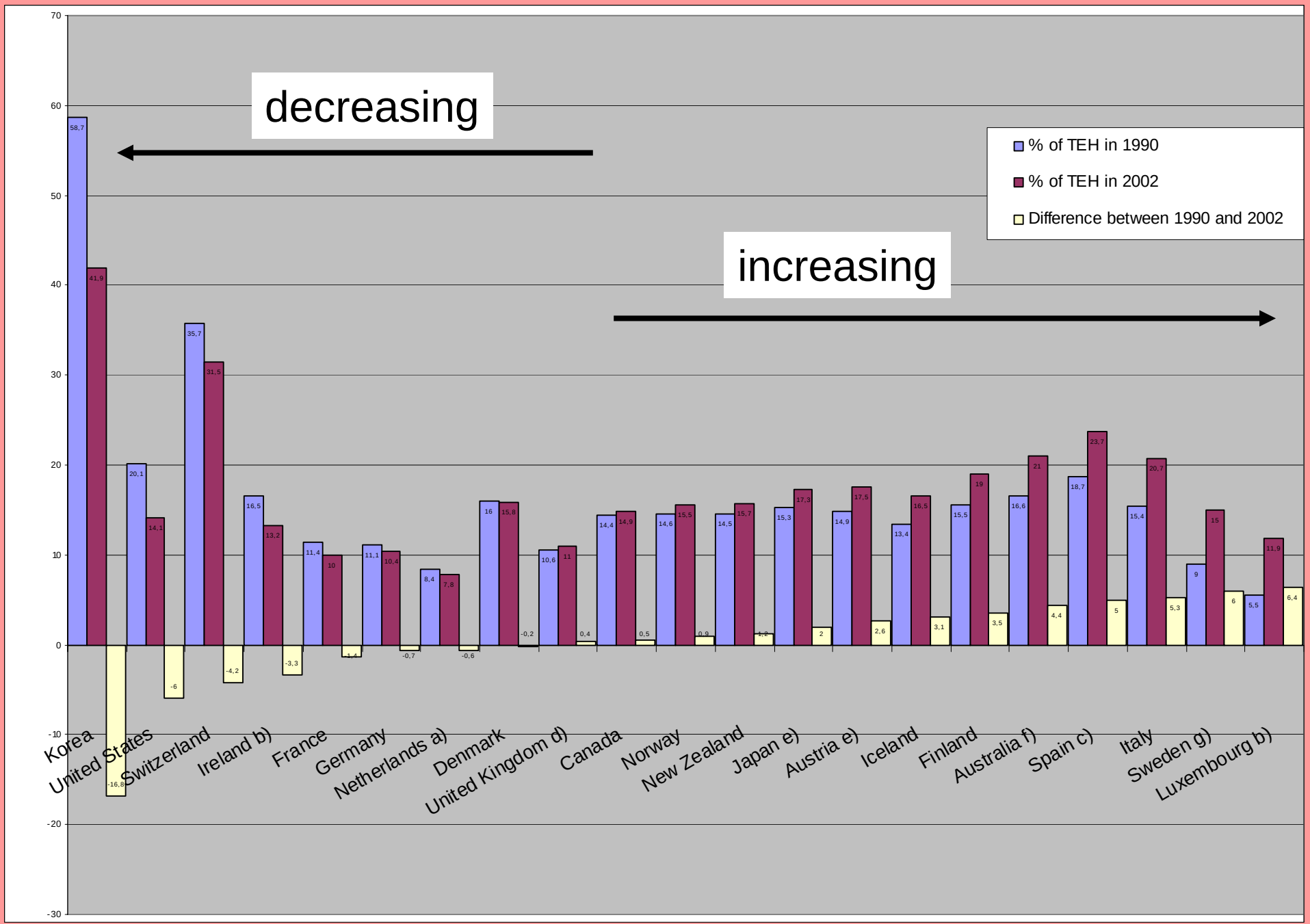
Covered benefits (benefit package)

- 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

Out-of-pocket: a mixed picture

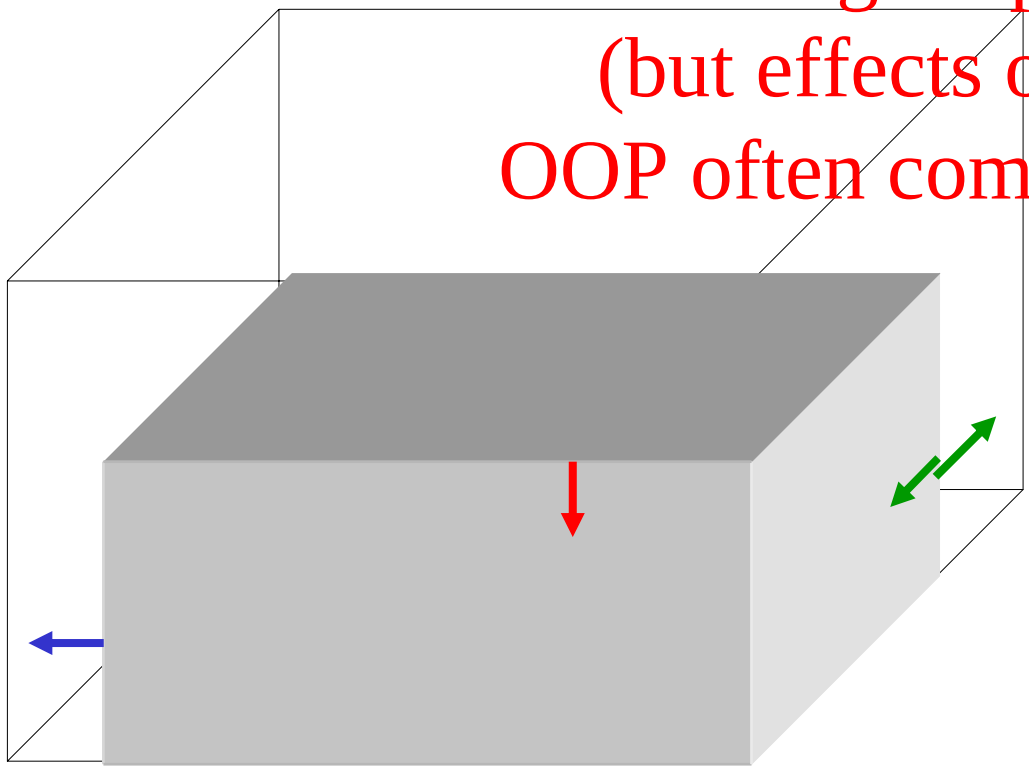


Reduced rates or exemptions commonly relate to one or more of the following:

