

# Financing for Universal Health Coverage: a global perspective



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# Main messages



Universal coverage is an explicit goal of countries around the world – a value consensus

Conditions for success (health financing)

- automatic or mandatory population coverage
- predominant reliance on public/compulsory funding
- reduced fragmentation
- data-driven and dynamic unified payment system to enable efficiency gains and ensure cost containment

It can happen here

# **PUBLIC POLICY ON HEALTH COVERAGE: A BRIEF HISTORY**

# Roots in Germany, 1880s



Policy concerns were

- economic and military development
- reduce growing political unrest in unionized workers

led to focus on benefits for the industrial workforce

- "Social Health Insurance" (payroll-tax funded health coverage) for organized workers

Spread to other European countries and Japan

The aim was not "universal health coverage" (UHC)

# UHC was born after World War 2 and is now widely embraced



An expression of “social cohesion” in **Europe** and “human security” in **Japan**

WHO constitution “highest attainable standard...” for all people

Universal Declaration of Human Rights, includes “right to...medical care”

“Right to health” embedded in many national constitutions (e.g. **Mexico** used this for their UHC push)

It is now “the” global health priority

# What UHC brings to public policy



Coverage as a right rather than merely an employee benefit

- Critically important implications for choices on **revenue sources** and the **basis for entitlement**
- Ensuring this right is realized is a government responsibility
- It is not unlimited, but must be progressively realized within resource constraints

# What UHC means to me as a “consumer”



Whether or not I have coverage, and the type of coverage I have, does not depend on my employment status

I can “sleep well at night” knowing that, even if I don’t need it today, my family and I have guaranteed access to a standard, quality-assured, common benefit package – **personal security**

# **SOME REFLECTIONS FROM AN AMERICAN ABROAD (WITH FOCUS ON SINGLE PAYER)**

# Similarities and differences



Despite differences in form, certain features (and certain problems) in common across countries

There are, however, certain situations and challenges that are more uniquely found in the US – things that people elsewhere find shocking

