



Approaching health system financing policy decisions: objectives, instruments and the sustainability dilemma

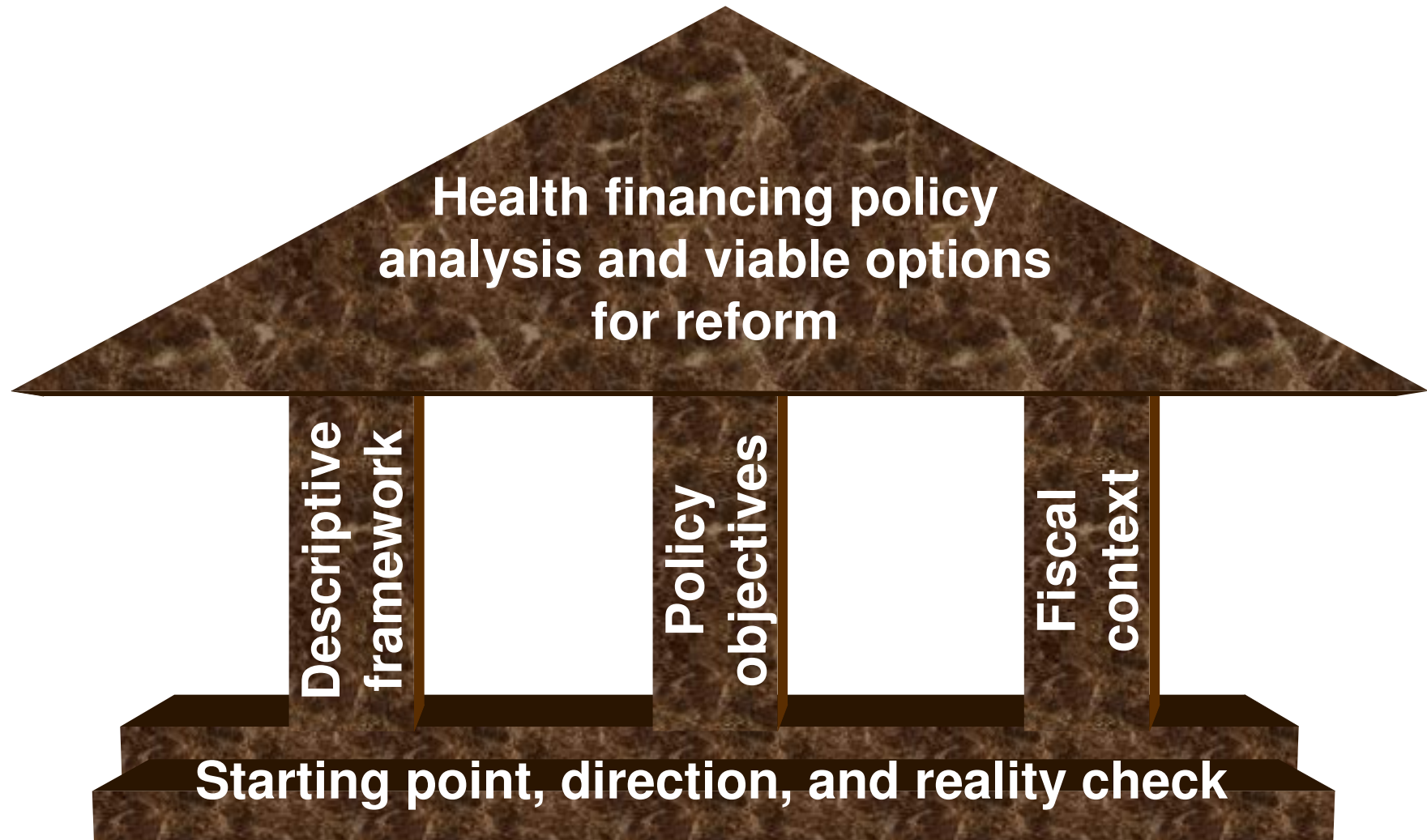
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Tallinn, 3 April, 2009.