- **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

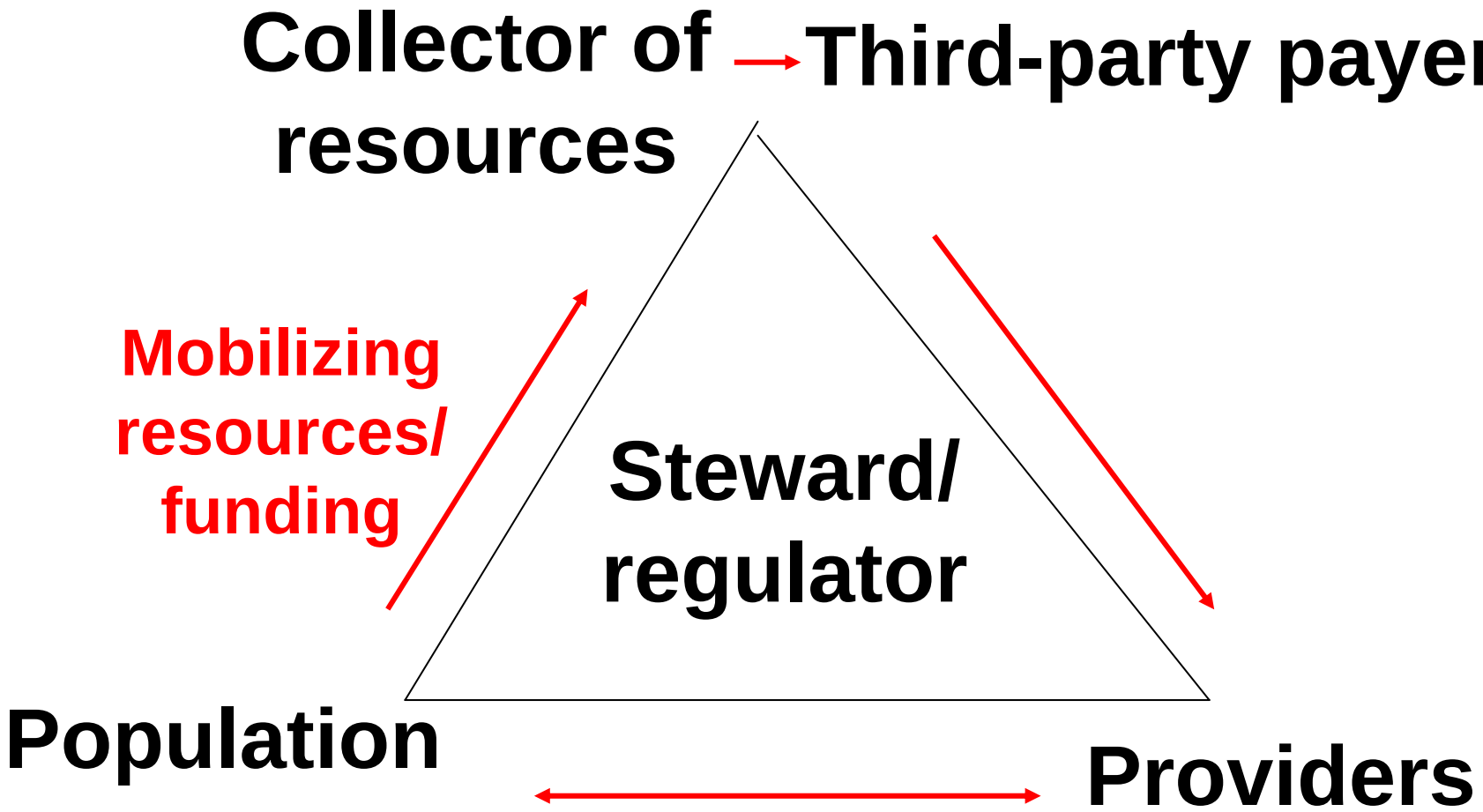
Reform trends I

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



More new benefits
than exclusions

Universal
coverage



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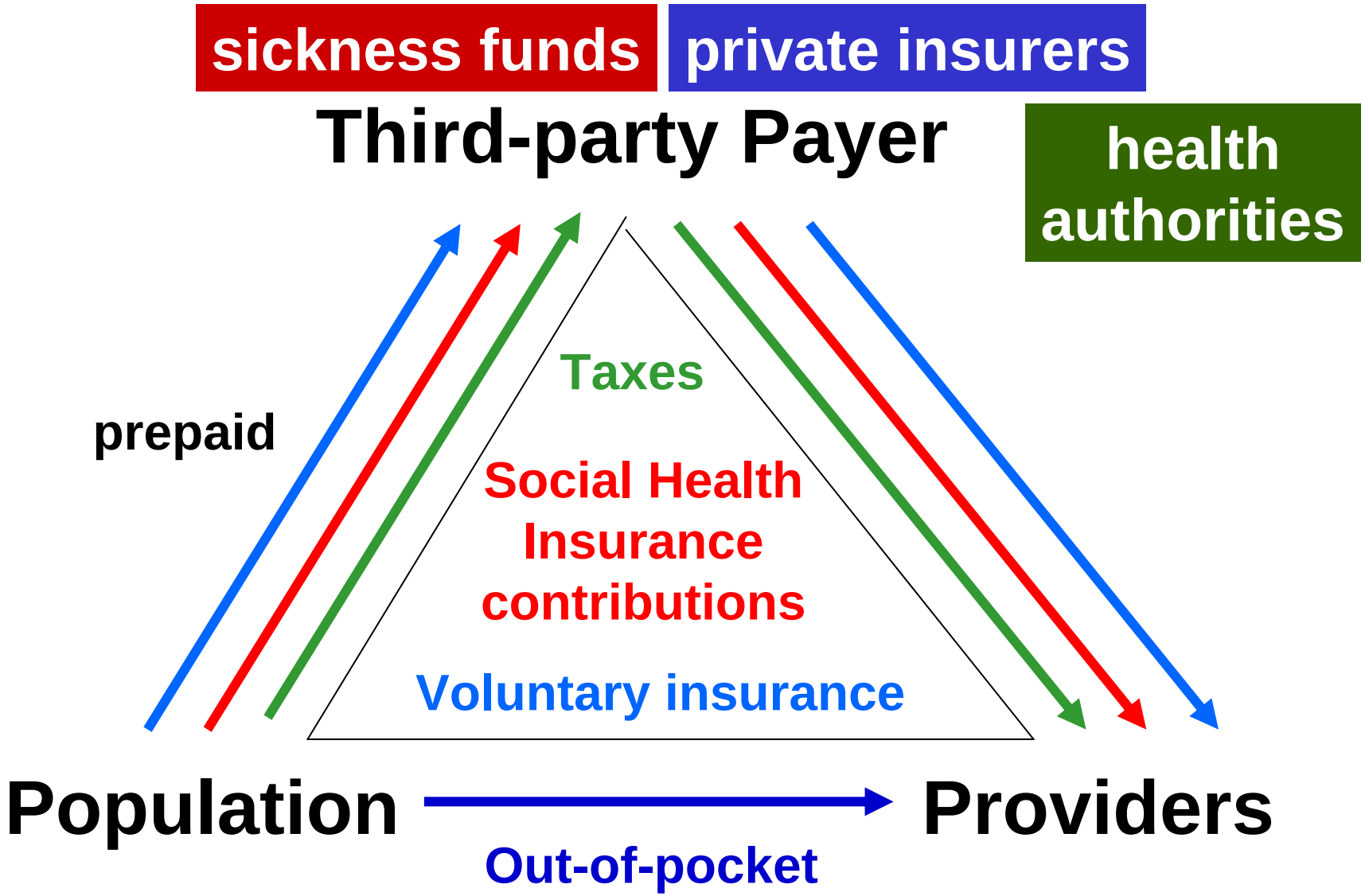

