Social inclusion & universal coverage: lessons from health financing reforms in transitional Europe

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Overview

• WHO’s approach to health financing policy in the European Region
  – beyond Bismarck vs. Beverage
• Albania in context: health expenditure patterns in the region
  – low priority for health by government hurts the poor
• Lessons from reform experience in the region
  – address inefficiency first through a strong single purchaser
• Conclusions
Conceptual approach to health financing policy

From values to action
Three pillars for approaching health financing policy

Health financing policy analysis and viable options for reform

- Where are we starting from?
- Where should we go?
- What kind of vehicle can we afford to get us there? How far and how fast?

Starting point, direction, and reality check
How can health financing instruments influence the goals of health systems?

To answer “where should we go?”
Health financing within overall system

- **Revenue collection**
- **Pooling**
- **Purchasing Benefits**
- **Service delivery**

How health financing can influence goals

- **Equity in utilization and resource distribution**
- **Quality**
- **Efficiency**
- **Transparency and accountability**
- **Choice**

Health system goals (WHR2000)

- **Health gain**
- **Equity in health**
- **Financial protection**
- **Equity in finance**
- **Responsiveness**

Core values (HFA)

- **Participation**
- **Solidarity**
- **Equity**
What we care about

• Assess a health financing system not by how much money is generated or by the functioning of any particular scheme, but by its impact on
  – Universality (equity in finance and service delivery, with financial protection for all)
  – Transparency, accountability, and choice
  – Quality and efficiency

• Put the values into action by transforming the objectives into the assessment criteria for health financing systems (and reform options)
Values ⇒ goals ⇒ objectives ⇒ measures(1):
Changes in financial protection over time in Estonia

Values ⇒ goals ⇒ objectives ⇒ measures(2): Improving equity in finance in Kyrgyzstan

Mean out-of-pocket payment for health care as share of total household consumption, Kyrgyzstan

Understand **systems** (and reform options) in terms of **functions**, not labels or models (to tell us where we are starting from)

<table>
<thead>
<tr>
<th>Functions and policies</th>
<th>Classifications or models</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collection</td>
<td>• “National Health System” (Beveridge)</td>
</tr>
<tr>
<td>• Pooling</td>
<td>• “Social Health Insurance System” (Bismarck)</td>
</tr>
<tr>
<td>• Purchasing</td>
<td>• “Semashko System”</td>
</tr>
<tr>
<td>• Benefits and copayments</td>
<td></td>
</tr>
</tbody>
</table>

Yes – all reform instruments available                        No – sources are not systems
Functional approach allows thinking outside the box (of Bismarck or Beverage...)

Source of funds does not have to determine how they are pooled, how providers are paid, and how benefits and co-payments are specified.
New mixes of collection, pooling and entitlement in both rich and poor countries

• Kyrgyzstan
  – General revenues for population-based entitlement
  – Payroll tax for complementary contributory entitlement
  – All pooled in “Mandatory Health Insurance Fund”

• Moldova
  – Budget transfers for specific population groups pooled with payroll tax funds in “National HI Company”

• Germany
  – In context of economic crisis, government injected more general revenues into system to reduce payroll contribution rate to minimize employment effects
Our commitment is to the objectives of health financing policy, but not to any particular institutional form or model.

- All financing systems are systems of insurance – assess performance by how well they do this job, not by what they are called.
- Put another way, German, Dutch, or Swiss citizens are not somehow more “insured” than UK or Swedish citizens just because their systems are labelled as “insurance” and the others are not.
An approach, not a blueprint

• Effective policy, and policy analysis, requires thinking in terms of functions rather than models
  – Don’t let labels limit your policy options!
  – Source of funds does not have to determine how they are pooled, how providers are paid, and how benefits and co-payments are specified

• To develop the Albanian Model, you must understand your own “starting point” (current arrangement of functions and policies) and your goals to reform effectively
A quick look at health expenditure patterns in the region

What can we afford?

Albania in the regional context
Accounting for government spending on health

\[
\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}
\]

- Government health spending as share of the economy
- Fiscal context
- Public policy priorities
Fiscal capacity varies considerably in EURO (Albania relatively constrained)

Source: WHO estimates for 2006, countries with population > 600,000
Despite rhetoric, priorities vary widely (and health appears not so important here)

Source: WHO estimates for 2006, countries with population > 600,000
The level of government health spending matters (for our objectives)

Source: WHO estimates for 2006, countries with population > 600,000

$R^2 = 0.75$
Attainment of policy objectives reflects both context and choice: could Albania have spent more on health?

