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REVIEW OF THE 2010 WORLD HEALTH REPORT. HEALTH SYSTEM FINANCING

Cristina Gutiérrez
Ministry of Health, Mexico
cgutierrezd@salud.gob.mx

The document that was presented by the World Health Organization (WHO) in February 2011 sets forth a series of proposals to encourage member countries to achieve universal health coverage. These proposals are presented in detail and are based both on world statistics and case studies.

Universal health coverage as defined in 2005 World Health Assembly Resolution 58.33 relates to consensus among member countries that everyone has the right to have access to health services and that no one should have to suffer financial hardships for doing so. In the *2010 World Health Report,* WHO acknowledges the fact that governments worldwide are making great efforts to finance health care for their population striving towards the goal of achieving universal health coverage. To support their efforts, WHO provides empirical evidence on potential alternatives to cover health care expenses that will allow countries to answer three basic questions regarding their health system financing:

1. How should the system be financed?
2. How can individuals be protected against the financial consequences of illness and against having to pay whenever they use health services?
3. How can optimal utilization of available resources be encouraged?

The alternatives presented focus on three main areas where changes can be made to solve the basic questions regarding health care financing: collecting more money for health care, collecting money in a more equitable fashion and spending it more efficiently.

The evidence presented in the *Report* indicates that in many countries the government has leeway to allocate more money to health care. The leeway is associated to the importance of health promotion and protection—particularly timely access to preventive services and timely health care—in both human well being and sustained socioeconomic development. Their importance is reflected by the fact that individuals consider health care is one of their top priorities, in most countries it is only behind economic problems such as unemployment, low wages, and the high cost of living. As a result, health care usually becomes a political topic, since governments try to meet the expectations of the population they serve.

The *Report* suggests that some of the alternatives for increasing financing for national health care are the following:

- Redefining State budget priorities. Global initiatives such as the Commission on Macroeconomics and Health or the Commission on Social Determinants of Health, as well as member country efforts have generated extensive evidence of the importance of health in population and economy. This evidence can help create an ironclad political will to allocate additional resources to health care, particularly in poor environments. The *Report* illustrates that if the 49 low income countries were to decide to increase their budget allocations to health care to 15% of total public expenditure, they would be able to collect from national sources an additional US $15 billion for health care.

- Increasing efficiency in the collection of revenue for the health system. The implementation and operation of mechanisms to improve efficiency in the collection of revenue for the system in conjunction with close collaboration between the health and tax authorities will increase revenue susceptible of being used to deliver health services. In this context, the *Report* admits that there are real difficulties in increasing collection efficiency, particularly in countries with large informal sectors of the economy. It illustrates the example of Indonesia, which by completely changing its fiscal system has achieved substantial benefits in terms of general public expenditure and in combination with the reestablishment of State budget priorities achieved a significant increase in expenditure destined for health care.

- Implementation of innovative financing sources. Applying solidarity taxes on a variety of products and services such as tobacco, alcohol, sugar sweetened drinks, foods high in sodium, or in trans fats, mobile phone services, diaspora bonds, or currency exchange transactions, would collect significant sums in certain countries. This revenue, previous negotiation with the tax authorities to set it aside to finance the health system, would represent a significant increase. The *Report* warns that the application of taxes generates distorting effects in the economy and meets the opposition of groups with vested interests. Based on the above, the *Report* recommends governments to identify and apply those mechanisms that are more suitable to their economic environment and are liable to receive political support.

- Contributing to health. World solidarity is still necessary to help low income countries to expand health coverage. The financing deficit faced by these low income countries highlights the need for high income countries to honor their commitment to provide official aid for development. In parallel, managing and monitoring this aid requires greater donor country efforts to improve efficiency by reducing the administrative burden and optimizing evaluation processes.

The *Report* indicates that the elimination of economic barriers to access health services, particularly in the case of poor populations, is a top priority to achieve universal coverage. Eliminating these barriers is essential to protect individuals against the financial consequences of illness and to keep them from having to pay for health services.