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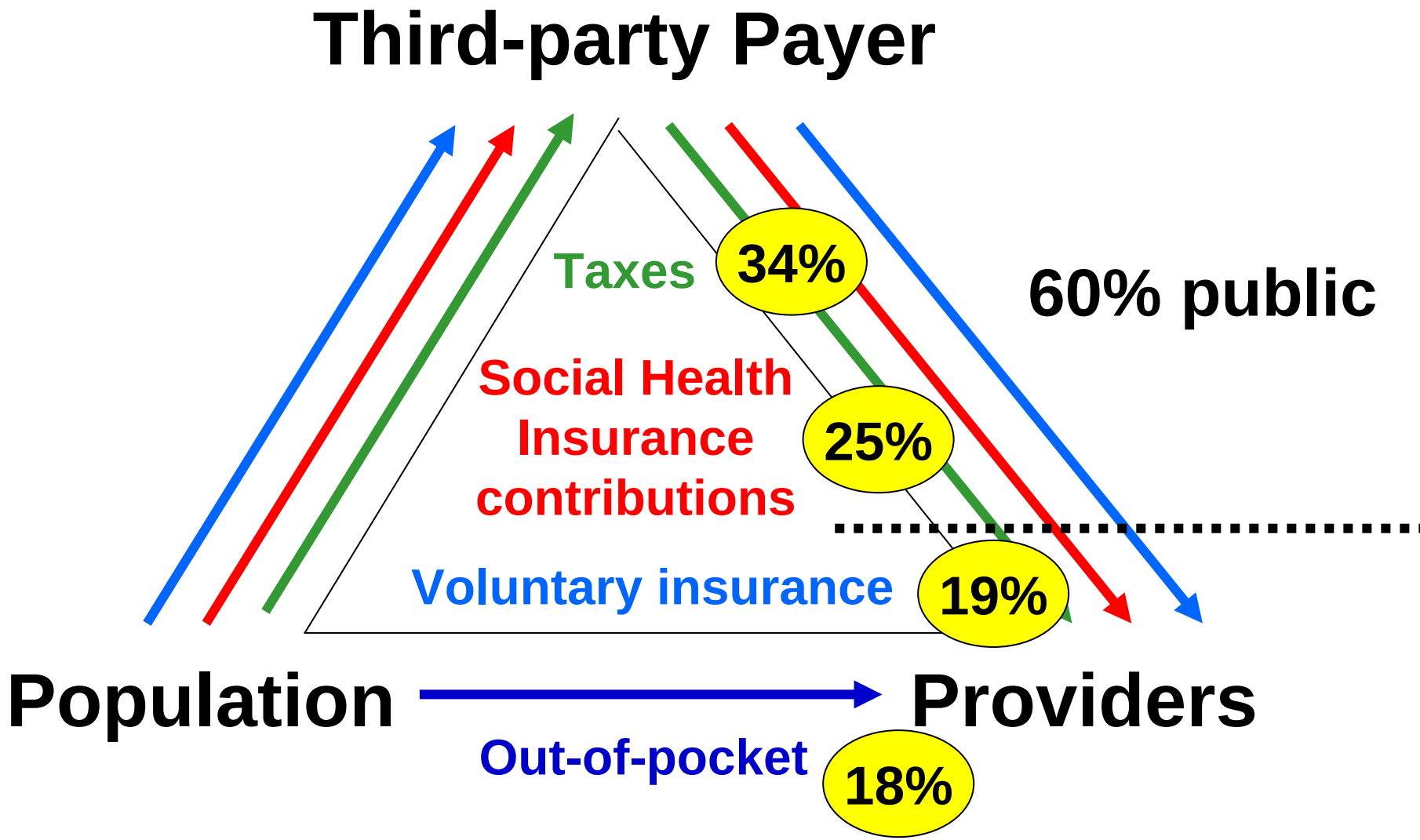