Outline

- WHO's guide to health financing policy analysis
- Sustainability: definitions, challenges and trade-offs decisions
- Illustrations and lessons from abroad



**Where are we
starting from?**

**Where should
we go?**

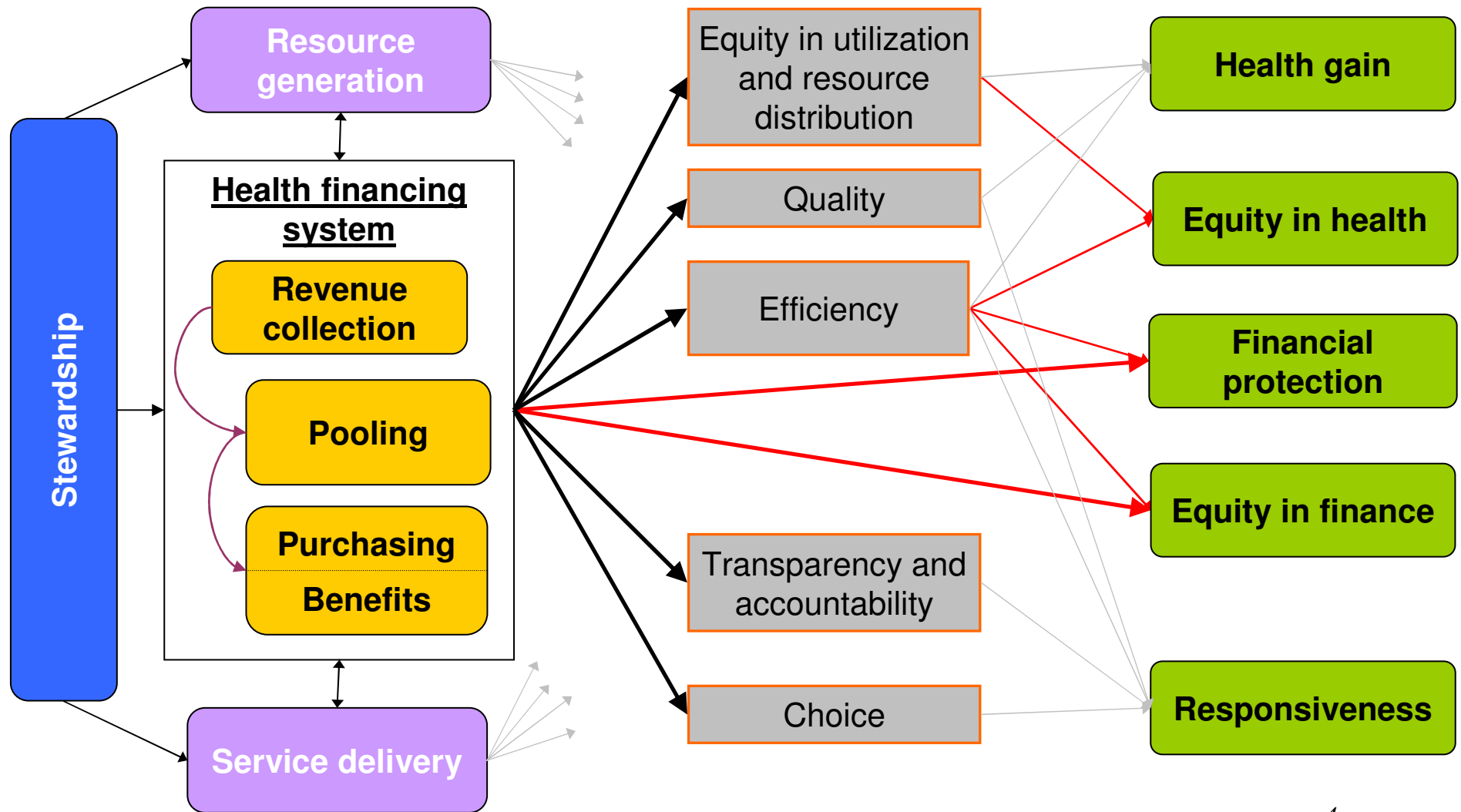
**What kind of vehicle can we
afford? How far and how fast?**

Source: Kutzin, J (2008) Health financing policy: a guide for decision-makers

Health financing within overall system

How health financing can influence goals

Health system goals (WHR2000)



Policy objectives

- What objectives do we want to maximize?

