

Achieving Universal Health Coverage

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Why Universal Health Coverage?

Equity

- In access to health care
- In Financial Protection
- Eradicating poverty

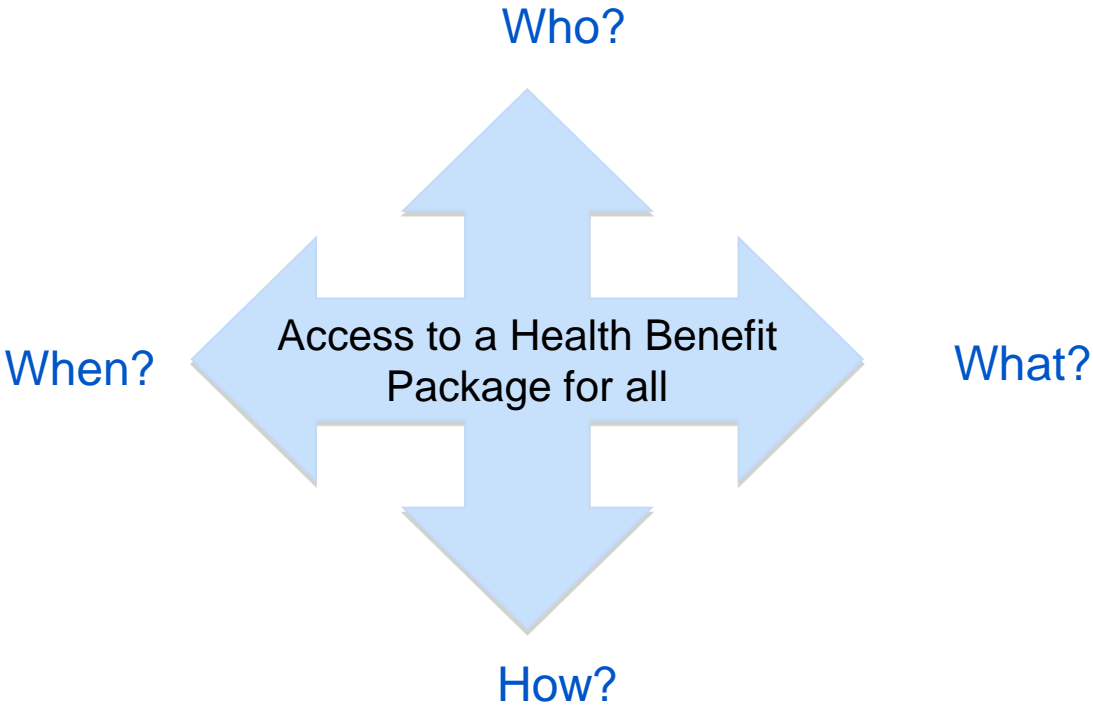
Productivity

- Healthy Population, higher aggregated labor productivity
- Higher household returns from labor market participation
- Better allocation of household savings / investments / consumption behavior