# How countries fund UHC



Predominant reliance on **public/compulsory sources**

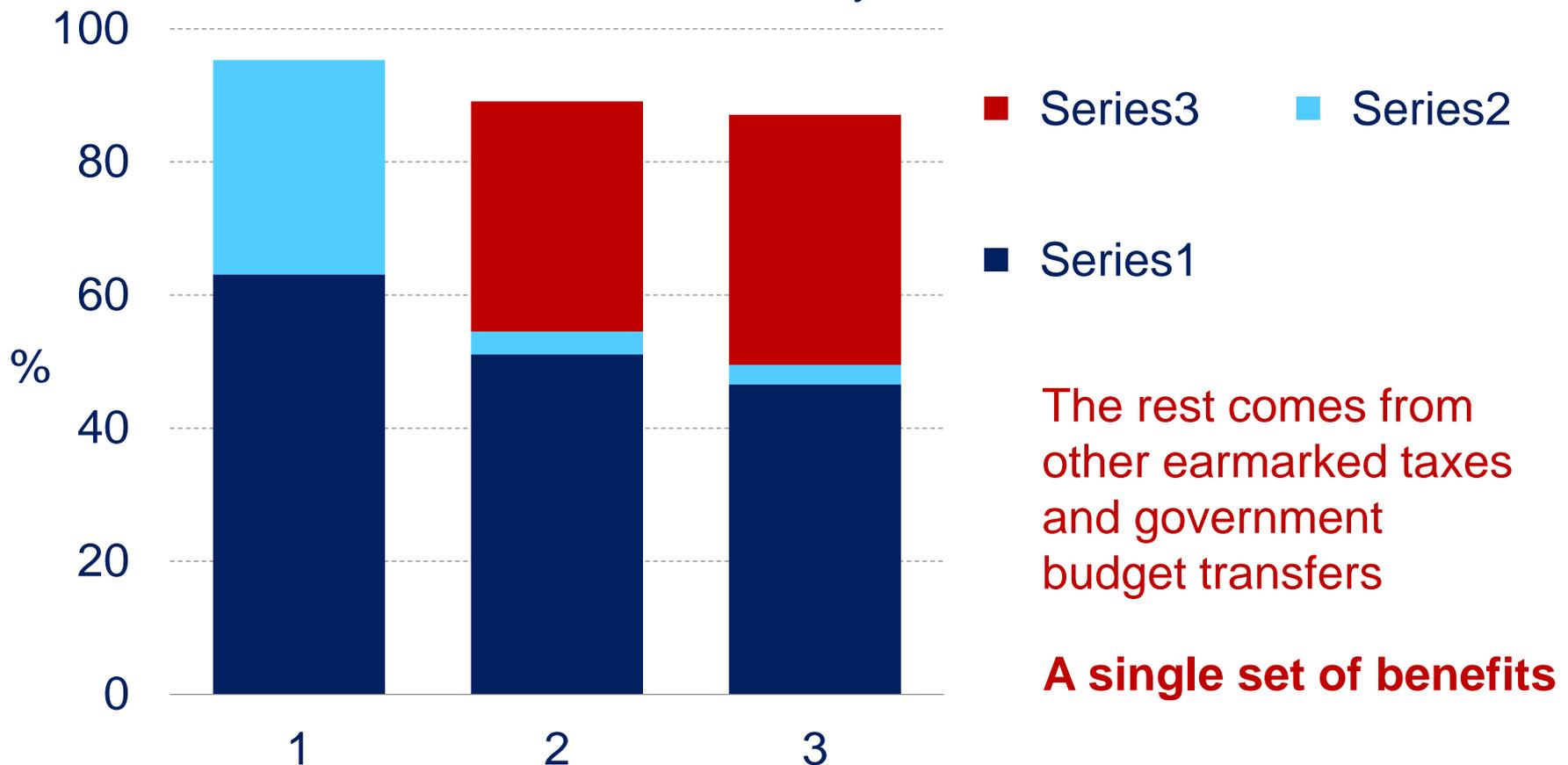
- Limited/prescribed role for voluntary health insurance

And within compulsory funding sources, we are seeing

- Progressive **de-linkage** of health coverage from employment status
- Shift in revenue mix from specific contributions for health insurance to general government revenues (to **reduce costs to employers and thus pressure on the labor market**)