INTERMEDIATE OBJECTIVES

- ✓ **Efficiency**
- ✓ **Equity in access**
- ✓ **Quality**

ULTIMATE OBJECTIVES

- ✓ **Health outcomes**
Level and distribution
- ✓ **Financial protection and equity in finance**
- ✓ **Responsiveness / satisfaction**

- Improvements may positively affect different objectives at the same time, but in many cases trade-offs are involved 5

Defining “sustainable health financing”

- What level of attainment of the health policy objectives are you **willing to -collectively- pay for**?
 - How much do we value what the health system can produce (as opposed to other -publicly funded- goods and services)?
- What level of attainment of the health policy objectives can you **sustain**, given your fiscal constraints?
- Financial sustainability should not be seen as a policy objective worth pursuing for its own sake, but as a constraint that needs to be respected.
 - If it was an objective, then a simple cost cutting exercise will do the job!

Asking the right questions

- What mix of objectives reflect the changing values of the societies?
 - Sustainability of the trade-offs
 - E.g.: What level of inequity is socially sustainable?
 - Erosion of solidarity:
 - How much are the rich willing to subsidize the poor?
 - What level of progressivity of financing is sustainable/acceptable?
 - What level of coverage for all are you willing to pay for?
- These questions become more apparent when economy is shrinking, the fiscal space is shrinking or the value foundations of the health system weaken

No easy answers

- There will always be trade-offs. Everyone wants a system that is
 - free of charge at the point of service,
 - provides instant access, and is of
 - high quality.
- The best that can be hoped for is **two out of three**. But at least the choice is yours!

Objectives and instruments

- Financial sustainability is primarily a question about values and preferences of the society in pursuing different social objectives
- Sustainability of the social health insurance system that is based on payroll tax is a secondary question
 - It is about the „sustainability” of an instrument we choose to achieve objectives

Implications for health financing (1)

- Near exclusive reliance on wage based taxation may not be “sustainable” as a source of funds for health insurance
 - Macroeconomic and employment consequences will require **diversification** and increasing **de-linkage** of health entitlement from labor-related contribution
 - “Sources” decision increasingly driven by **tax policy**
 - Health insurance arrangements are in the sphere of public policy: think of insurance as a function and not as an institution

Implications for health financing (2)

- Balancing public expenditures with *ex ante* decision about the level of public revenues to be made available for the sector
 - Reflects (normative) position that the level of public spending should not be the product of a formula (e.g. contribution rate), but rather a political choice based on a comprehensive fiscal framework
 - Reflects technocratic desire towards explicit decision making process (may not always be realistic)