Efficiency

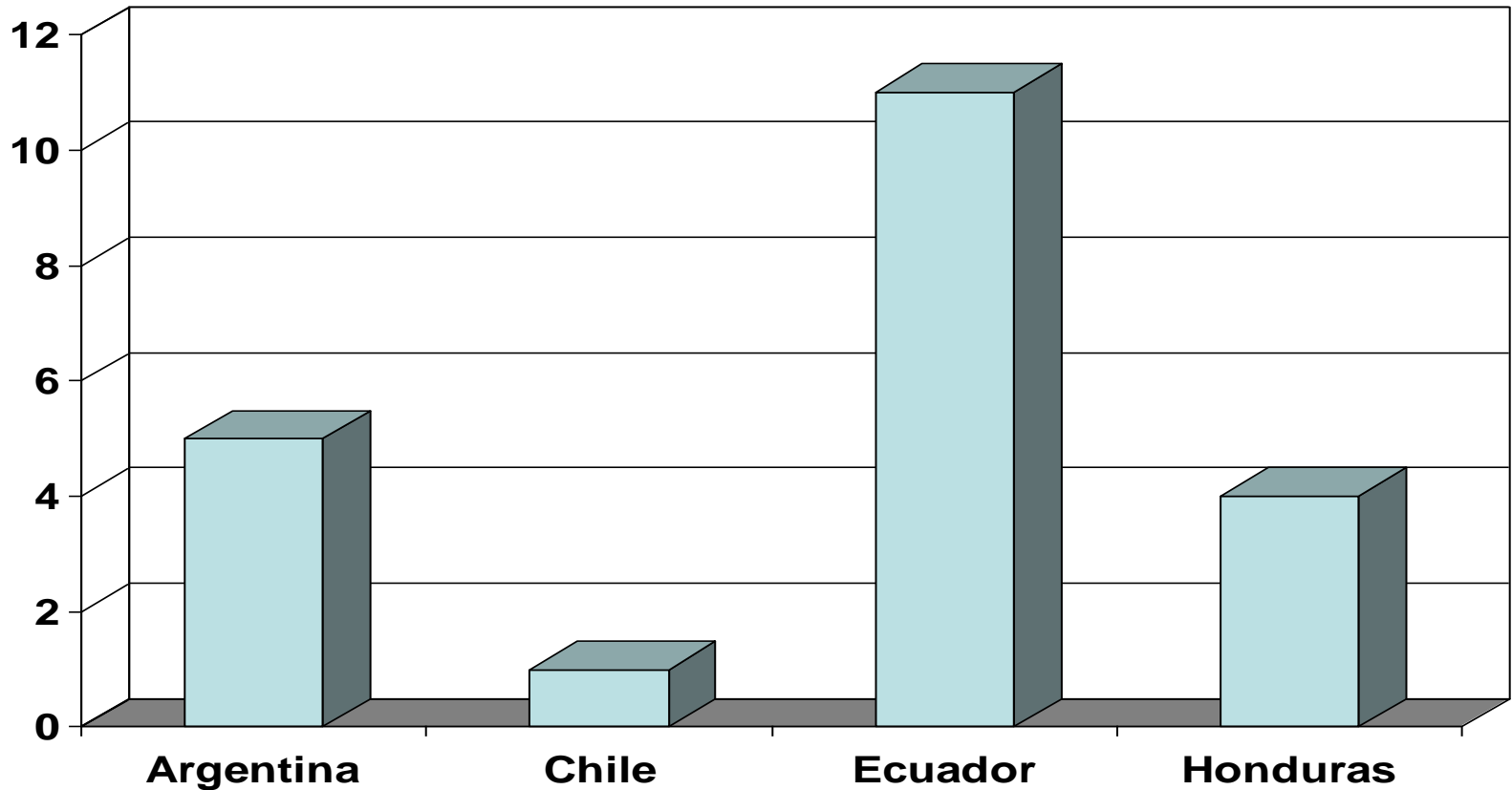
- Large (universal) risk pools entail significant gains in efficiency in protecting people against health shocks
- Large (universal) risk pools, when used for strategic purchasing of health services (provider payment) set right incentives for provider efficiency and responsiveness
- Large (universal) risk pools increase revenue predictability for health service providers

What is Universal Coverage?



Many countries in a journey to Universal Health Coverage

Illness and Health Systems Failure to protect Households from it, significantly contribute to Poverty and inequality



■ % of total non-poor population that falls below the poverty and/or indigence line due to out-of-pocket health expenditures

What is Universal Coverage?

Who?

- Formal workers?, The Poor?, Informal Sector?, Mothers and Children?
- All?
- How do we know who is who?

What?

The Benefit Package

- Insurable and non-insurable interventions?
- What criteria should drive package composition? –life expectancy, financial protection, satisfaction, other
- Governance: Who decides what is in and what is out, how, and how often ?

How?

- Who pays, for whom and how? State? Any contribution from households?
- General Taxes? Payroll-Tax? Premiums? All?
- Single or multiple insurers? Public or Private? Competing or not competing?
- Financial effects on Treasury (fiscal), on households (financial protection), on labor cost (country competitiveness)