Depending on direct payments, including user contributions is also identified as the greatest obstacle to achieve universal coverage, particularly in low income countries. Based on the above, in the *Report* is indicated that a viable alternative to reduce this dependency would be a more equitable collection, thus ensuring delivery of health services to the entire population and increasing

pre-payment of services. Collection could be made via medical insurance, income taxes, value added taxes, salary taxes for public medical services, or any combination of these mechanisms. Revenue thus obtained and negotiated with the tax authorities to be allocated to the health system, would be pooled so the financial burden does not rest only on the sick or poor population. This alternative is used in many European countries and is one towards which Brazil, Chile, Colombia, Costa Rica, Mexico, China, Thailand Turkey, Ghana, Rwanda, Kyrgyzstan, and the Republic of Moldova have been advancing over the few last years.

Several examples provided in the *Report* present evidence that collecting funds through mandatory pre-payment is the most efficient and equitable basis to expand health coverage. This mechanism implies cross-subsidies from the rich to the poor and from the healthy to the sick. The experiences presented show that collecting money in a more equitable fashion works better when pre-payments come from a large number of individuals, with the ensuing pooling of funds to cover everyone's health care costs.

With respect to the growth of the pooled fund to finance universal coverage, the *Report* indicates that there are three dimensions to consider. On the one hand, the proportion of direct expenses covered. On the other hand, the package of health services that is being financed. Finally, the percentage of the population that is covered. Universal coverage requires a long-term commitment from the health system to finance a basic service package for the entire population, striving to reduce patient participation in the financing of direct health expenses to a minimum. As the health systems matures and both its financing and health care cost control mechanisms have been strengthened, the package of health services could include additional services to try to cover more health needs making sure patient participation in its financing is kept at a minimum.

Additionally, the *Report* acknowledges that there are other financial barriers to access health services, particularly transportation costs in conjunction with poor patient income and the unavailability of health services required by the population near their area. The *Report* suggests exploring the use of conditional cash transfers if beneficiaries carry out certain actions, mainly preventive, to improve their health. It also suggests considering the use of coupons or reimbursements to cover transportation costs. Finally, it mentions microcredit loan schemes targeted at poor households as a means to allow them to make money to cover expenses that are not directly related to health services.

In terms of improving efficiency in health expenditure, the *Report* indicates that conservatively speaking between 20% and 40% of total health expenditure is lost due to inefficiencies in several stages of the health care process. It particularly points out several specific sources of inefficiency where more suitable policies and practices could significantly increase the availability of resources. However, it recognizes that in some cases inefficiency may be more likely due to insufficient expenditure on health than to squandering.

The fundamental role played by health care personnel is conspicuous among the sources of inefficiency. Even though it acknowledges that personnel is essential for a sustainable health system, in terms of inefficiencies the *Report* underlines that in a significant number of national health systems the staff is inadequate—expensive owing to the number of staff, but insufficiently paid at an individual level—and not very motivated in terms of training and participation in the decision making process. These personnel characteristics in conjunction with inflexible human

resource policies and staff resistance to change are key factors that lead to inefficiencies in other areas such as medication prescription, excessive use of technology, underutilization of infrastructure, low quality service, squandering, corruption, and fraud. To address the inefficiency related to the personnel, the *Report* suggests an evaluation to determine the scope of both the methods applied to adjust existing personnel skills and personnel training based on the present and future health needs of the population. It also suggests reviewing remuneration policies and more flexible contracts, pointing out the possibility of paying for performance. Finally, it admits that these proposals will have to be assessed in the light of trade union relationships as well as in terms of the country's general labor policy.

As regards personnel, it admits that payment to service providers is a permanently changing and complex process. The *Report* indicates that certain countries have developed a mixed payment system combining "strategic or active purchase" payments—based on the health needs of the population—and "passive purchase" payments—through salaries—based on the concept that it is more efficient than a single payment modality. In terms of payments, countries should decide where strategies such as mixed payments might be likely to function based on their ability to gather, control, and interpret the information required as well as to encourage and enforce quality and efficiency standards. It stresses that the closer countries are to strategic purchasing, the higher the probabilities that the system will be efficient.

In terms of inefficiency associated to drug prescription, the *Report* highlights the underutilization of generic drugs, overpriced medications, and absence of robust drug surveillance systems to ensure that the product acquired is a legal and quality drug and to prevent improper and inefficient use. The proposals made to address these inefficiencies include improving orientation, information, training, and prescription practices among health personnel; requiring, allowing, or offering health personnel incentives to prescribe generic drugs; developing active acquisitions based on cost benefit evaluations of the alternatives; ensuring transparency in acquisitions and tenders; eliminating taxes on medicines; controlling excessive commercial margins; supervising and disseminating drug prices as well as public information on the subject; strengthening the application of quality standards for drug manufacturing; product analysis; improving public contracting systems by pre-qualifying suppliers; separating prescription from provision, and regulating promotional activities.