Reducing the severity of the trade-offs

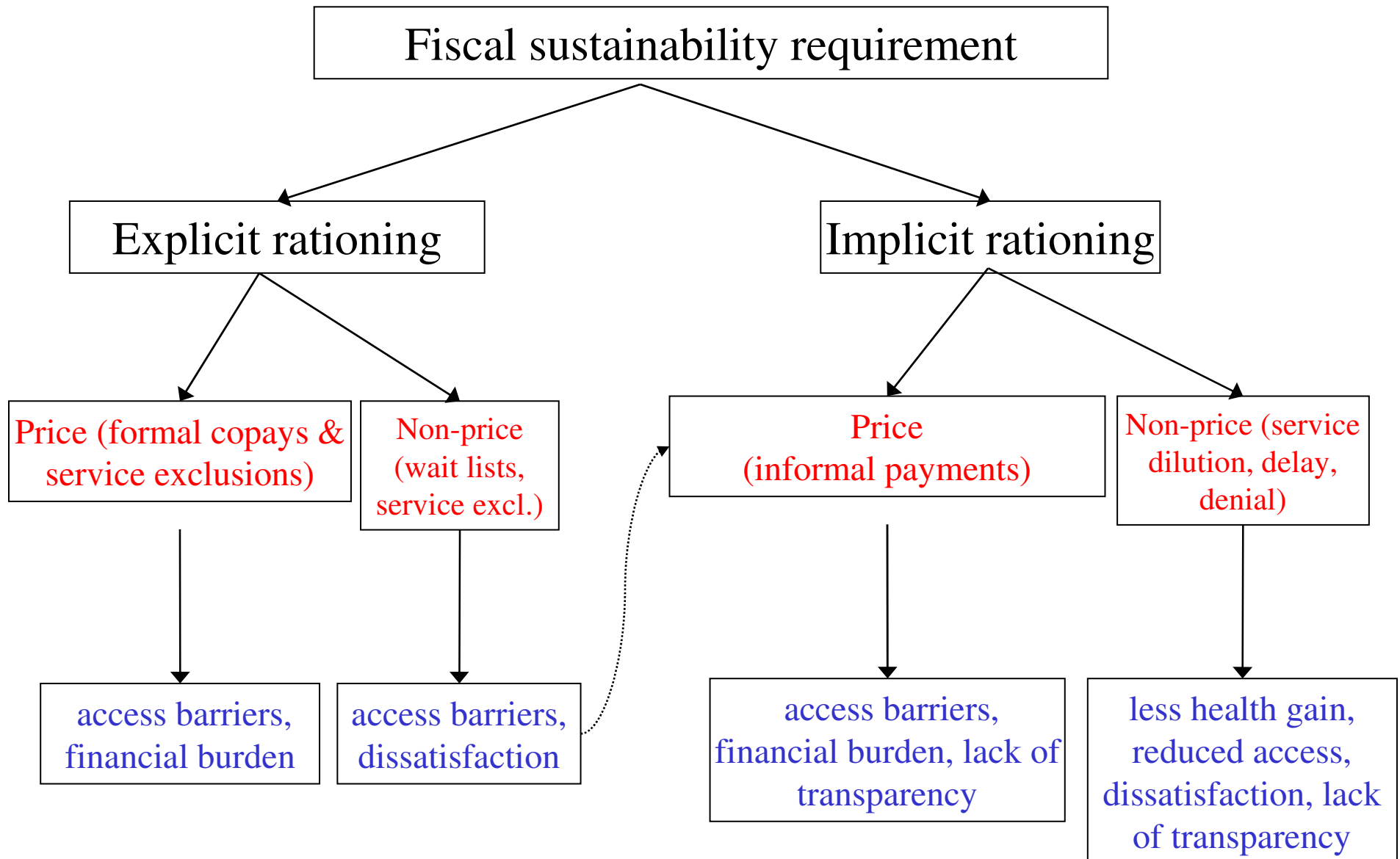
1. Set realistic objectives and accepting/making trade-offs decision
 - ⊖ Adjusting public-private expenditure to reflect preferences of the society

2. Secure sufficient revenue for achieving objectives
 - ⊖ Priority to health in public expenditure
 - ⊖ If you have to cut expenditure, then be selective and clear about priorities (or rather posteriorities)