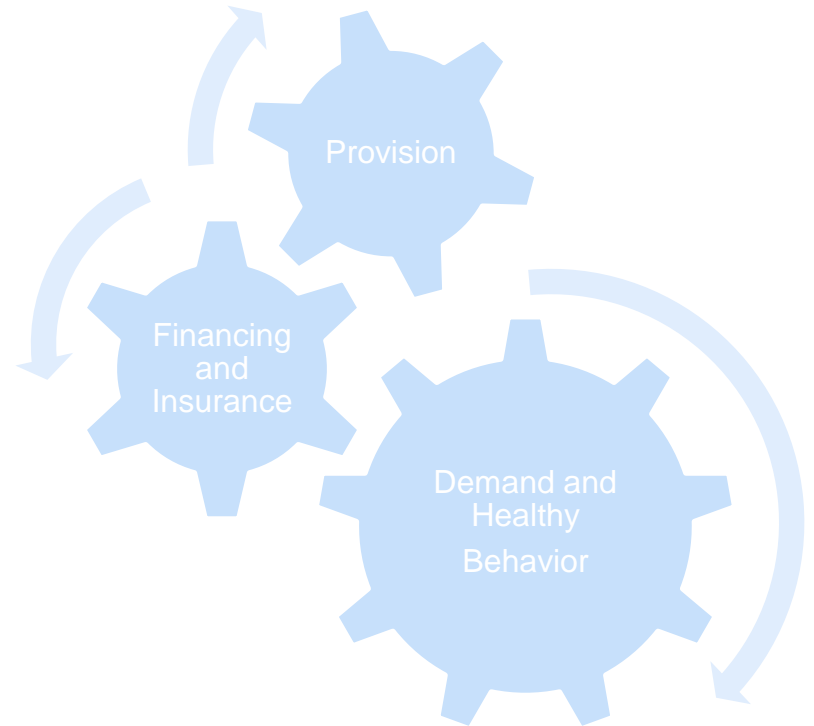
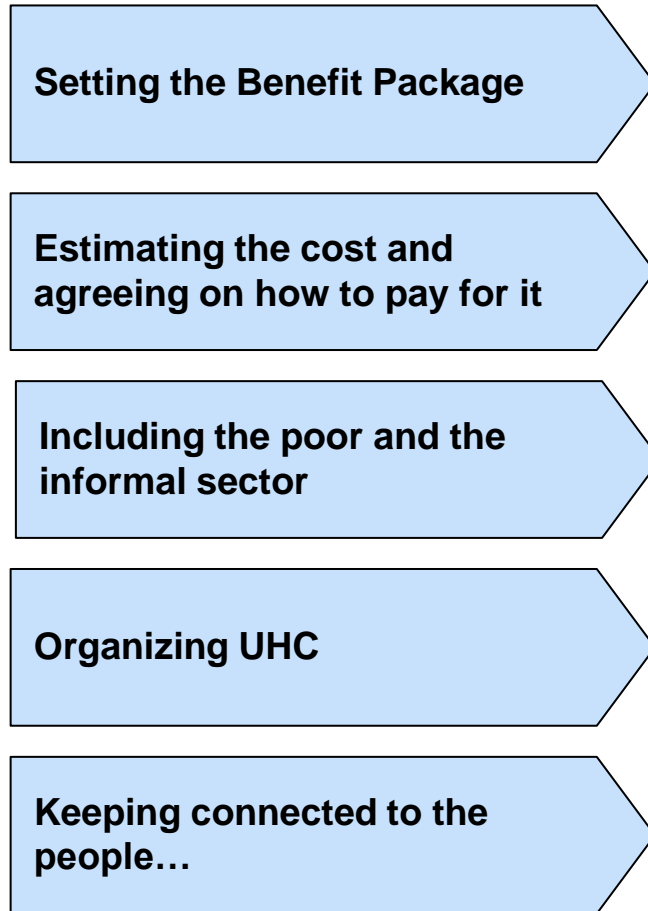
When?

- All people and all benefits at the same time?
- The Breath v/s Depth Dilemma
- When to open “the gates” for full system components to integrate
- Planning the Transition: Making technical, people’s, and political timing compatible

What have we learned?

Five key challenges from experience in middle-income countries

(not to worry ... there are many more...)



What have we learned?

Five key challenges from experience in middle-income countries

(not to worry ... there are many more...)



**Setting the
Benefit Package**

- What criteria should drive package composition?
 - What proportion should be focused on improving life expectancy?
 - What on financial protection?
 - What on people satisfaction?

- Setting the Governance of the Package: Who decides what is in and what is out, when, and how ?

- How to update the package periodically?

Societies define peoples entitlement in the health system through the benefit package

The benefit package (BP)

Examples

Defines **interventions** covered

The BP may exclude certain services such as dental procedures or glasses

Defines **quality** of service and its timing

The BP may specify certain targets for maximum waiting times (such as in the UK) or minimum quality standards

Sets **co-payments, deductibles** (if any), and stop-loss provisions

Conditions such as cost-sharing via co-payments can have significant effects on utilization behavior and coverage (e.g. some states in the US)