# France de-linked coverage from employment and shifted funding base

Breakdown of health insurance fund revenue by source



# It's also clear that no country can just spend its way to UHC



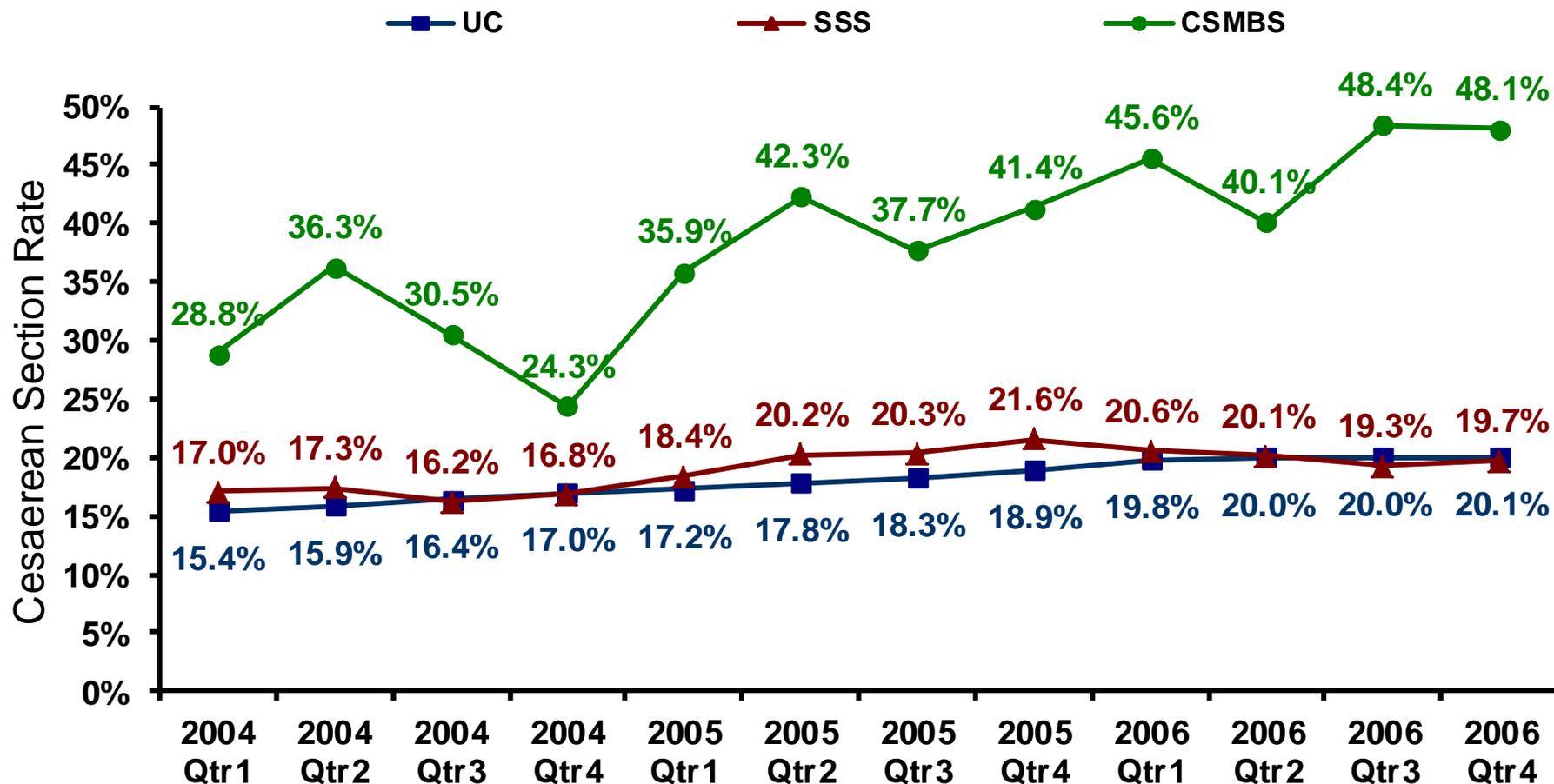
Other side of the coin is efficiency – no open-ended commitments, and manage expenditure growth

Need an active purchaser because unmanaged health markets won't get us there

- We don't go for MRIs or CT scans because they are on sale
- **Supplier-induced demand** is seen around the world in fee-for-service systems

**Conflict-of-interest** (e.g. physician-owned diagnostic centers) just makes it worse

# Thailand: different payment methods, different results



Source: Electronic claim database of inpatients from Thai National Health Security Office, 2004-2006 (N=13,232,393 hospital admissions)