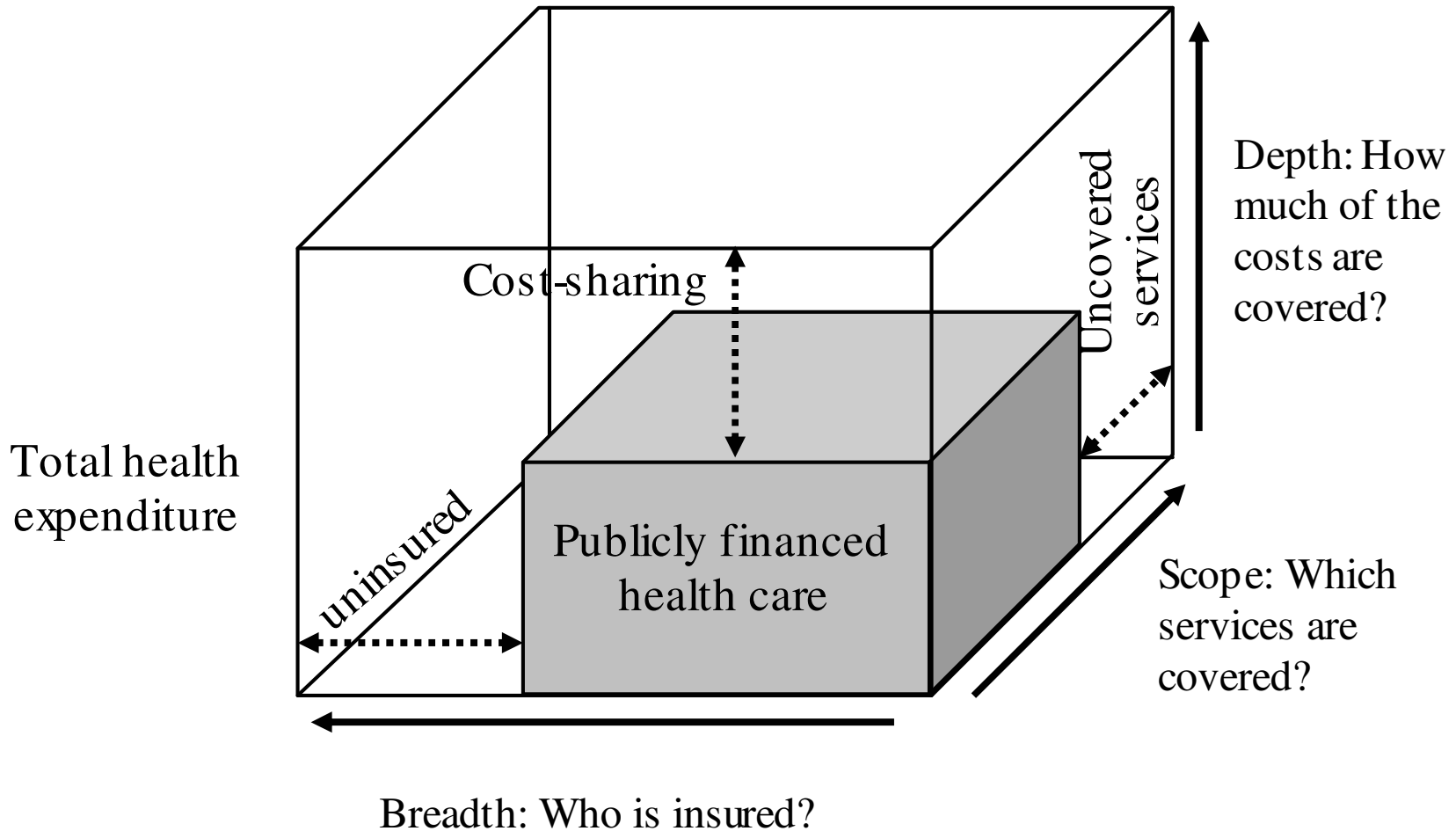
3. Improve the efficiency of resource use
 - ⊖ Collection
 - ⊖ Pooling
 - ⊖ Purchasing

Sustainability trade-offs

The need to give up something in order to meet the fiscal sustainability requirement (and as a result settle for lower financial protection, solidarity, access to services, quality etc.)



What coverage do you cut?



Where is clinical quality (and service quality) in this chart?

