TOPIC 3: HEALTH FINANCING FOR ACHIEVING UNIVERSAL HEALTH COVERAGE

PEOPLE'S-UNI HEALTH ECONOMICS MODULE

THE QUEST FOR UHC – ISSUES COVERED IN THIS PRESENTATION

1. Understanding the definition of Universal Health Coverage (UHC)
2. Populations covered
   - Ensuring health equity
3. Services covered
4. Health financing
   - Out-of-pocket spending
   - Health insurance programs
   - Government-funded health programs
   - Controlling expenditures

SOME DEFINITIONS

Definition of health financing (Hsaio, W and Liu, Y, 2001)

- **mobilization of funds for health care;**
- **allocation of funds, to regions and population groups and for specific types of health care**
- **mechanisms for paying for health care**

Definition of UHC

- **The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. (WHO)**

Let us explore this definition in pieces:

- ***"all people"***
- ***"the health services they need"***
- ***"without suffering financial hardship"***
- ***"obtain"***

THE DEFINITION OF UHC

- The goal of universal health coverage is to ensure that **all people** obtain the health services they need without suffering financial hardship when paying for them.

- The first piece to consider is the population covered by the health system – "all people"
- The definition incorporates a requirement for equity
  - Are all income groups receiving coverage?
  - Are all geographic regions receiving coverage?
  - Are there social groups that are discriminated against?
  - Are there age groups that are neglected?
  - Are there barriers to coverage for some groups of people?

THE DEFINITION OF UHC

- The goal of universal health coverage is to ensure that all people obtain **the health services they need** without suffering financial hardship when paying for them.

- The second piece to consider is the health services that are provided by the health system
  - Does the health system provide a limited set of services?
  - What are the priority services included?
  - Are there types of needed health services that are missing in some geographic locations or population groups?
  - Is the system providing equivalent and appropriate services to everyone and everywhere?

THE DEFINITION OF UHC

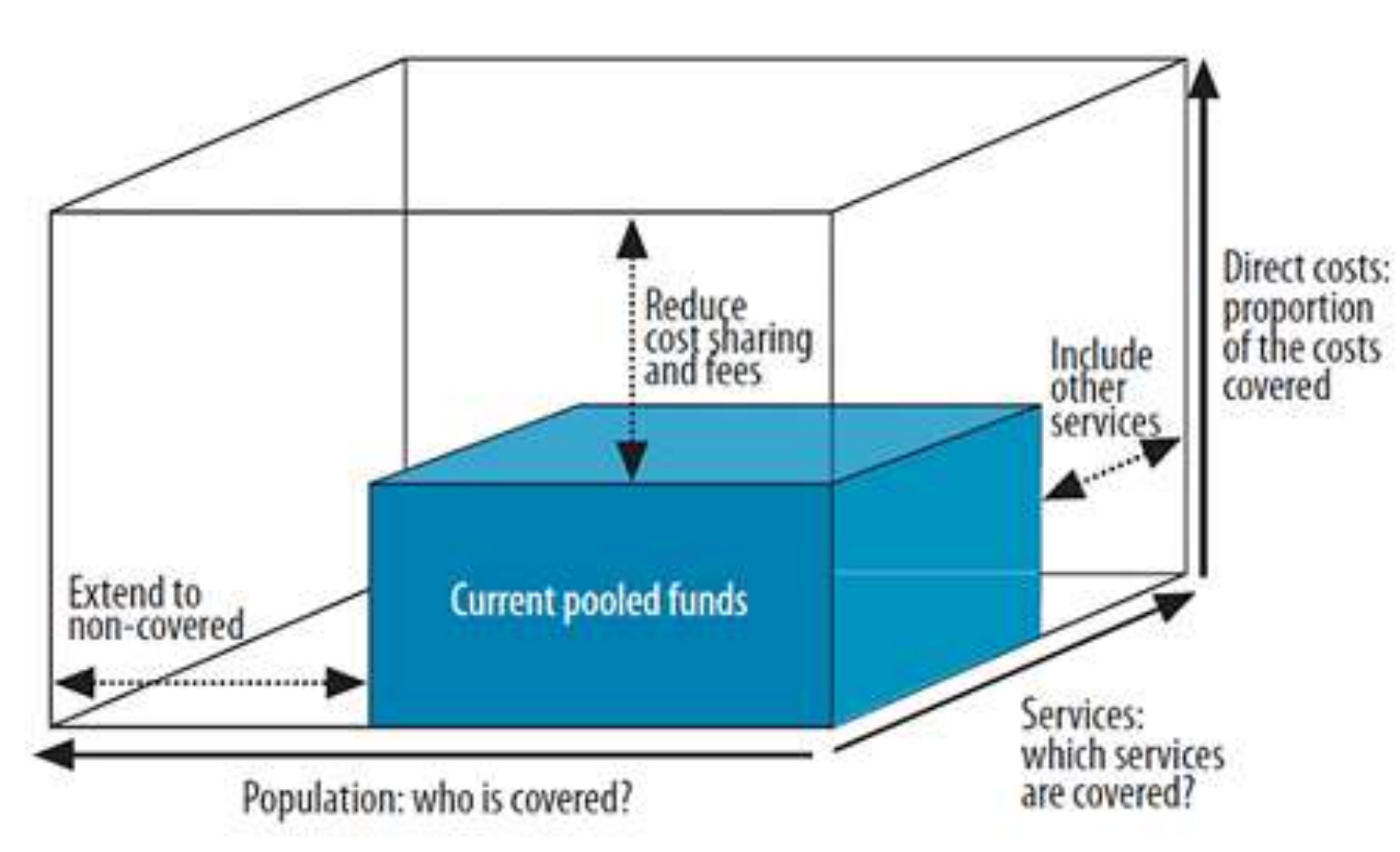
- The goal of universal health coverage is to ensure that all people obtain the health services they need **without suffering financial hardship when paying for them**.