# China's "public for-profit" hospitals: perfect alignment of wrong incentives



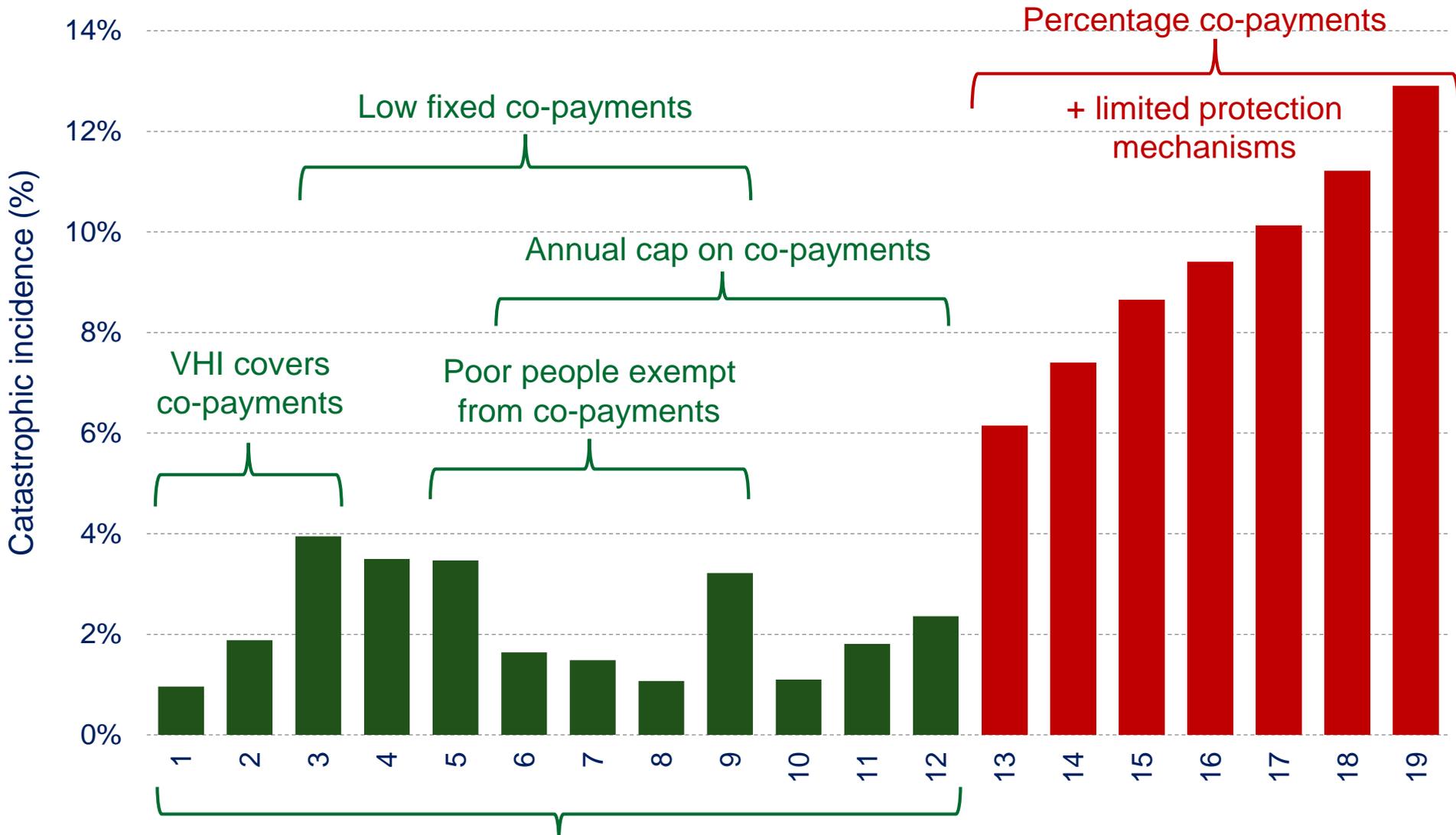
Source of slide: Prof. Winnie Yip, Harvard TH Chan School of Public Health

All staff of the hospital are investors in the CT scanner with objective to maximize its use