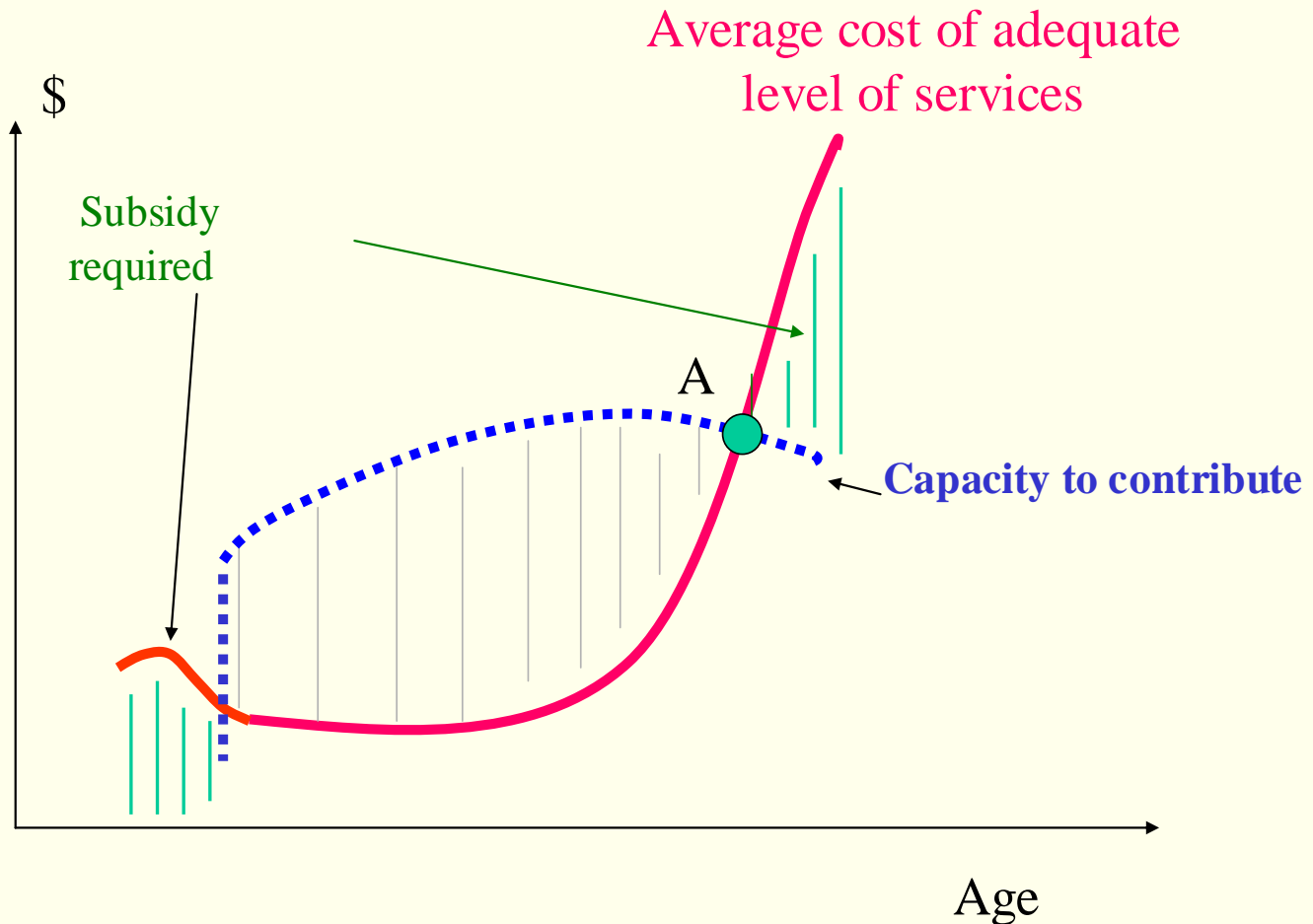
Contains conditions of responsiveness (**confidentiality**, minimum standards of accommodations, privacy, access to patient information, patient rights and other elements for the preservation of dignity)

Patient rights and the security of confidential information such as patient records are secured by law in many countries (e.g. Germany)

Key considerations

- The BP discussions often ignore the impoverishing events dimension and the need to ensure financial protection
- Modification of BP (extension or exclusion) has widespread effects in financing and health status through utilization changes

Understanding the “benefit – contribution gap”, critical incentives for informal non-poor



Policy Options for Extending Risk Pooling in a Mixed Health System (with Contributory and Noncontributory Risk Pooling)

Subpopulation	Policy option	Possible instruments
Poor	Increasing <i>breadth</i> and <i>depth</i> ^a of publicly subsidized risk pooling	<ul style="list-style-type: none"> •Additional fiscal resources, and/or •Increasing efficiency through changes in the incentive framework in the allocation of public subsidies (e.g., provider-payment reform; purchaser-provider split; private provision of publicly financed health services)
High risk	Ensuring availability of equity subsidies at old-age/high-risk stage	<ul style="list-style-type: none"> •Mandating savings (own inter-temporal subsidies) •Regulating contributory risk pooling in a way that ensures either intra-pool or inter-pool subsidization^b •Public (societal-level) subsidies
Informal / self employed Nonpoor	Eliminate barriers for participation in contributory risk pooling	<ul style="list-style-type: none"> •Facilitate supply of contributory health insurance •Facilitate (through regulation) participation of self-employed and informal sector in contributory health insurance
	Improving incentives for participation in contributory risk pooling, particularly for the informal and unsalaried nonpoor	<ul style="list-style-type: none"> •Improve enforcement of mandatory participation and evasion control •Increase means testing for access to free, publicly subsidized health services •Reduce the contribution-benefits gap^c