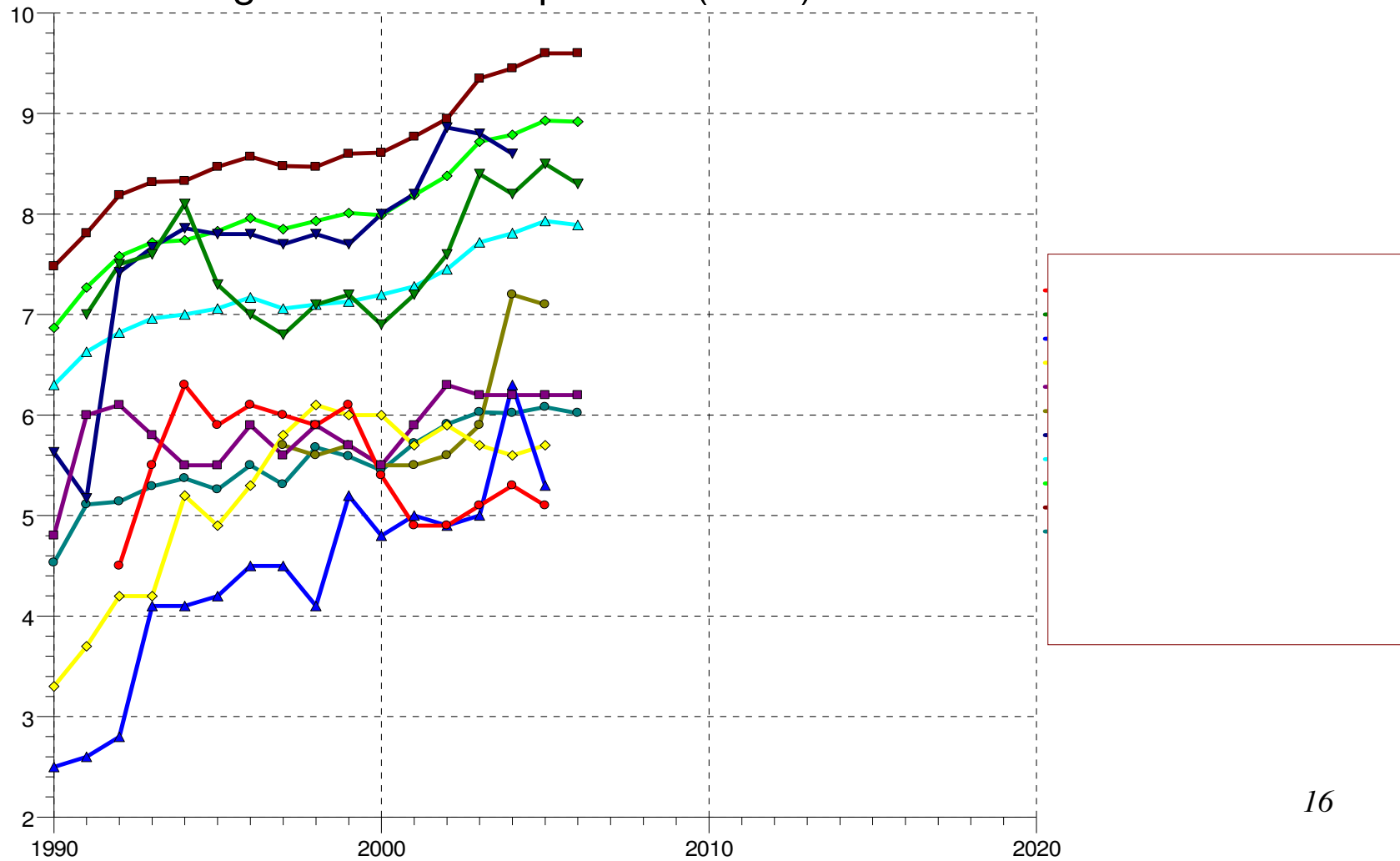
Empirical evidence for the discussion on options

„DATA CAN HELP MOVE THE DEBATE TO A MORE HONEST AND CONSENSUAL UNDERSTANDING OF THE OPTIONS AVAILABLE, SO THAT MYTH, IDEOLOGY AND GROUP INTERESTS WILL NOT DOMINATE AND DRIVE A DEBATE”