World-wide 2004 *(large US market!)*

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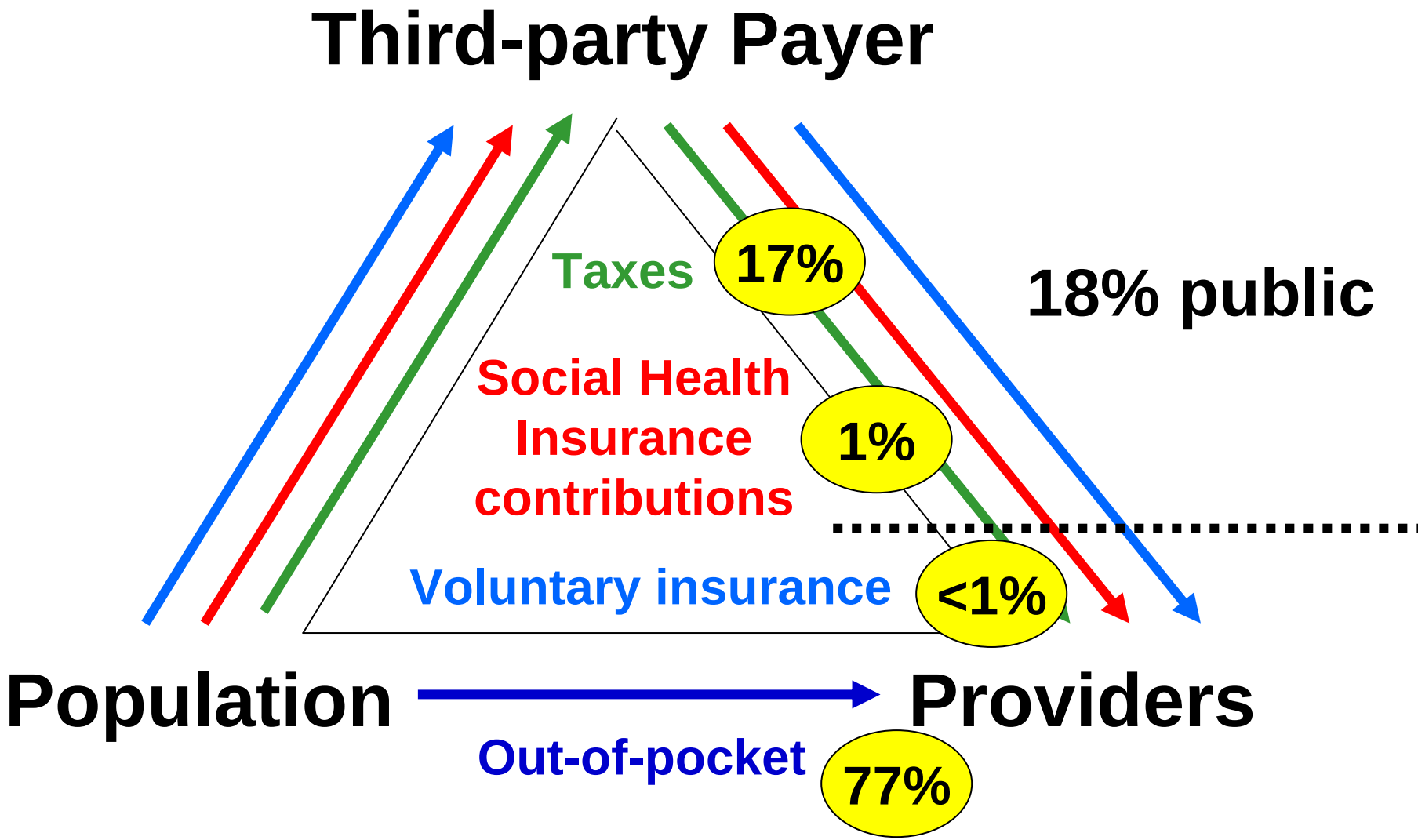

India 2005

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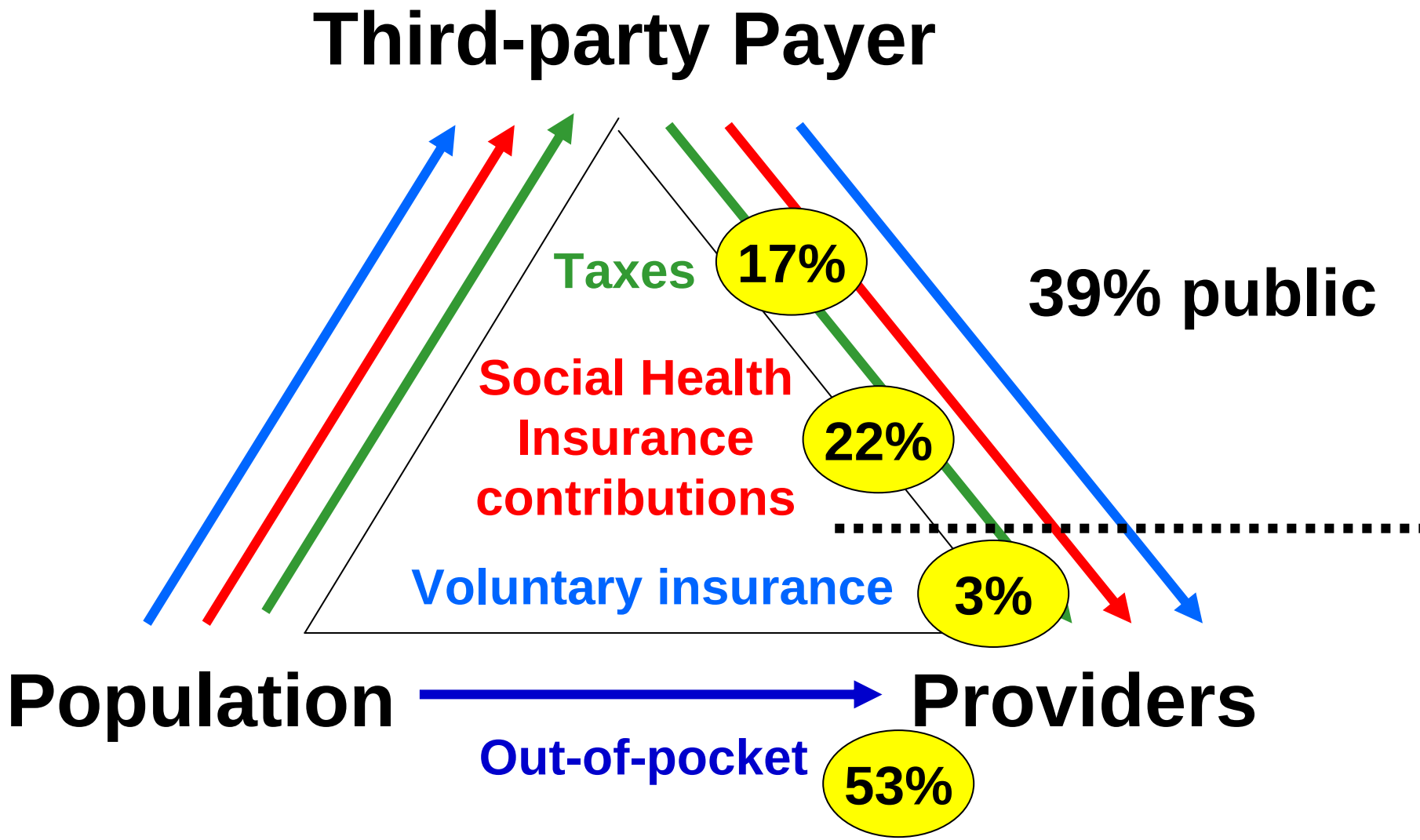