Policy Options for Integrating the Informal non-poor Sector

Reducing the Contribution-Benefits Gap

Strategy	Instruments	Challenges	Remedies
1. Delink risk-pool financing from labor market status and employment sector	Shift away from payroll tax financing toward general taxation or risk-rated premiums	<ul style="list-style-type: none"> •Fiscal sustainability (general tax strategy) •Equity (risk-rated premium strategy) •“Unobservability” of employment status and income in largely informal labor markets 	<ul style="list-style-type: none"> •Incremental delinking •Tax reform, use of value added tax as main taxation instrument •Proactive and explicit public equity subsidization
2. Mandate minimum consumption (coverage) rather than minimum spending	Move away from mandates that specify percent of payroll taxes for health coverage and define mandatory benefits package of mainly insurable events. Mandate package as minimum universal coverage, provided by multiple or single insurers.	<ul style="list-style-type: none"> •Equity: part of the population might not be able to afford the minimum package •Political economy of explicit prioritization 	<ul style="list-style-type: none"> •Incremental growth of the package •Focus incremental general taxation financing on subsidizing the package first for those who cannot afford it. •Contain package cost (efficiency gains)
3. Reduce perceived costs (contribution)	<p>Seek efficiency gains resulting in service unit cost reduction (e.g., implementation of strategic purchasing)</p> <p>Regulate to create incentives for large pools and aggregate catastrophic events (risks) in a single pool (truncation of pyramid of risk).</p> <p>Subsidize the cost of the benefits package</p> <p>Unbundle health insurance from other “benefits” (e.g., pensions)</p> <p>Reduce risk-pooling fragmentation through at least “virtual pools” (single rules, single benefits package, portability).</p>	<ul style="list-style-type: none"> •Political economy of implementing purchaser-provider split and strategic purchasing •Fiscal sustainability 	Incremental growth of mandatory benefits package
4. Increase perceived benefits	<p>Increase access, quality and responsiveness of service providers</p> <p>Bundle contributory risk pooling with desirable benefits (e.g., burial insurance)</p> <p>Concentrate benefits package on insurable events</p> <p>Increase choice of service providers and insurance providers</p> <p>Increase portability of public subsidies</p>	<ul style="list-style-type: none"> •Fiscal sustainability •Political economy of introducing strategic purchasing •Political economy of excluding uninsurable events from benefits package (e.g., gender, public health) •“Cherry picking” behavior by insurers •Political economy of demand-side subsidization 	<p>Incremental implementation</p> <p>In multiple pool environment, truncation of risk pyramid, basic risk-equalization in the allocation of public subsidies for benefits package, and strong consumer protection regulation</p>

Organizing UHC

How to organize the payor (insurer)?

- Single or multiple? Public or multiple private?
- If public, contract out with single or multiples or own management?
- If multiple, choice of insurer?