- The third piece to consider is how the health system is financed – that is, how it is paid for
  - Is health care in the system completely paid for by the government?
  - Do individual consumers pay for some of the costs?
  - Do employers or private insurance companies have a role?
  - How does the government fund their health system spending?

THE DEFINITION OF UHC

WHO's definition of Universal Health Coverage is captured in this figure (the "UHC Cube")

1. Population covered
2. Interventions (services) covered
3. Proportion of costs covered by a prepayment method



THE DEFINITION OF UHC

- Creating a UHC system will include ways to expand coverage in all of the three dimensions:
  1. Expanding the population covered will increase the number of people able to receive services
  2. Expanding the services covered will increase the number of health conditions that can be prevented or treated
  3. Expanding the proportion of costs covered will increase the rates of use by individuals because of affordability

THE DEFINITION OF UHC

- The goal of universal health coverage is to ensure that all people can obtain the health services they need without suffering financial hardship when paying for them.

- The definition uses the word "obtain" to mean that individuals or households are able to overcome any access barriers that might keep them from receiving health services.
  - What access barriers might contribute to a consumer not obtaining health services?
  - How do education, social norms, infrastructure, and poverty impact whether or not a consumer obtains health services?

DISCUSSION TOPICS

- At a meeting in 2014 the World Bank and World Health Organization proposed a framework for monitoring progress towards UHC. The framework sets out clear commitments to reduce out-of-pocket payments and improve access to health care for the poor with two new targets:
  - **halve the number of people impoverished by health care payments from 100 million to 50 million by 2020, and eliminate the problem altogether by 2030;**
  - **double the number of poor people (the poorest 40%) with access to health care services by 2020 – from 40% to 80%.**

- What do you think is the most difficult component of Universal Health Coverage to achieve in your setting?
- Consider your country's health system, and describe which of the three parts of Universal Health Coverage has had the most success – reaching all people, providing needed health services, or collecting funds and controlling costs?