# Instead, align policies for financial protection

**Stronger financial protection**

**Weaker financial protection**



OOPS account for <15% of total spending on health in most of these countries

# Different forms of (mostly) single payer UHC models



Country	Insurance market	Single payer?
Netherlands, Switzerland	Multiple insurers (mostly for-profit) under strict regulation, with risk adjustment	Unified payment system for standard package; supplemental HI allowed
Germany	Multiple non-profit "sickness funds" with risk adjustment for standard package; about 10% of pop opts for private coverage	Unified for main system; private insurers generally pay more
Sweden, Denmark, Spain	Managed through sub-national governments (Spanish regions with separate purchasing agency); supplemental HIF allowed	Unified for standard national package; supplemental HI extra
Japan	Multiple, non-competing	Unified payment system
Korea, Estonia	Single national fund	Single payment system
Maryland (hospitals)	Multiple, competing	Unified "all-payer" system

# Reasons for Single Payer



## Potential for greater efficiency

- Reduce scope for **cost-shifting** (very difficult to manage system expenditure growth when provider scope for doing this is large)
- Reduce administrative costs and burden on providers
- Enable more effective service purchasing from unified national database

## Potential for greater equity (fairness)

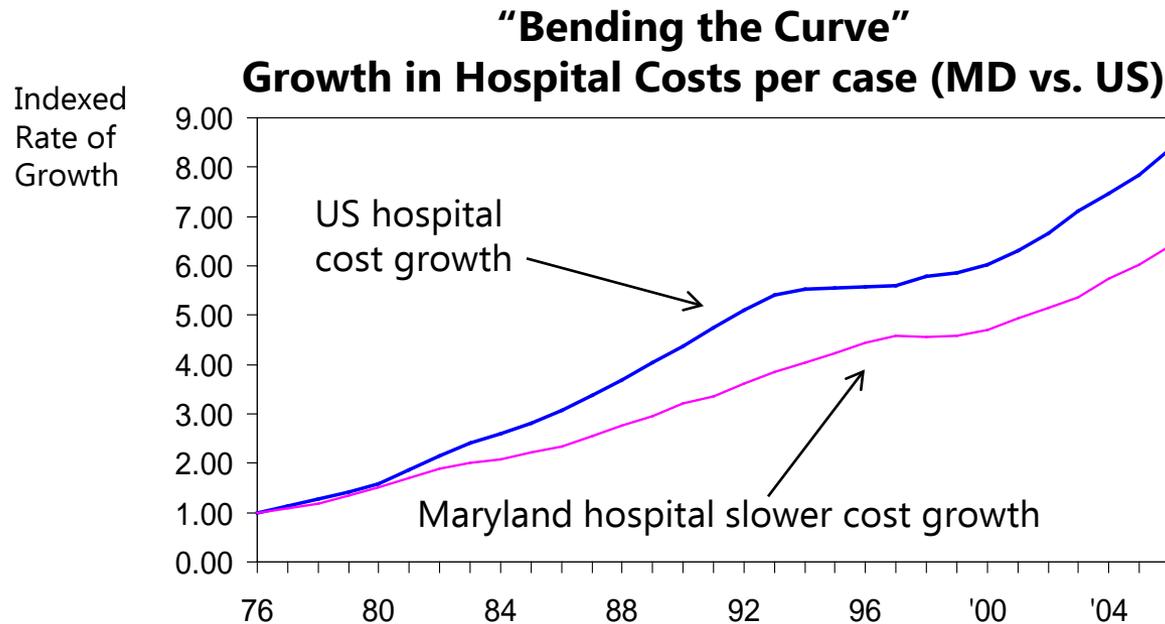
- Reduce scope for selection/discrimination because **same benefits (and cost sharing) and payment rates for all patients**

# Not quite international experience: Maryland's all-payer system (for hospitals)



Since early 1970s, all insurers – private, public – pay same for inpatient care throughout the state

Source of slide: Robert Murray, former executive director of Maryland rate setting commission



Maryland achieved by growing the system more slowly – at Inflation + 1% vs. the U.S. grew at Inflation + 2-3%

- Had the US grown at the slower Maryland rate of growth – hospital spending would have been **\$2.0 trillion lower**

# But establishing a Single Payer is not enough



There is no magic in structural change that will automatically yield the benefits