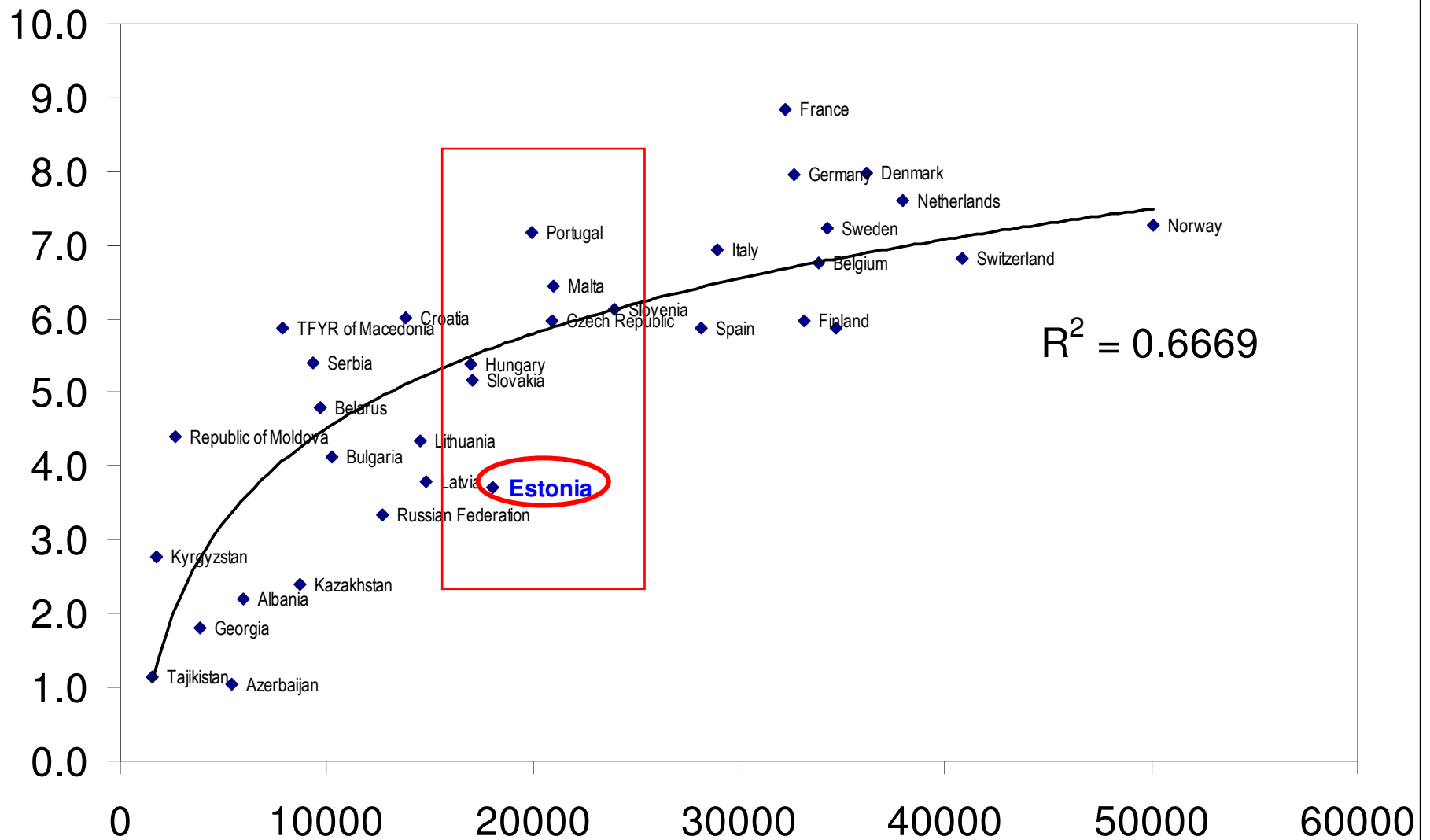
Roberts M, Hsiao W, Berman P and Reich M. 2004, "Getting Health Reform Right", Oxford University Press, p. 25

Which one is Estonia?