China 2005

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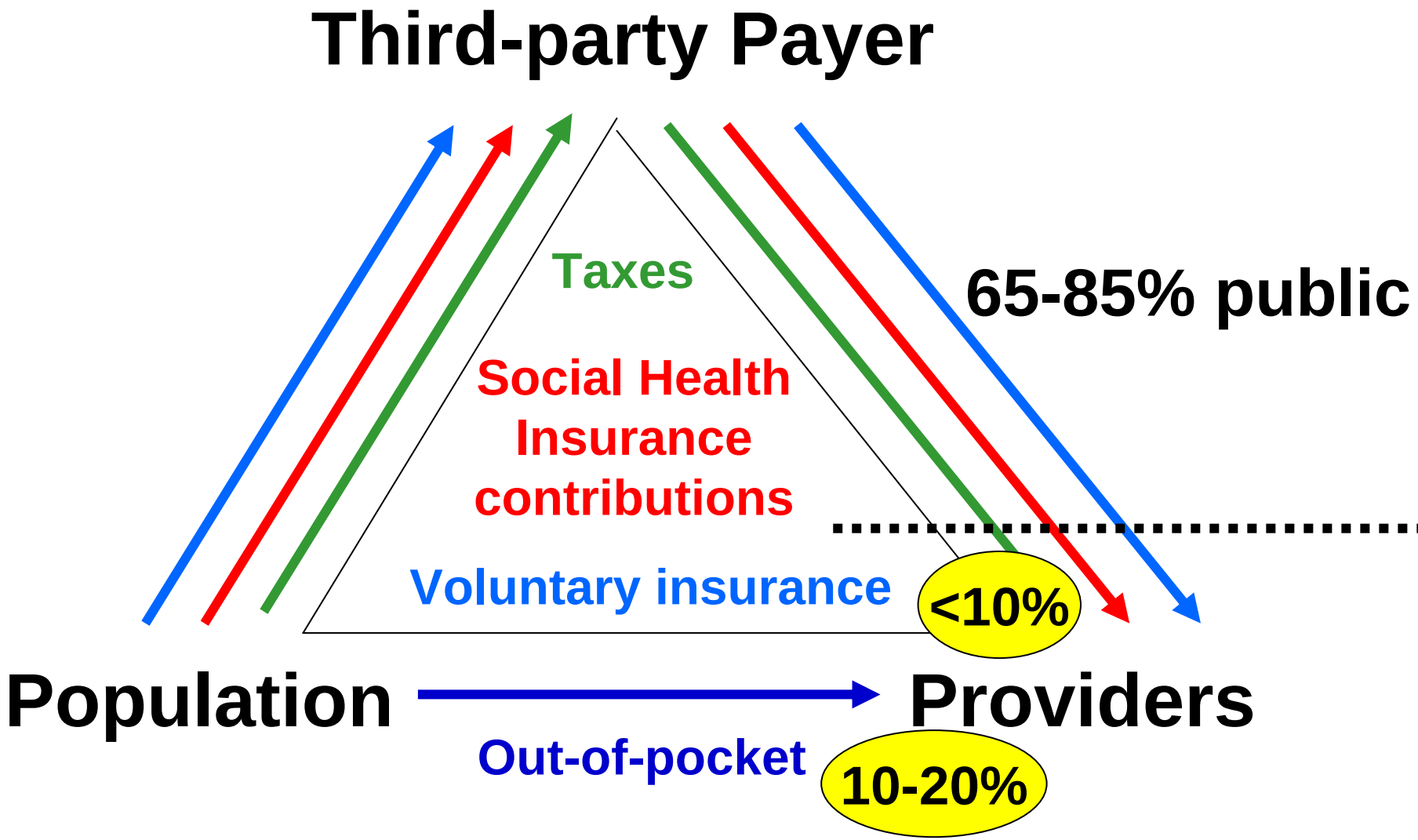