POPULATION COVERED

SECTION 2

POPULATIONS COVERED

- Because the population of a country varies in income level and health status, not everyone has the same resources and health service needs. The main goal of an **equitable** health system is to reduce differences in health status as much as possible.
- **Equity** incorporates the idea that individuals should contribute to health care funding according to their ability to pay and should benefit from health services according to their need for care. Some people would just call this "fairness".
- Let us consider this definition in pieces

EQUITY IN FINANCING HEALTHCARE

- Equity can mean that "**individuals (or households) should contribute to health care funding according to their ability to pay** and should benefit from health services according to their need for care"

- Fairness is established if individuals/housholds contribute to the pooled fund in accordance with their ability to pay.
  - Exempting the poorest when ill from paying the costs, but requiring the rich to pay greater share to the pooled fund is a fair payment system. The effect is similar to redistributing income, which is acceptable in some societies, but not in all.
- A fair payment system is crucial to establishing an equitable system.

TARGETING THE POOR AND THE ILL

- Since achieving equity requires targeting the poor and ill, the health system must include a way to identify who is considered poor or ill
- There are two main strategies for targeting the poor and ill
  - Identify the poor based on income level (means testing).
  - Identify the ill based on the health services needed

TARGETING THE POOR AND THE ILL

- Means testing is one method, which involves verifying the income level of a person, identifying them as poor or not poor, and creating a system that allows the poor to identify themselves to health service providers
  - This has a fairly high administrative burden
  - When user charges were introduced in many developing countries, it was assumed that the poor would be exempted. However, it proved very difficult to accomplish this.
  - It may not be practical to base health financing on means-testing where there is much informal employment or high unemployment.

TARGETING THE POOR AND THE ILL

- Selecting health service priorities to cover diseases that are common among the poor is an another way to making health systems more targeted to consumers with the greatest health needs. This means high emphasis on preventing communicable diseases, birth spacing, etc.
  - This has less administrative burden, but may encourage the rich to seek health services outside of the system
  - It should also include the goal of gender equity in countries where females have greater difficulty accessing health services

DISCUSSION TOPICS

- Use the online forum to discuss:
  - What are the challenges to using means testing?
  - Describe the types of health services that might be prioritized in order to ensure equity in the health system.

SERVICES COVERED

SECTION 3

AFFORDABILITY OF UHC

- In the UHC definition, "proportion of costs covered" considers how much the individual or family must pay to use the health system
  - UHC does not always mean that all health services are free for all consumers
- To achieve UHC, the amount that the consumer pays must be affordable, so that there is no hardship in seeking care
  - However, people incur costs even if health services are "free", such as transportation and opportunity costs (lost earnings)
  - "Affordable" is sometimes defined as an amount that does not hurt a household's ability to buy adequate food and other necessities.

SERVICES COVERED

- "Services covered" considers what types of health services are provided by the health system. No health system can provide all needed services, so even in rich countries there is some kind of rationing.
- Common "essential" services focus on achieving the Millennium Development Goals, and include:
  - HIV, tuberculosis, and malaria prevention and treatment
  - Services for non-communicable diseases and mental health
  - Sexual and reproductive health (family planning, skilled birth attendants)
  - Child health services (growth monitoring, oral rehydration therapy, vaccinations)

