Universal Coverage: A Noble Goal
Demands Complex and Difficult Choices

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Outline

• Universal Coverage: the difficult choices
• Efficiency gains as an approach to finance universal coverage
• The strategy of United States to achieve and sustain universal coverage through efficiency gains.
Reliance of countries on Out-of-Pocket Spending (OOP)

Source: WHO estimates for 2010, countries with population > 600,000
Cost Growth in Europe

Public Health Care Spending in Eastern European Countries

Source: European Commission 2010
What is Universal Coverage and Why?

• Universal Coverage (UC) is “all people have access to services and do not suffer financial hardship paying for them.”
  
  WHO, WHA 58.33, May, 2005

• Why UC?
  
  “Promoting and protecting health is essential to human welfare and sustained economic and social development.”
  
  WHO. The World Health Report, 2010
Universal Coverage

• Universal coverage is an effective strategy to achieve noble goals.
• Universal coverage involves difficult choices and trade-offs:
  ➢ Breadth
  ➢ Scope
  ➢ Depth
Performance Dimensions of Health Systems

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<tr>
<th>Health Outcomes</th>
<th>Financial Risk Protection</th>
<th>Public Satisfaction</th>
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<td>Level</td>
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Source: Hsiao, 1998
Where we start for universal coverage?

Depth (share of cost from pooled sources)
- top 20% income class
- next 30% income class
- bottom 50% income class

Breadth (proportion of people covered by income level)

Scope (Service covered)
Need Fund to Make UC a REALITY
Difficult Choices Under Financial Constraint

*Trade-offs:*

• **Breadth**: Expand population covered?
• **Scope**: Expand health services covered?
• **Depth**: Expand amount of charges covered? Reduce patients’ out-of-pocket payment such as co-payment or under the table payment for covered services.
Where we start for universal coverage?

- Depth (share of cost from pooled sources)
- Top 20% income class
- Next 30% income class
- Bottom 50% income class
- Breadth (proportion of people covered by income level)
- Scope (Service covered)
How to Finance Universal Coverage?

- Expand coverage and/or sustain UC require funding
- How to generate the funding for UC?
  - Additional or new sources of financing
  - Efficiency gains
Alternative Financing Pathways
Efficiency Gains
Financing Sources
Potential Efficiency Gains

WHO World Health Report 2010:

“This report estimates that from 20% to 40% of all health spending is currently wasted through inefficiency.”

$1 of efficiency gain = $1 of new funding

Financing sources for UC: Additional funds + Efficiency Gains.
The Causes of Inefficiency

• Allocative inefficiency
• Politics and bureaucratic management
• Poor Governance structure, patronage
• Poor management
• Corruption
Potential Efficiency Gains: Drug Pricing

Catalonia

- **Reforms**
  - Global budgets for Primary Health Centers with financial incentives for prescription of generics
  - Benchmarking of physician prescription patterns
  - Dissemination of multidisciplinary guidelines and academic detailing
  - Reference Pricing and mandatory substitution of generics in some cases (national)

- **Results**
  - 51% drop in expenditures per dose for PPIs
  - €4.6 million in net savings on statins despite 75% increase in utilization

Austria

- **Reforms**
  - Prescribing support systems which rank medications by class
  - Benchmarking physician prescription patterns at the regional level
  - Incentives for generic prescription from social insurance funds
  - Reference pricing for “brand” generics
  - Negotiated price reductions for name brand drugs by social insurance funds

- **Results**
  - 56-77% reduction in expenditure per dose for PPIs
  - 60% reduction in expenditure per dose for statins

Sources: Coma (Catalonia), Godman (Austria)
*Expert Rev. Pharmacoeconomics Outcomes Res. 2009*
An Illustration of Drug Reference Pricing in Austria

Potential Efficiency Gains: Hospital Payments

- **Prospective Case-Based Reimbursement**
  - US/Germany: Diagnosis Related Group
  - England: Payment by Results
  - Norway: Activity-Based Financing