- Effective **implementation** is key (remember early problems on ACA exchanges)
- Critical early step is to establish **unified/inter-operable data platform on patient activity** – without this it won't work

Need to put in place building blocks and mechanisms to enable this to work (**or start with Medicare!**)

And insurance alone does not **solve supply-side problems**, underserved areas, etc. (needs targeted policies and incentives)

# On the other hand...



It is almost impossible to get those efficiency and equity gains with multiple payment streams

- Regulatory demands are huge, given the potential for provider cost-shifting and discrimination (and to undermine/capture the regulators)
- Can't internalize benefits of prevention/promotion
- Multiple payment streams weakens ability to influence
- **ACA only tinkered at the margins** – need more teeth

That's why other countries have moved to single payment system, regardless of insurance market

- **Elsewhere, it is not politically acceptable** to have differences in benefits for different population groups (as we do with Medicaid, for example)

# So if you want universal coverage...



The arguments to retain a fragmented, multi-payer system with non-uniform benefits are weak

- It will be almost impossible to address the cost problem
- Insurers will “innovate” on the wrong things – exclusion, delays, denials, and cost-shifting

# What to expect when you're expanding



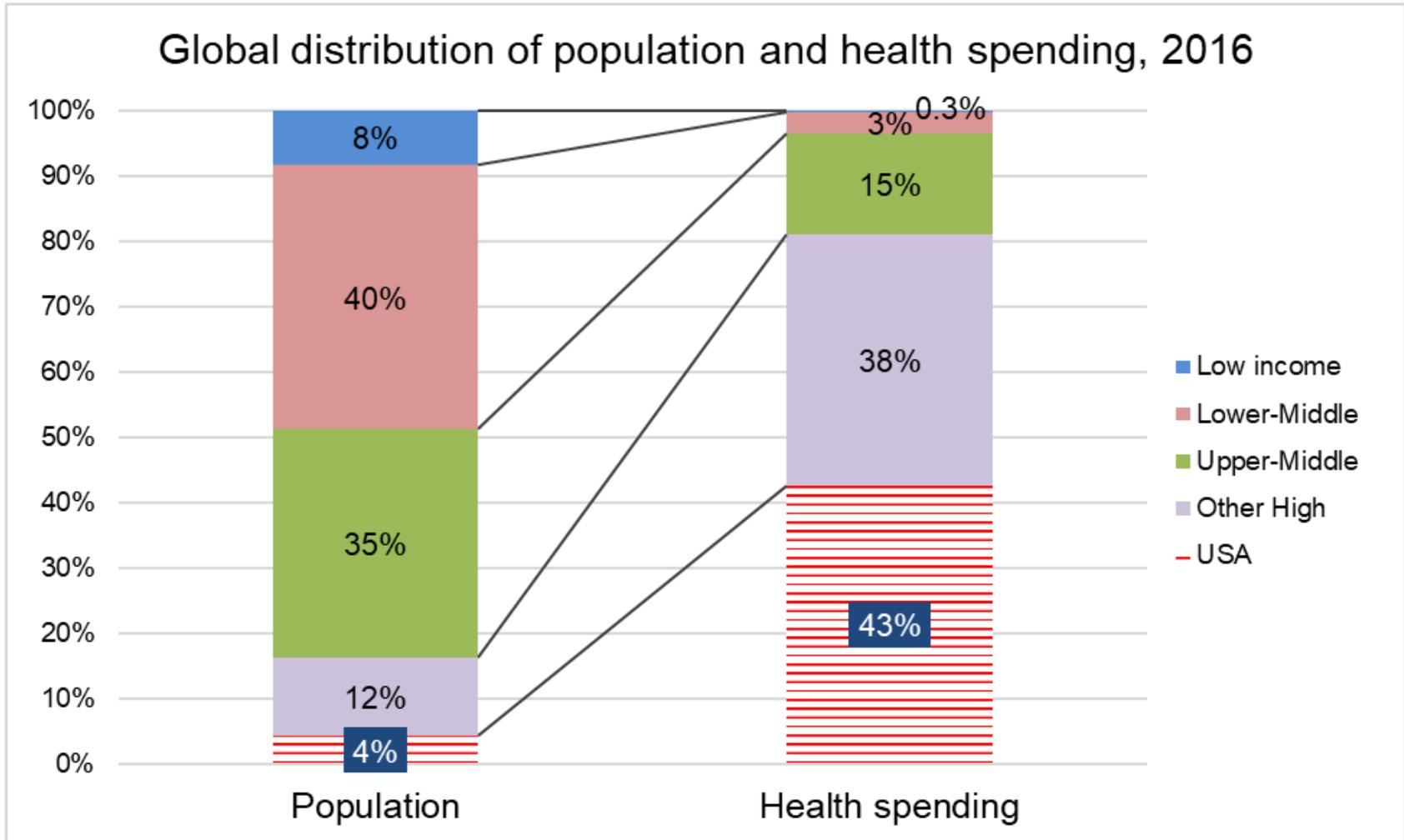
Remember that the initial aim of moving to a universal health system is to address unmet need