FINANCING HEALTHCARE

SECTION 4

HEALTH FINANCING

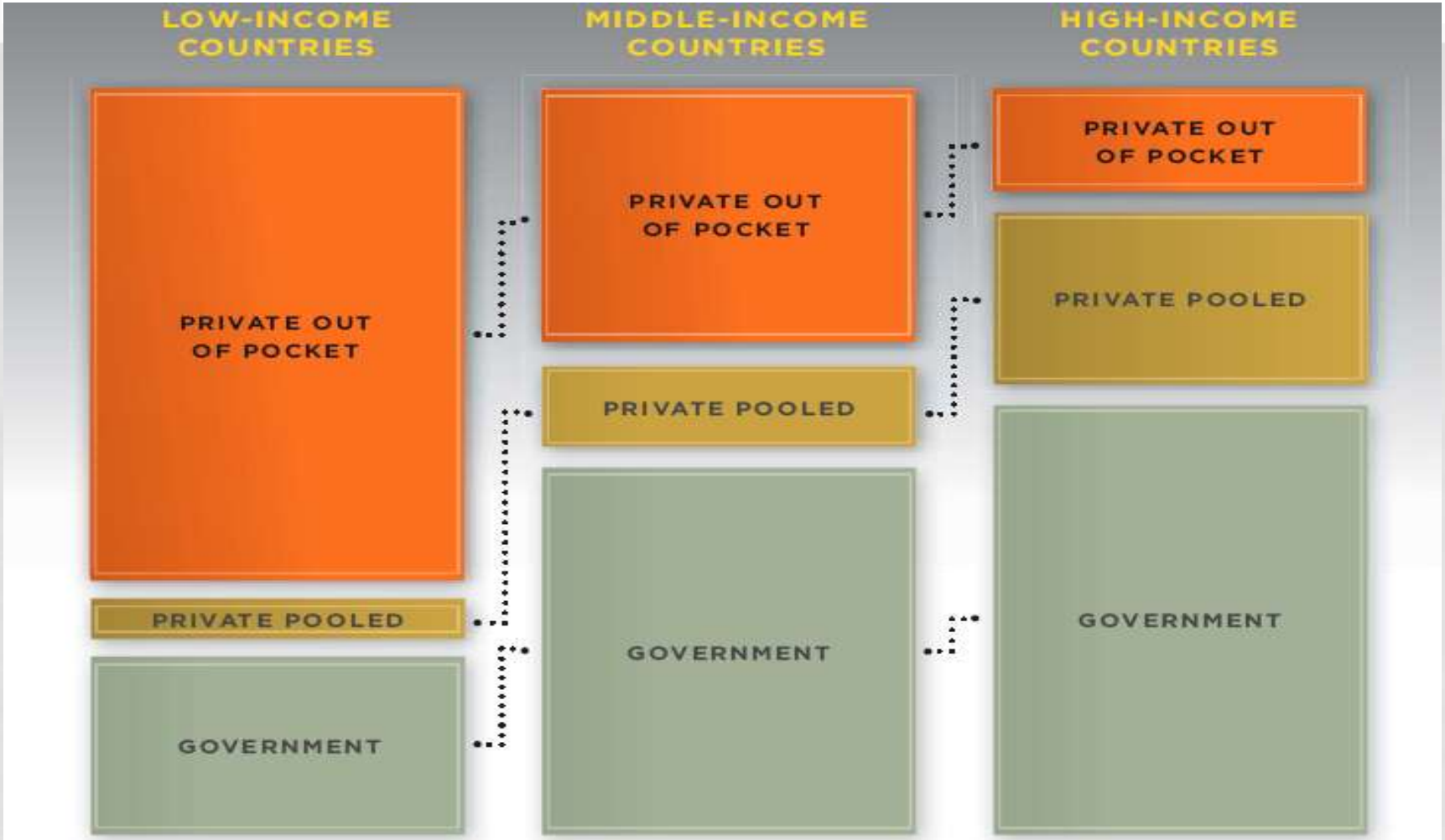
- **We will consider two aspects of health financing:**

A. How funding for health services is collected
B. How funding for health services is spent

EVOLUTION OF HEALTH FINANCING IN DEVELOPING COUNTRIES

- Free health care was provided in many developing countries after independence
- In the 1980s health budgets were cut, low health worker salaries, poor service, informal payments, and lack of basic medicines
- 1980's **Health Sector Reform** was pushed by donors
  - Paying a little to get treated was better than "free" care in a system where drugs were often out of stock.
  - User charges (cost-sharing, cost recovery) were introduced, at an "affordable level" not to exceed 5% of total household income..
  - Exemptions for the poor were planned, but difficult to implement.
  - Equity studies showed payment at time of illness is always most difficult, and poor people have more difficulty paying for care.
- 1990's: Evidence of **deterrence from using basic services** led to abolishing user charges in in some countries.
- 2000's: Evidence of **"catastrophic" levels** of Out-of-Pocket spending -- global policy shift to prepayment by tax-financed health budgets and social health insurance.