With respect to excessive use of technology, it mentions the importance of supplier induced demand, service payment mechanisms, and the fear of legal action against health personnel. To address these inefficiencies, the *Report* suggests reforming the incentive and payment systems and exploring other options such as capitated payment or payment by diagnosis related groups to complement a salary based payment scheme. It also suggests developing, implementing, and monitoring the use of clinical practice guidelines.

As regards the underutilization of infrastructure, it places emphasis on the inadequate level of management resources to coordinate and control both personnel and physical resources, as well as on the lack of planning for health care services infrastructure. To address this inefficiency the *Report* suggests incorporating contribution estimates and service results in health unit (hospital or ambulatory) planning; adjusting managing capacity according to health unit size and reducing excess capacity in order to raise utilization or occupancy rates to 80% or 90%.

Inefficiency associated to poor quality service is addressed in the *Report* from a perspective of hospital admissions and medical errors. This perspective is associated to the absence of alternative therapeutic programs; insufficient incentives to discharge patients; limited knowledge of standards, best practices and clinical care protocols, as well as to the absence of guidelines and inadequate supervision. To address this inefficiency, it suggests the option of providing alternative health care in non-hospital day centers to patients that require long-term care; modifying financial and non-financial health personnel incentives to optimize days of hospitalization; providing comprehensive information on efficient hospital admission practices; making evaluations to improve hygiene standards; provide continuing health care; performing more clinical audits and supervising hospital performance.

Waste, corruption, and fraud are associated with unclear resource allocation guidelines, lack of transparency, inadequate accountability, and management mechanisms, as well as with low employee salaries. According to the *Report,* these inefficiencies can be addressed by introducing effective sanction mechanisms to improve regulations and management; it also requires assessing transparency and vulnerability in terms of corruption as well as follow-up studies of public expenditure and the promotion of conduct codes among personnel at every level of the health service supply chain.

Finally, the *Report* indicates that inefficiencies arising from an inadequate composition of strategies to achieve universal coverage generate unbalances between medical care, preventive services, and health promotion. To address these inefficiencies, it suggests regular impact evaluations and using the results of these evaluations as feedback to adjust health intervention policies.

The *Report* indicates that WHO and its associates will launch a program to help countries analyze their systems and financing strategies as well as their national health care policies and programs. The goal of this program is to encourage and foster the exchange of experiences among countries and to help them adjust their financing systems so more people can have access to the health services they require.

It also emphasizes that there is a potential conflict in striving for increased efficiency in health expenditure, because the most efficient way to utilize resources is not always the most equitable one. Based on the above, the *Report* underlines that it is necessary to pay special attention to the difficulties faced by vulnerable groups,—women, ethnic groups, groups of foreigners—when trying to gain access to health care and to solve the particular problems faced by these groups.

It acknowledges that as the system improves the demand for more services, for higher quality services, and for higher levels of protection against risks, will increase to meet growing demand and expectations, as well as to pay for rapidly expanding technologies and options. The above indicates that governments are responsible for making sure providers, both public and private, are properly operating and handling patient needs effectively and efficiently under a sustainability framework, both financially and in terms of human and physical resources. It is also essential for countries to develop their own analysis capabilities and to understand the strengths and weaknesses of their current system to be able to adjust their health financing policies, applying, controlling, and modifying them over time. The *Report* emphasizes that these adjustments are

necessary not only because there is always room for improvement but because the epidemiological characteristics of the population evolve, resources vary and service providers undergo transformation.

The *Report* concludes that no combination of political decisions to strengthen health system financing in order to achieve universal coverage will function correctly in every environment. It warns that any successful and effective health care financing strategy must be developed according to the social, economic, and political characteristics of each country. In this context, the *Report* emphasizes that commitments are unavoidable and public policy decisions will have to find the right balance between the proportion of population covered, the supply of services included and the cost that should be cover under an environment of financial sustainability for the health system.

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