- And that's costly – late presentation with more severe conditions, more emergency room visits, more burden on public hospitals and local budgets, etc.

Evidence from around the world shows that there will be a large initial “**utilization bump**” to an expansion of coverage

- It means that the plan worked; but need to be prepared
- More good news: costs will moderate over time as more people are in an organized system of care and administrative efficiencies of consolidation are realized

# What's different about the USA: "it's the spending, ..."



Source: WHO Global Health Expenditure Database (<http://apps.who.int/nha/database/Home/Index/en>)

# What is not part of the debate elsewhere (1)



In virtually all countries, there is a consensus (and often constitutional obligation) on equal and affordable access to health care

- With recognition that this requires some degree of redistribution (healthy=>sick; rich=>poor)
- Even Thatcher's reforms did not alter the fundamental consensus in the **UK**

The way that health care is financed does not...

- **put small businesses at risk** if an employee develops an expensive condition
- pose obstacles to individual decisions about **changing jobs or starting a new business**

# What is not part of the debate elsewhere (2)



All recognize that **government policy must steer markets**, and that public/compulsory funding must predominate

All recognize that they **cannot afford everything for everyone**, so there must be some type of explicit rationing rather than relying solely on rationing by markets, i.e. by ability to pay

All enable those with the means to do so to buy additional services and coverage beyond what is publicly guaranteed – **there is space for supplemental or complementary private coverage**

# In countries pursuing UHC, this does not (and can not) exist



There is no such thing as a "Denial Nurse"

- Active efforts to deny care in the name of profit would be a national scandal



## Coverage Denied: Medicaid Patients Suffer As Layers Of Private Companies Profit

Marcela Villa isn't a big name in health care — but she played a crucial role in the lives of thousands of Medicaid patients in California. Her official title: denial nurse.

Each week, dozens of requests for treatment landed on her desk after preliminary rejections. Her job, with the assistance of a part-time medical director, was to conclusively determine whether the care — from doctor visits to cancer treatment — should be covered under the nation's health insurance program for low-income Americans.

She was drowning in requests, she said, and felt pressed to uphold most of the denials she saw. "If it was a high-dollar case, they tried to deny it," Villa said. "I told them you can't deny it just because it's going to cost \$20,000."

This story also appears in the [New York Times](#). This story is available for free [details](#).

Los

# FINAL REFLECTION

# Does our approach to policy dialog make sense here?



Build consensus on objectives (UHC) first, then negotiate on the instruments

Can this proposition be sold here?

- **"Everyone should be able to have access to good quality health services, without fear of the financial consequences for themselves, their families, their businesses, and their jobs"**

Win that battle first, then debate options for the best way to get there

**THANK YOU**