HOW HEALTHCARE IS FINANCED



HEALTH FINANCING – COLLECTING FUNDS

SECTION 4-A

GENERATING REVENUES FOR HEALTH SERVICES

- There are several different methods for collecting the funding needed to pay for health services
- We will consider three methods:
  1. Out of pocket (OOP) spending by individuals or households
  2. Health insurance programs, including:
     - Private health insurance
     - Community health insurance
     - Social or public health insurance
  3. Government-funded health care programs

(1) OUT-OF-POCKET SPENDING

- In this method, individuals or families pay for medical costs directly, usually when they are sick
- Because of the high costs of coverage, out-of-pocket payments push millions of people worldwide into poverty every year. **Out-of-pocket spending is considered to be a "catastrophic payment" when its proportion is equal to or greater than 40% of non-food household income.**
- Out-of-pocket spending often causes delays in seeking care, and individuals being more sick by the time they receive health services
- Out-of-pocket spending is the least equitable way of financing a health system – it places the largest burden on the poorest population

(2) HEALTH INSURANCE

- Insurance programs pool risks and funds, so that members are protected against high and unexpected health service costs
- Generally, an insurance program requires members to regularly pay regularly into the financing pool, regardless of whether or not health services are used. These are often called "premiums" for private insurance or "contributions" for social insurance.
- When health services are needed, the costs are paid for from the pooled fund, instead of by the member directly. The risks of high costs are transferred from the patient and the provider to a third party (the insurance system).

(2) HEALTH INSURANCE

- There are many types of health insurance, classified by factors such as
  - The size of the risk pool
  - The management of the program
  - Whether participation is compulsory or voluntary
  - Source of health service providers
- We will look at three main types of health insurance:
  - Private insurance
  - Community insurance
  - Social or public insurance

(2) TYPES OF HEALTH INSURANCE

- Private insurance: individual or family pays for participation in the program (usually a private company)
  - In an employer-sponsored insurance program, an individual's employer contributes all or some of the cost for the individual or family's participation in the program
- Social or public insurance: usually a national-level program that is mandatory for certain groups or all, and administered by a public agency.
  - Formal employment is usually a requirement because contributions are deducted from wages.
- Community insurance: more informal pooling of funds within a community (not for profit)
  - Sometimes known as "micro-insurance" programs. The advantage is that formal employment is not necessary.

(2) TYPES OF HEALTH INSURANCE

	Private health insurance	**Community health insurance**	**Social or public health insurance**
Size of the program	Small to large	Small	Large
Management of the program	For-profit companies	Non-governmental or community-based organizations	Governments
Participation	Voluntary	Voluntary	Compulsory
Source of Services	Contracted "network" of doctors and hospitals	Usually local health centers and district hospital	Government hospitals and clinics, or those owned wholly by the social insurance scheme

(2) REQUIREMENTS FOR EFFECTIVE HEALTH INSURANCE PROGRAMS

1. Large risk/fund pool
   - The larger and more diverse the risk pool, the better protected participants are from catastrophic costs
2. Many healthy participants
   - Insurance programs require many healthier (possibly younger) participants to offset the costs of the less healthy participants
3. Knowledge and control of healthcare and administrative costs
   - An insurance scheme can only continue to operate if expenses can be covered by revenues. Social or public insurance programs may be subsidized by governments or donors

(2) SOLIDARITY, CROSS-SUBSIDIZATION, RISK POOLING

- In health insurance schemes, the healthy and young in effect subsidize the ill and old by using less health services. This is *risk pooling*.
- In social and public health insurance schemes, the amount of premium paid depends only on income. High-paid workers subsidize lower-paid workers by paying higher premiums into the funding pool. This is *cross-subsidization*.
- These are aspects of *social solidarity*. Mandatory participation ensures that social insurance programs have a large membership pool, with mixed ages, incomes, and levels of health.