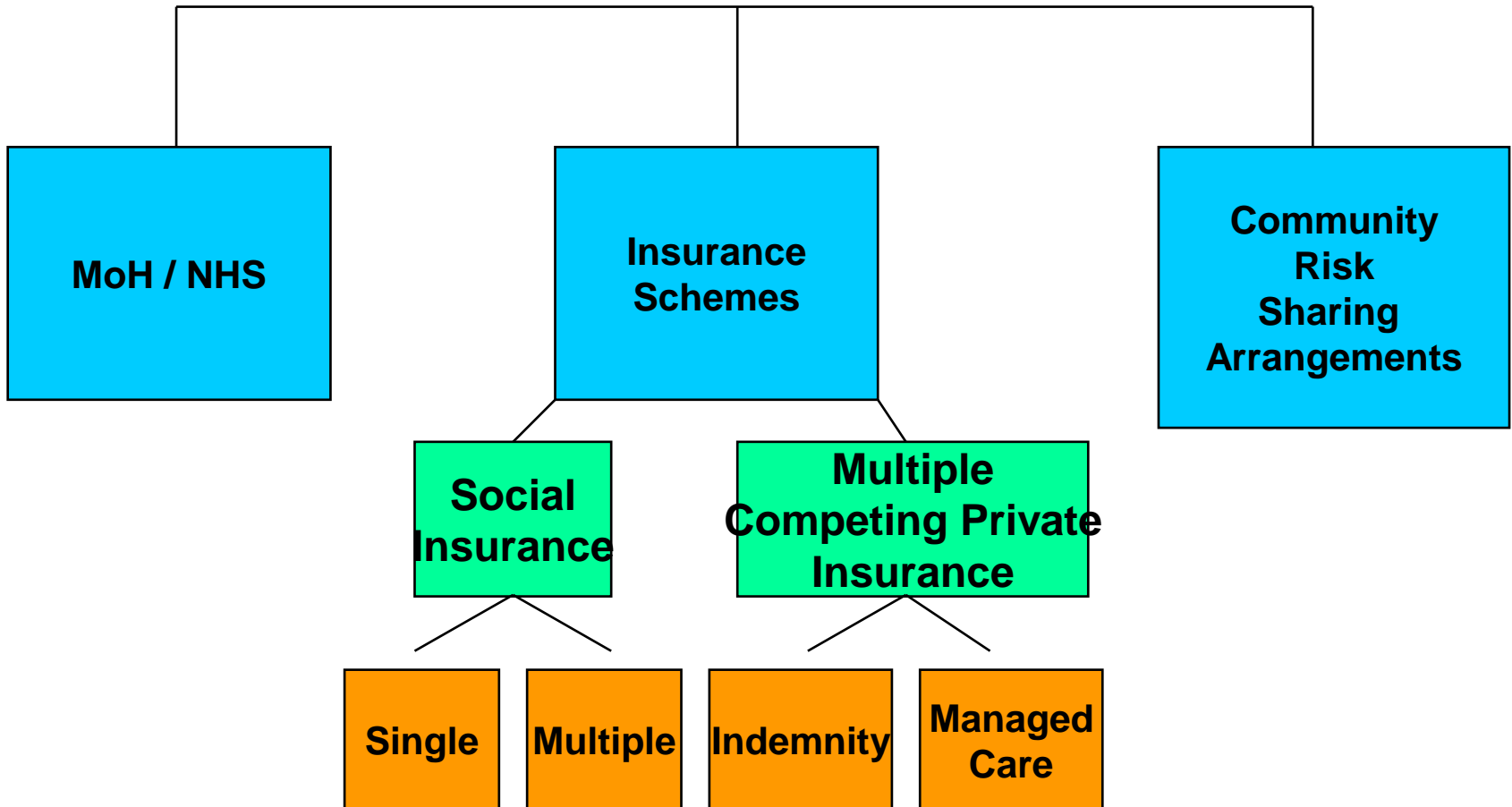
How Should providers be paid?

- Continue with input financing and budgets or transition to output based payments?
- Does payor also pays primary care providers? How?
- How to transition from today financing to desired state?

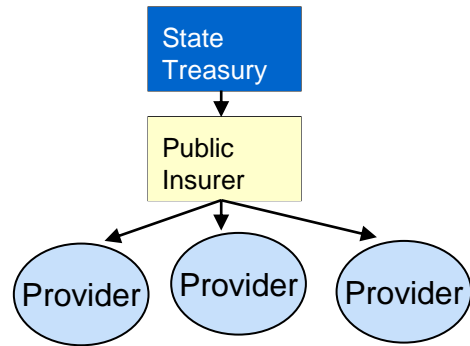
Are providers ready to respond?

- Is there sufficient public and private service supply capacity to match the package?
- What needs to be done for providers to be paid (billing?, eligible population screening? Contracting arrangements?)
- How to transition from today financing to desired state?

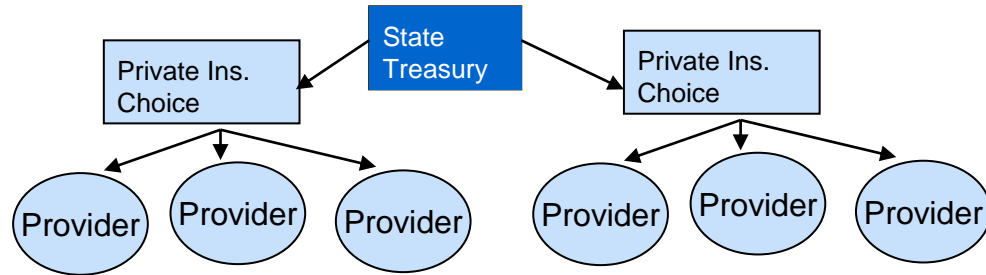
In practice, most countries have a fragmented risk pooling (insurance) arrangement