- **Technical Efficiency Improvements**
  - US/Germany: Decreased Length of Stay and Cost Savings
  - Norway/UK: Increased day cases and patient access
  - No Adverse effects on patient outcomes

Kyrgyzstan: A Case Study in Efficiency Gains Through Comprehensive Reform

**Delivery System Restructuring**
- State-run family medical centers as first point of care
- Changes in referral patterns and communication
- Restoration of primary care infrastructure and hospital closures
- Use of community health workers in rural areas

**New Financing Mechanisms**
- Hybrid single payer system pooled at the national level
- Purchaser-Provider split with Capitation and Cased Based Payments
- Increased financial autonomy of providers
- Direct government funding for universal coverage of minimum preventive services

Kyrgyzstan: Health System Performance

Access to Services

- 98% of women deliver babies in a health care facility
- 97% coverage of preventive antenatal services
- 99% childhood immunization coverage

Cost Control

- Sharp Declines in Informal Payments and Financial Burden
- Lower Health Expenditure per Capita than CIS Average
- Smaller Percent of Government Budget Spent on Health than CIS Average

Health Outcomes

- 50% drop in infant mortality rate from 1997-2006
- Sharp drop in TB and circulatory deaths relative to other CIS countries
- Life Expectancy Above CIS Average

Problems Confronting USA

• 50 million Americans uninsured; another 50-70 million inadequately insured.

• How to achieve universal coverage?---Affordable Care Act (ObamaCare).

• How to finance and sustain coverage---Efficiency Gains:
  ➢ Prevention and primary care
  ➢ Medical homes; Accountable Care Organizations
  ➢ Payment reform: Capitation, Pay-for-performance
The Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

MASSACHUSETTS STATE BUDGET, FY2001 VS. FY2011

STATE SPENDING (BILLIONS OF DOLLARS)  FY2001  FY2011

+$5.1 B  (+59%)  -$4.0 B  (-20%)

$14

$12

$10

$8

$6

$4

$2

+$0

Health Care Coverage (State Employees/GIC; Medicaid/Health Reform)  Public Health  Mental Health  Education  Infrastructure/Housing  Human Services  Local Aid  Public Safety

-38%  -33%  -15%  -23%  -13%  -50%  -11%

Source: Massachusetts Budget and Policy Center
Massachusetts: Alternative Quality Contract

Reforms

- Five year global budget contracts for physician groups for HMO enrollees
- Two sided risk for provider groups
- Bonuses of up to 10% of budget based on quality measures
- Data and technical support from Blue Cross to participating providers

Preliminary Results

- 1.9% savings per quarter per enrollee in first year due to changes in referral patterns
- Significant quality improvements for chronic disease management
- All groups earned surpluses
- Bonus payments likely to have exceeded savings
- No effect on utilization

Potential Efficiency Gains through Medical Homes

Medical Home Pilot

- **Interventions**
  - Staff Increases and Expanded Visit Times
  - Salary Payment for Physicians and Time Allotted for “Desktop Medicine”
- **Results**
  - Improvements in Patient Satisfaction, Quality, and Hospitalization Rates
  - Estimated savings of $10.30 per member per month

Proven Health Navigator

- **Interventions**
  - Transfer of Case and Population Management to Primary Care Practice
  - Shared savings Incentives for Physicians
- **Results**
  - 18% reduction in hospital admissions
  - 36% reduction in hospital readmissions

Summary

• Achieving UC requires priority setting and difficult trade-offs. Alternative pathways are:
  ➢ Breadth: population covered.
  ➢ Scope: essential services to be covered.
  ➢ Depth: amount of patients still have to pay.
• Efficiency gains + additional funding is the strategy to mobilize necessary financing for UC.
• Assure adequate supply of effective and efficient services require health system reforms in organization, payment, regulation, governance and management