(2) POTENTIAL CONCERNS WITH HEALTH INSURANCE ("MARKET FAILURE")

- **Adverse selection**
  - Occurs when participation is voluntary and only people who are sick or think they will soon become sick enroll in health insurance, resulting in over-representation of high risk people in risk pool. The risk pool is not effective without enough healthy participants who contribute more funding than they use.
- **Cream selection**
  - Occurs when insurance programs are able to choose participants and only enroll healthier, younger people. If older or sicker individuals are enrolled they must pay higher premiums and copayments (called "risk-rating"), and people with many kinds of pre-existing conditions are rejected to reduce expenses to the insurance company.
- ***This is why social health insurance programs try to have 100% participation. Social health Insurance is never risk-rated, and compulsory membership eliminates both forms of "selection bias"***
- **Moral hazard**
  - Occurs when the participant deliberately consumes more health services than actually needed because the cost is covered by the risk pool (demand side). It also occurs when the provider knows the will pay all bills and over-prescribes services (supply-side, or "supplier-induced demand"
- ***Insurance schemes attempt to control moral hazard by using special reimbursement methods for providers, or by requiring consumers to pay some out-of-pocket costs for health services***

SOCIAL HEALTH INSURANCE FOR INFORMAL SECTOR WORKERS

- Coverage of people who are in formal employment is easy since the government will have records about their employer, wages, etc. It is much more difficult to cover people who are not formally employed, such as small farmers, tradesman, vendors.
- Community or micro-health insurance has been shown to be hard to sustain, but some countries like India and Bangladesh have had successes.
- In recent years there have been efforts to introduce social health Insurance for the informal sector, mainly aimed at the poor, often fully or partially subsidized by governments and external donors.

  LMIC countries that recently introduced insurance for the informal sector include China, Thailand, India, Mexico, Vietnam, Philippines, Indonesia and several Latin American countries

(2) OUT-OF-POCKET COSTS TO HEALTH INSURANCE PARTICIPANTS (CO-INSURANCE

- Premium/contribution: the prepayment due annually or monthly to participate in the insurance program
  - The premium is determined by the costs and overheads of providing health services that are available, the probability that services are used, and deductible and co-pay amounts.
- Deductible: some insurance programs require participants to pay a fixed amount out-of-pocket before "coverage" starts from the pooled funding
  - Schemes with a high deductible amount are "catastrophic" insurance since they effectively only protect members against large costs such as hospital care, but their premiums are lower.
- Cost-sharing: participants pay a share of healthcare costs by a flat fee per visit or percentage of medical care costs
  - This lowers the premiums and may reduce unnecessary use of services (see moral hazard on previous slide)

(3) GOVERNMENT-FUNDED HEALTH PROGRAMS

- In this model, the government provides health services to citizens. Funding for the health services is allocated through the government's budget, which in turn comes mainly from different kinds of taxes and loans (e.g. government bonds).
  - Taxes can be "regressive" if a higher share is paid by the poor, or "progressive" if a higher share is paid by the rich.
    - Income taxes are usually progressive (rates increase with income)
    - Utilities and petrol taxes, which often affect the poor more than the rich are often regressive. Some countries tax cell phone services
    - "Sin taxes" on disease-causing goods such as tobacco, alcohol, or sweets (regressive for the poor, but have positive effects on health and are often used for specific risk-reduction programs)
  - The health budget usually funds directly-provided services, but can also subsidize social health insurance.
  - Donor funding for health, usually paying for specific programs such as HIV/AIDS, malaria, family planning. About 10% of global funding for health comes from aid donors

COMBINATION OF METHODS

- In practice, many countries have a combination of payment methods in place for health services
- For example:
  - Individuals or families may pay a small amount out-of-pocket for a health service, while the majority of the cost for that health service is paid for by an insurance or a government-funded health program
  - Government programs or insurance programs may cover only a part of the entire population, while other individuals or families pay out-of-pocket for costs or participate in an insurance program
  - But - The reality in many developing countries is that most people still do not have good access to, or can't afford "formal" healthcare, so buy medicines from the market and use traditional healers.