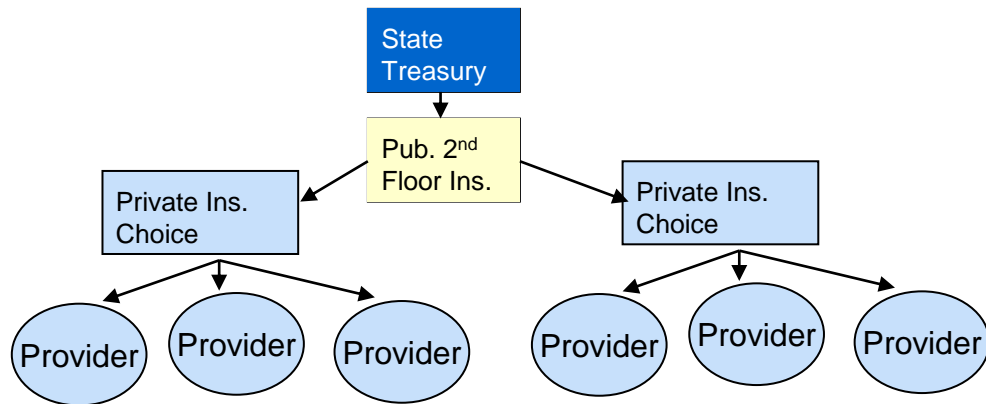
Single Public



**Multiple Private
“first floor”**



**Multiple with
“Second Floor”
Public Insurer**



Implications of Options in Organizing the payor / insurance system

Single Public

- Potentially less costly from transaction costs perspective but usually more costly given governance and resource administration constraints
- Usually takes longer time to set up → opportunity cost of time for reform
- Complicated (and demanding to overcome) potential misalignments in maximizing beneficiaries interests and government interests

Multiple Private “first floor”

- Potentially more costly from transaction costs perspective but usually less costly given governance and resource administration constraints
- Allows for the shortest time to set up → opportunity cost of time for reform
- Demanding in terms of regulatory and oversight capacity as well as resource allocation systems → it may become a significant burden for Treasury to manage allocations directly.

Multiple with “Second Floor” Public Insurer

- If well run, it may allow for best combination of two options above
- Allows for a shorter time to set up than public option → opportunity cost of time for reform
- Equally demanding in terms of regulatory and oversight capacity → but it allows for a specialized management of the “outsourcing” of insurance function contracts and allows for choice.
- Well regulated competition may allow for efficiency and satisfaction gains.

Risk to mitigate in rapid transition to UHC for components of the system

Public Service Providers

- Providers may face significant increase in demand and may not be able to match it → Expand via contracting with private providers and/or develop new public supply capacity
- Providers will need to develop patient identification systems and, possibly, billing capacity if move to output based payment is implemented (recommended) → needs to be faced in as soon as possible in the process
- Providers will need increased flexibility in managing resources, including human resources, to respond to the fluid needs (and output based payment) of the insurer and its population

State Treasury

- The program may have significant fiscal impact. → fiscal space need to be assessed carefully
- Size of the package and funding level needs to consider also (in addition to fiscal space), supply availability → failing to do so may result in increased resources fully absorbed by increased provider prices and not by increases access and quality
- Treasury – Insurance relationship, governance and systems needs to be in place as soon as possible → design of resource allocation mechanisms and financial management mechanisms essential.

Provision of Services for non-poor

- There is a risk of new insurer payment crowding out service delivery by public providers for those not included in the program (desirable for rich population; undesirable for near poor population)
- To avoid undesirable crowding out it is essential to:
 - Carefully develop payor pricing policy and coordinate it with public provider transition into output based payments
 - Rapidly move non-insurance state financing for public providers into output based payments at comparable prices

Options for Addressing initial Service Supply Constraints in rapid transition to UHC (beware of fiscal impact potential)

Expanding Public Providers productivity and capacity

- Reforming Public provider management capabilities and structure (including regulatory framework) to increase productivity
 - Flexibility in managing all resources
 - Introducing output based financing gradually
- When Investing in Public infrastructure to expand supply facilities need to come under new management framework