<table>
<thead>
<tr>
<th></th>
<th>Health as % total public spending</th>
<th>Public spending as %GDP (Albania 2006)</th>
<th>Gov't health spending as %GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>8.7%</td>
<td>28.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Armenian priorities</td>
<td>9.7%</td>
<td>28.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Moldovan priorities</td>
<td>11.0%</td>
<td>28.0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Lithuanian priorities</td>
<td>12.9%</td>
<td>28.0%</td>
<td>3.6%</td>
</tr>
<tr>
<td>German priorities</td>
<td>17.9%</td>
<td>28.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Source: WHO health expenditure estimates, applying different country resource allocation priorities to Albania’s fiscal level

This simply illustrates that even in constrained fiscal contexts, the level of public spending on health still depends on policy priorities. Relative to most other countries in the region, it appears that the Albanian government could do more to protect people against out-of-pocket payments.
Some lessons from health financing reform in central and eastern Europe, the Caucasus, and Central Asia
Fix two major problems inherited from the past

1. Fragmentation of systems for financing and delivery, and especially of pooling
   - Limits scope for re-distribution and hence protection against financial risk
   - Inhibits restructuring reforms

2. Incentive environment driving capacity expansion and other forms of inefficiency in health systems
Old system in the new context: consequences

- Consequences of structural inefficiencies of the inherited health system became apparent
  - Shortages of critical treatment supplies
  - Arrears in paying public utilities & health workers
  - Need for patients to supply their own inputs and pay health workers under-the-table, with greatest burden on the poor (inefficiency hurts the poor!)
  - Universal coverage became more declarative than real (breadth without depth)
Fragmentation needs to be addressed
(ISKSH was embedded within an incoherent system)
What have we learned from reform experience?

- Align instruments to reduce fragmentation and change the incentive environment
- First things first (get the objectives and instruments in the right order)
- Learn as you go (also helps you sell the process)
- Some things to avoid
Equity problems and social exclusion have grown, but first you have to fix the system

- Need to first address structural inefficiencies before making progress on equity
  - Don’t throw money into a broken system
  - The poor suffer more from inefficiency
- Doesn’t mean that inefficiency is more important than inequity; just means that the fundamentals need to be addressed first
Real progress on universal coverage requires strong role for general budget revenues, from the beginning

- Starting with the formal sector and gradually scaling up contributory coverage was relevant 60 years ago, but no more (an idea to avoid)
  - Will lead to political capture by initially insured, worsening fragmentation, and making it much harder to address efficiency and inequity concerns

- Good examples from the region (Czech Republic, Kyrgyzstan, Republic of Moldova) of stable flows of budget revenues into insurance pool as integral part
  - Requires switch from subsidizing supply to subsidizing purchase of services for the population
Some lessons on sequencing reform actions

• Create conditions to strengthen the purchasing function
  – Strong purchaser can be the change agent for entire system
  – Can’t get far on entitlements until agency is able to purchase them (negative experience in Caucasus)
  – Reduce fragmentation (e.g. move towards real single payer in Albania)
  – Ensure predictable revenue flow from public sources (both general budget and payroll)
Purchaser needs to focus on purchasing

1. The agency (ISKSH) needs to focus on purchasing, not revenue collection
   - Collection is a matter for the tax authorities and overall economic development policy

2. Freedom from strict constraints of public financial management system but with clear reporting/accountability measures

3. **Time** to develop systems (e.g. information) and skills to relate purchasing to population needs and provider performance
With coherent arrangements for purchasing established, then turn to benefit package

• Must have means to purchase the package
  – Avoid unfunded mandates

• Package is policy instrument for transparency
  – Population entitlements and obligations
  – Keep it simple (e.g. level of care, not long list of diagnoses) or people won’t understand
  – Addressing informal payments is one objective, but requires combination of instruments; simply legalizing them does nothing to solve underlying problems of transparency and financial barriers
  – Budget impact analysis essential for any proposed change in package (e.g. adding new drugs)
Conclusions

• Build focus on goal of universal coverage into the reform agenda from the start
  – Reduce fragmentation
  – Explicit role for general budget revenues

• Understand the importance of addressing efficiency problems to sustain progress
  – Strong single payer at the centre of things is a promising approach

• Specify concrete objectives and related indicators and studies
  – Use these to document progress, win support, and adapt implementation as needed