Western Europe

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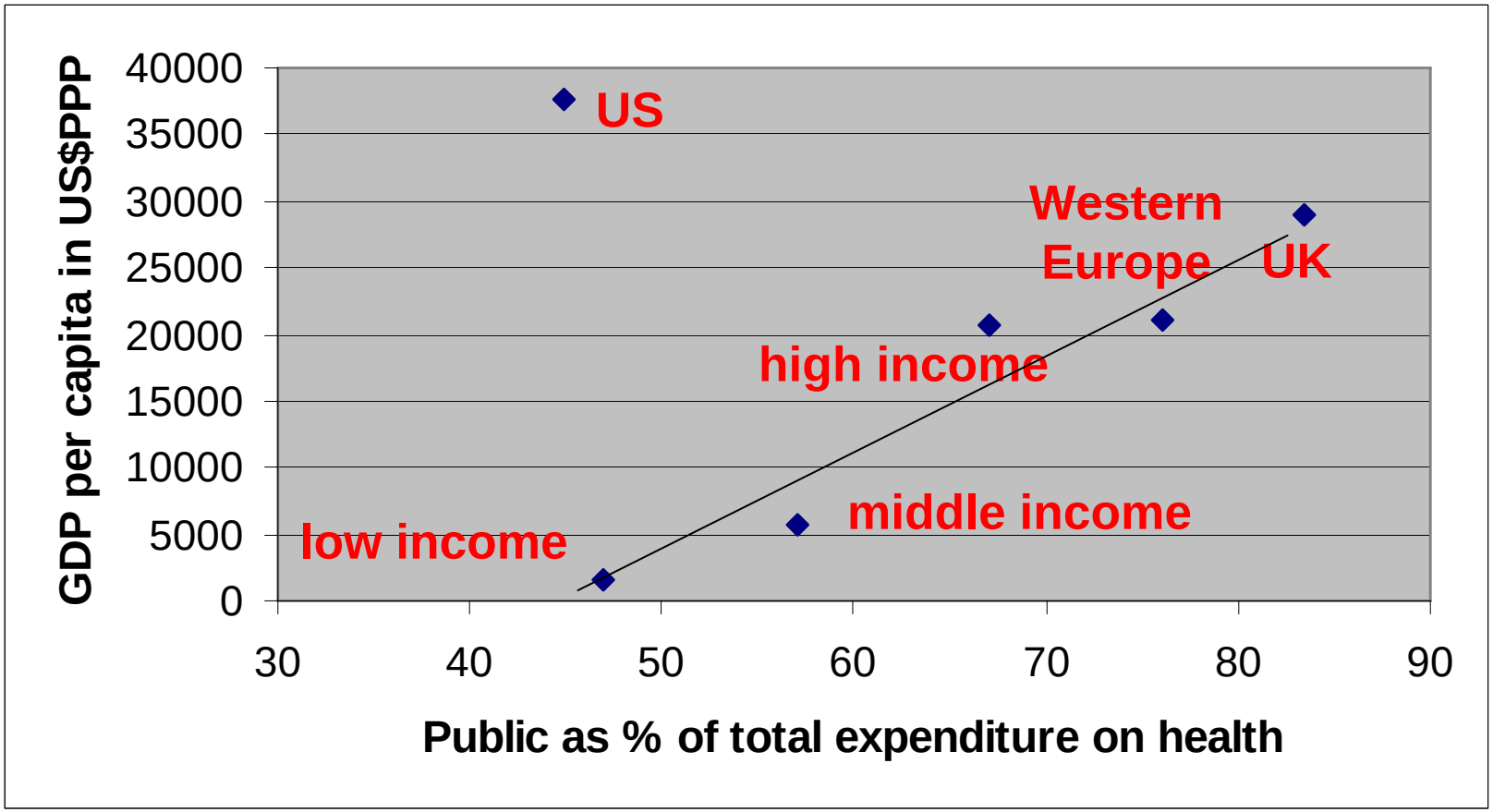
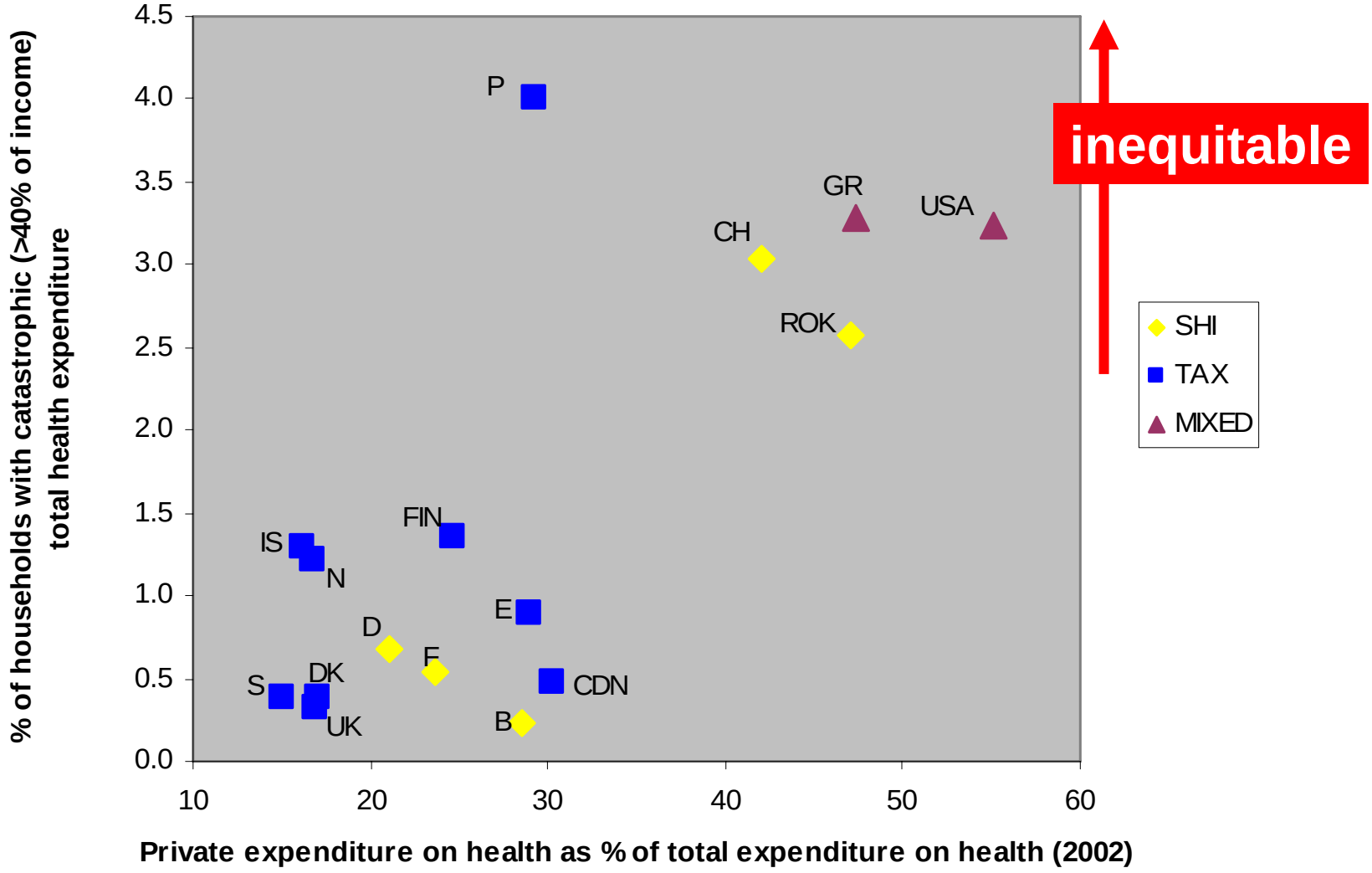
GDP per capita and public expenditure on health, by country income group



Source: Schieber and Maeda 1997 and OECD 2004

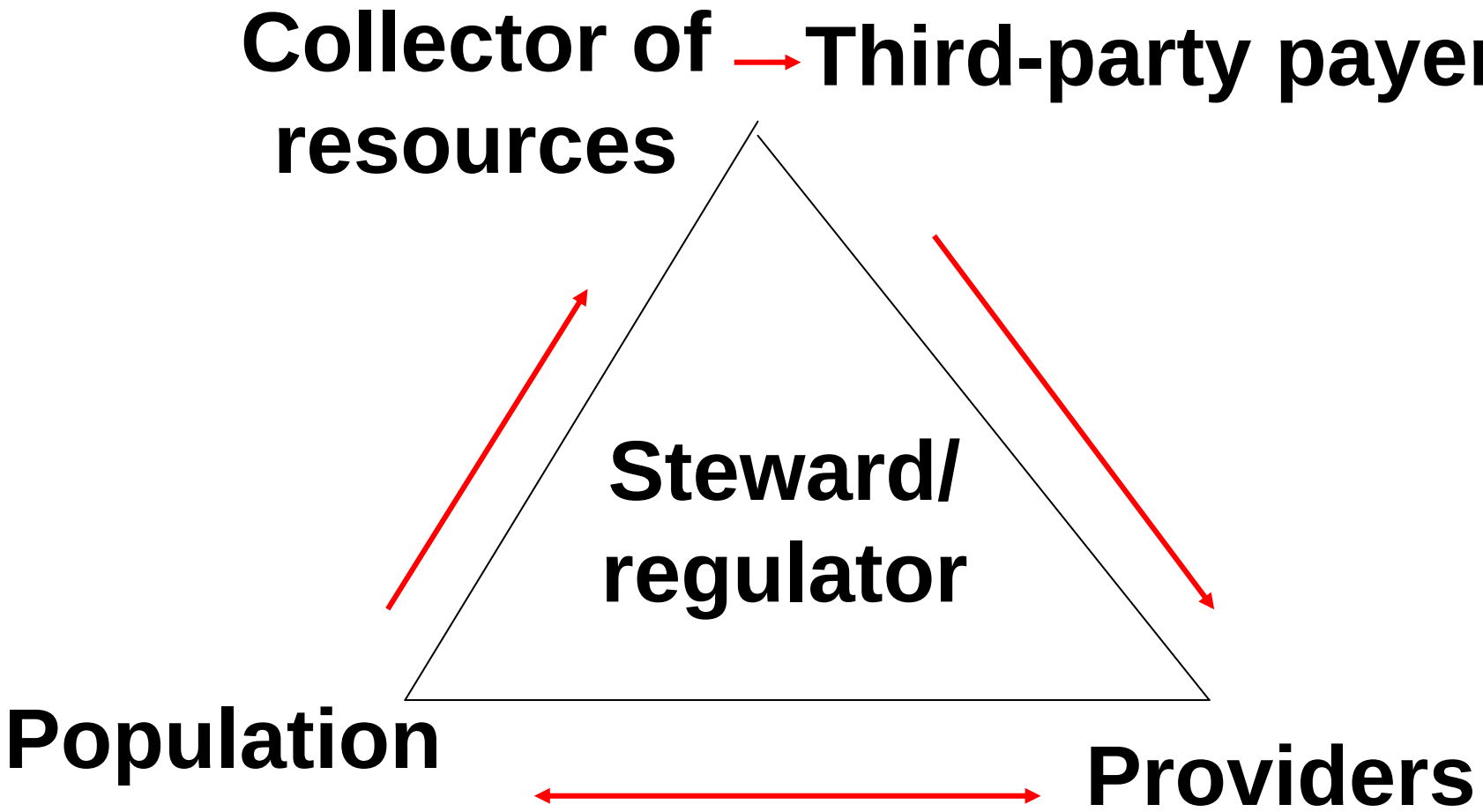
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure



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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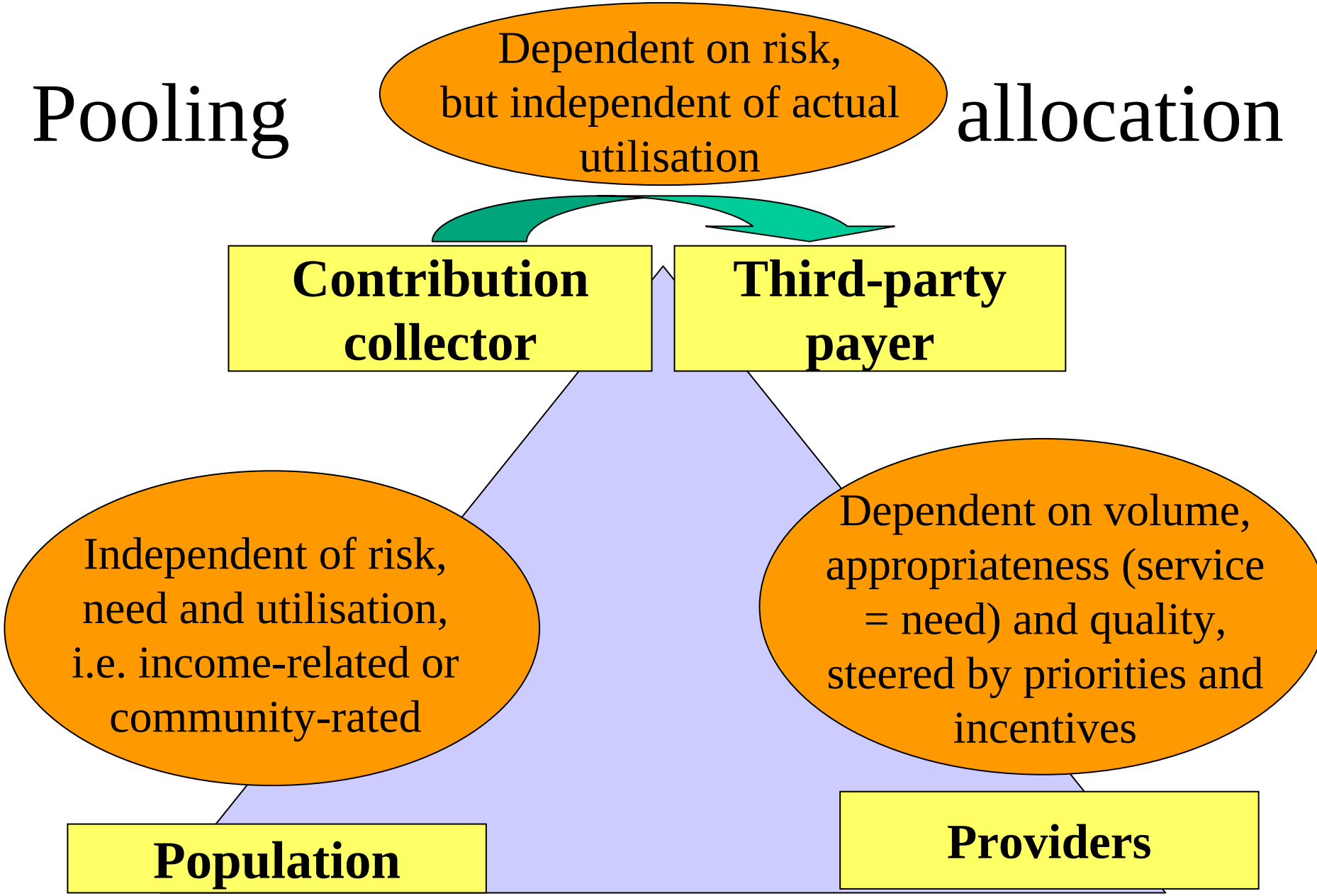
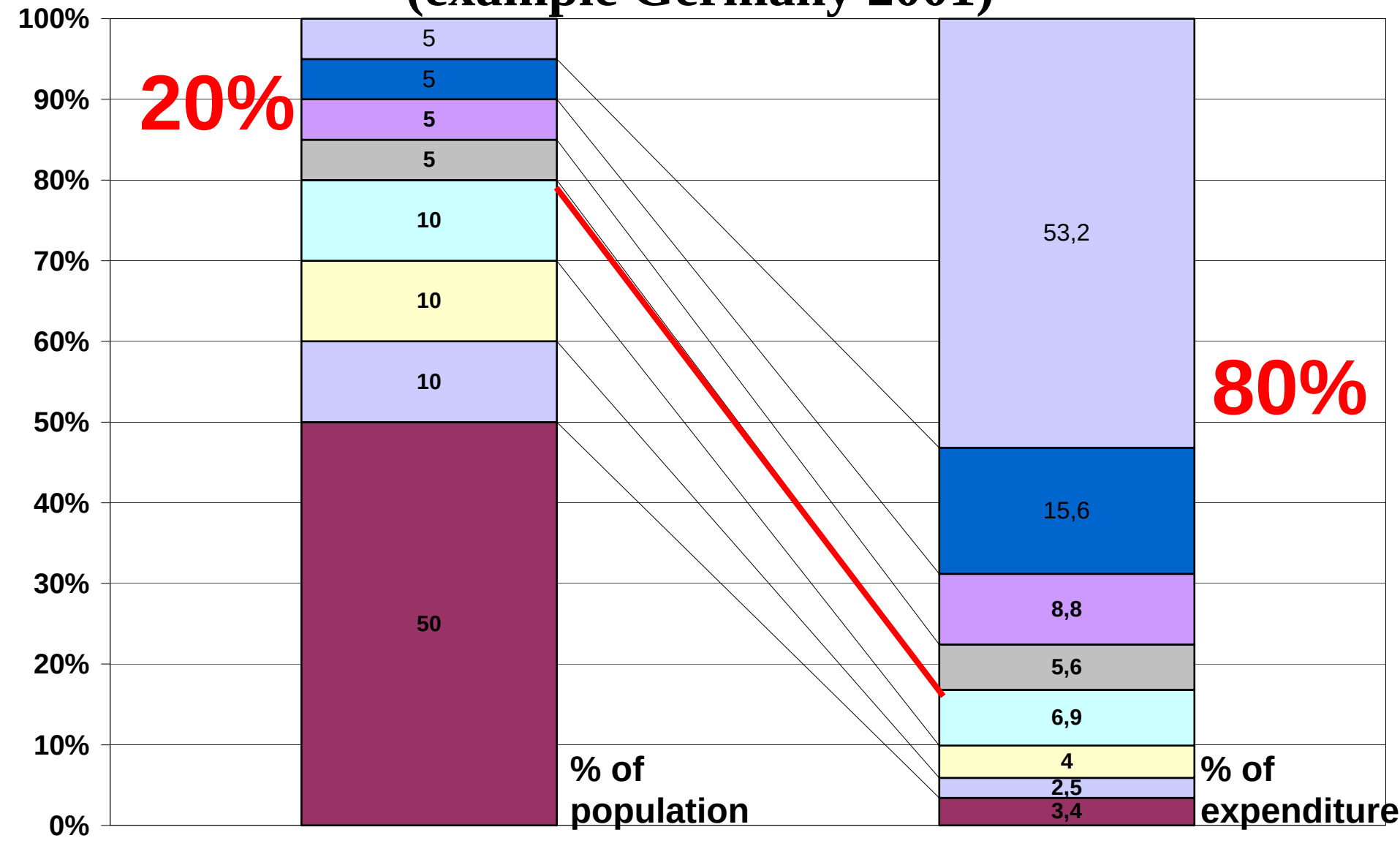