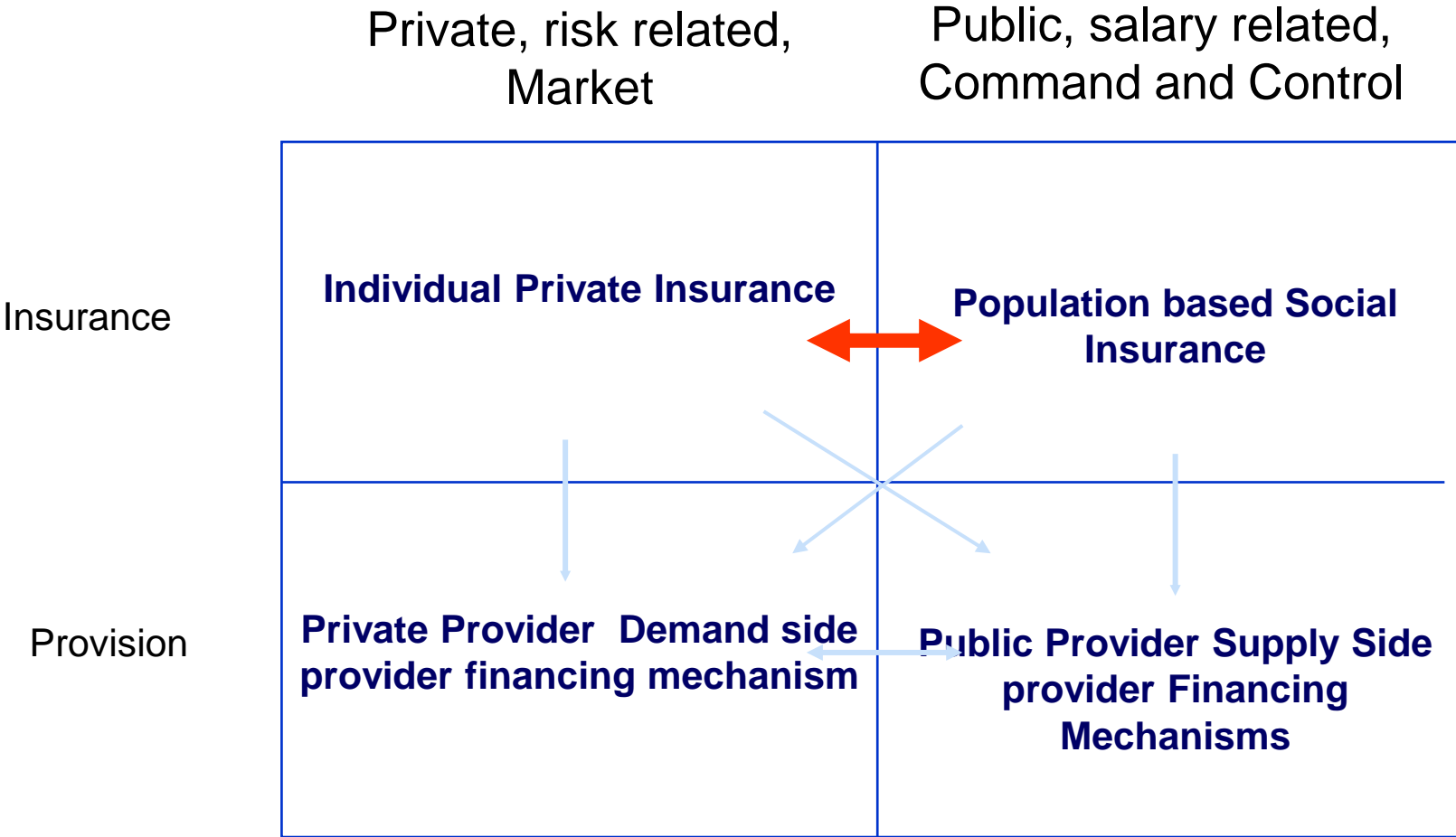
Manage breadth and depth of the Benefit Package

- Mitigating supply and fiscal constraints may require transitioning benefit package incrementally → begin by relatively small but highly impactful package (e.g. maternal and child)
- Potentially introduce initially small co-payments to contain demand

Contracting with private providers?

- Contracting provision of services with existing acceptable (qualitywise) private providers
- Potential PPPs to expand service supply: To succeed:
 - The PPP program should not be run by the Payor or payor related authorities but, payor should contract service delivery.
 - No special revenue/price guarantees can be issued
 - Address early the multiyear contract complications (as compared to year public budgets) with MoF

Reducing Fragmentation
The challenge of Private - Public Integration



What have we learned?

Five key challenges from experience in middle-income countries

(not to worry ... there are many more...)

**Keeping
connected to the
people...**

- UHC needs to be a overall country level policy process, the technical sector specific discussion is crucial but it is only part of it...
- It is all about what people gain from the reform and when (short, medium, and long term)
- Communicate, communicate, communicate...
- Many diverse audiences... but many messages is no message...