DISCUSSION TOPICS

- Use the online forum to discuss:
  - What type of insurance schemes exist in your country?
  - What are their strengths and weaknesses in terms of the three dimensions of coverage?
  - How has donor financing of specific health programs affected the overall performance of the health system?

HEALTH FINANCING – CONTROLLING COSTS

SECTION 4-B

WHY IS IT IMPORTANT TO KNOW HEALTHCARE **COSTS AND EXPENDITURES**?

- **Demand for healthcare is unlimited! Knowing costs and ways to control expenses make it more possible to provide needed care and prevention. Related reasons are:**
  - identify the extra resources needed to add or increase certain services
  - identify inefficiencies in service delivery, including the human resources situation
  - choose cost-effective services and delivery mechanisms,
  - negotiate with providers for contracted services

SPENDING FUNDING FOR HEALTH SERVICES ("REIMBURSEMENT')

- The second part of health financing considers how to best use health services spending to achieve the most effective outcomes.
- Regardless what kind of "risk pool" is paying providers of health services – social insurance fund or government health budget – there must be effective ways to ensure that costs do not exceed the available funding.
- We will look at three different models for payment to health service providers
  - Capitation
  - Fee-for-service
  - Salary/ global budget

FEE-FOR-SERVICE

- Providers are paid by a "third-party" insurer, but also out-of-pocket. There is some fee for every health service provided regardless of the health outcomes of the patients. There are established fees for each individual service such as checkup, labs, X-rays, minor surgery etc.
- This approach may encourages providers to meet with patients more than may be necessary, and to perform optional tests or services in order to earn more money
- Usually patients do not know how much they will be charged, so they cannot control the amount of services they get. (Inelastic demand also plays a big part.) This is especially true when they have insurance that will cover all costs.
- Fee-for-service is now considered to be the old, inefficient way of reimbursing providers. Providers can make a lot of money and therefore resist change, but it has made insurance very expensive in countries like the USA.

CAPITATION
(PAYMENT "PER HEAD")

- Providers are paid by an insurer or the government a standard amount per enrolled patient, regardless of the amount of health services needed or the health outcomes of those patients.
- Providers have an incentive to provide preventive care so their enrolled patients stay healthy.
- However, the approach may encourage providers to provide fewer health services to the patients, in order to spend less. Allowing patients a choice of providers may minimize this risk.
- The UK National Health Service is the best-known example of this (for primary care), but it is also the basis of the HMO (health maintenance organization) model in some countries.

SALARIED/GLOBAL BUDGET

- Providers are paid on a fixed salary basis, regardless of the number of patients seen or health services performed
- This method has a predictable cost for the system
- However, providers are not encouraged to see a large number of patients, or to work efficiently
- Adding additional payment incentives based on patient outcomes can correct these problems while still keeping within a budget. ("Performance-Based Financing")
- A common example is a hospital budget, where staff salaries are all fixed, and a "line item" budget is provided by government for medicines, power, and other expanses. It is the hospital managers' responsibility to use the budget in the best way.

OTHER COST CONTROL METHODS

- There are other "tools" that are used to control costs in some health systems.
  - Medical treatment guidelines help limit unneeded procedures
  - Essential drug lists (or hospital formularies) limit prescribing to lower-cost generic medicines.
  - "Reference pricing" places caps on drug cost reimbursements.
  - Diagnostic-related groups (DRGs) define a group of services and inpatient days for a given illness that the insurer will pay the provider for. Any additional services provided must be covered by the provider or the patient.
  - Reduce high administrative costs that result from having many different insurers. See this article for a discussion of the advantages of "single-payer" insurance: **http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961488-3/fulltext**

DISCUSSION TOPICS

- What do you think are the most effective ways of controlling costs for health services?
- Can you think of any additional strategies that might work to control the costs of health services in your setting?