Pooling
Dependent on risk, but independent of actual utilisation
allocation
Contribution collector
Third-party payer
Independent of risk, need and utilisation, i.e. income-related or community-rated
Dependent on volume, appropriateness (service = need) and quality, steered by priorities and incentives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

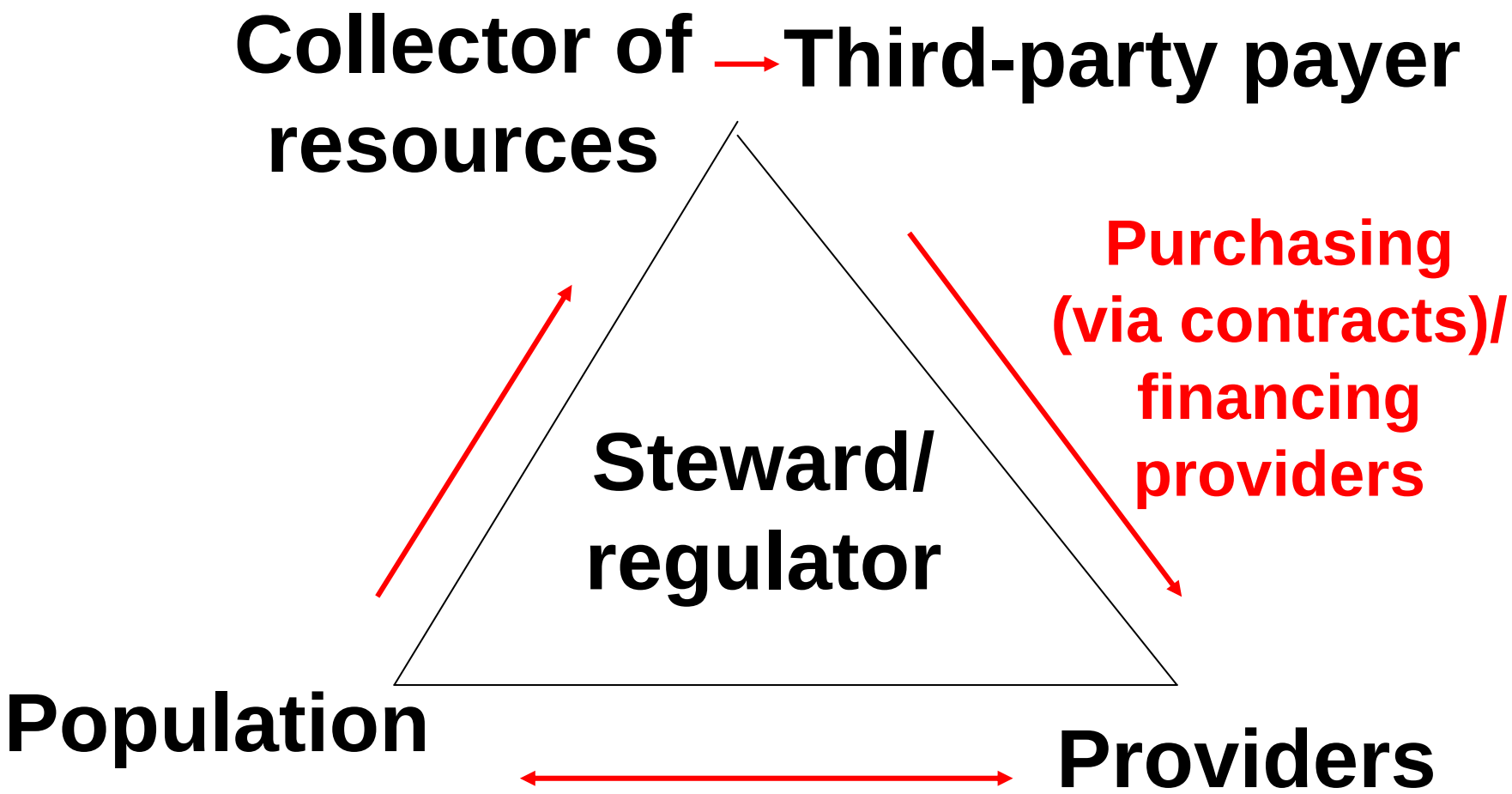
Capitation methods

- 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