Total health expenditure as % of gross domestic product (GDP)



General government expenditure on health as % of GDP and GDP of selected European countries, 2006



Accounting for government spending on health

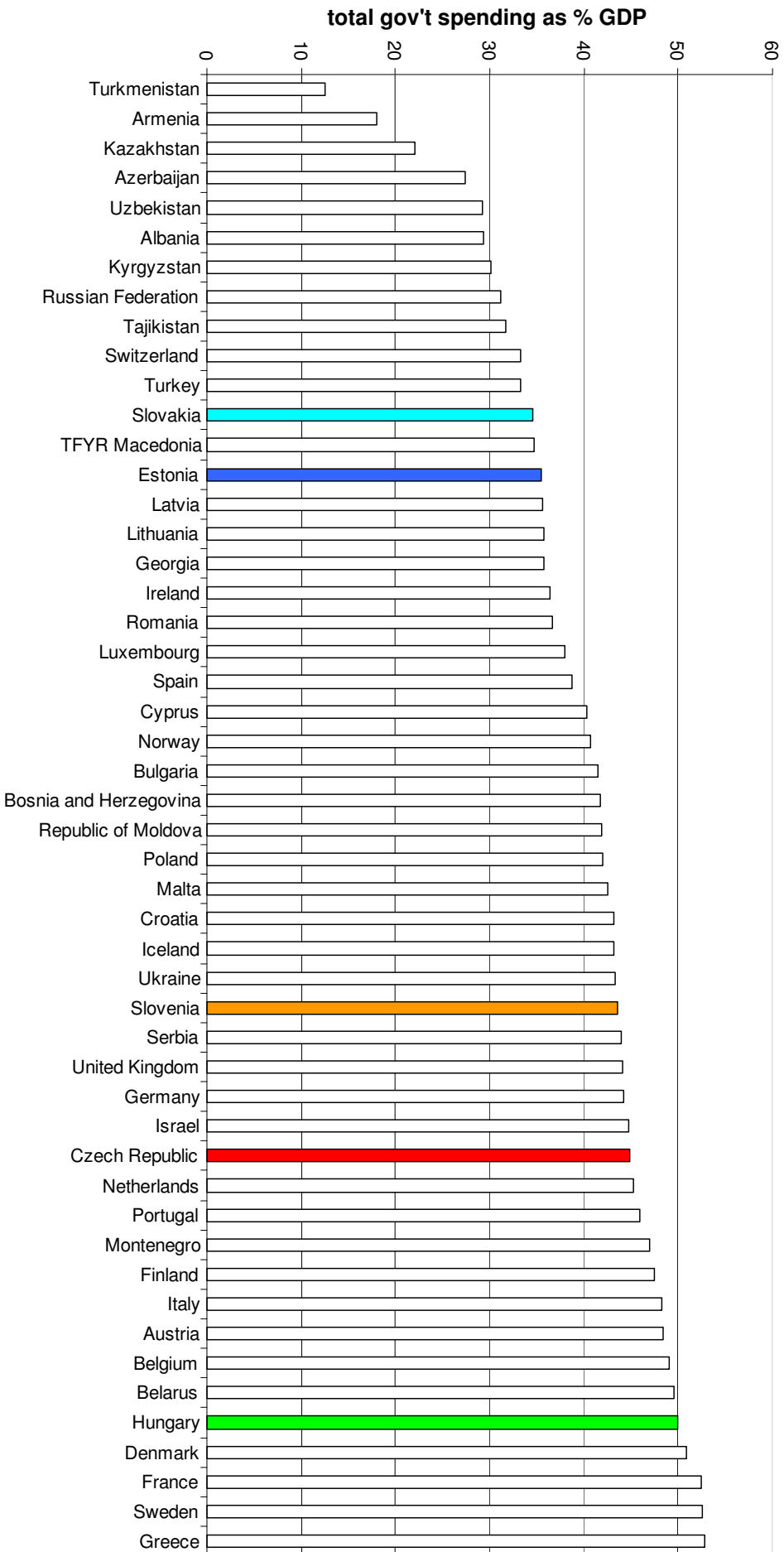
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

↑
Government health spending as share of the economy

↑
Fiscal context

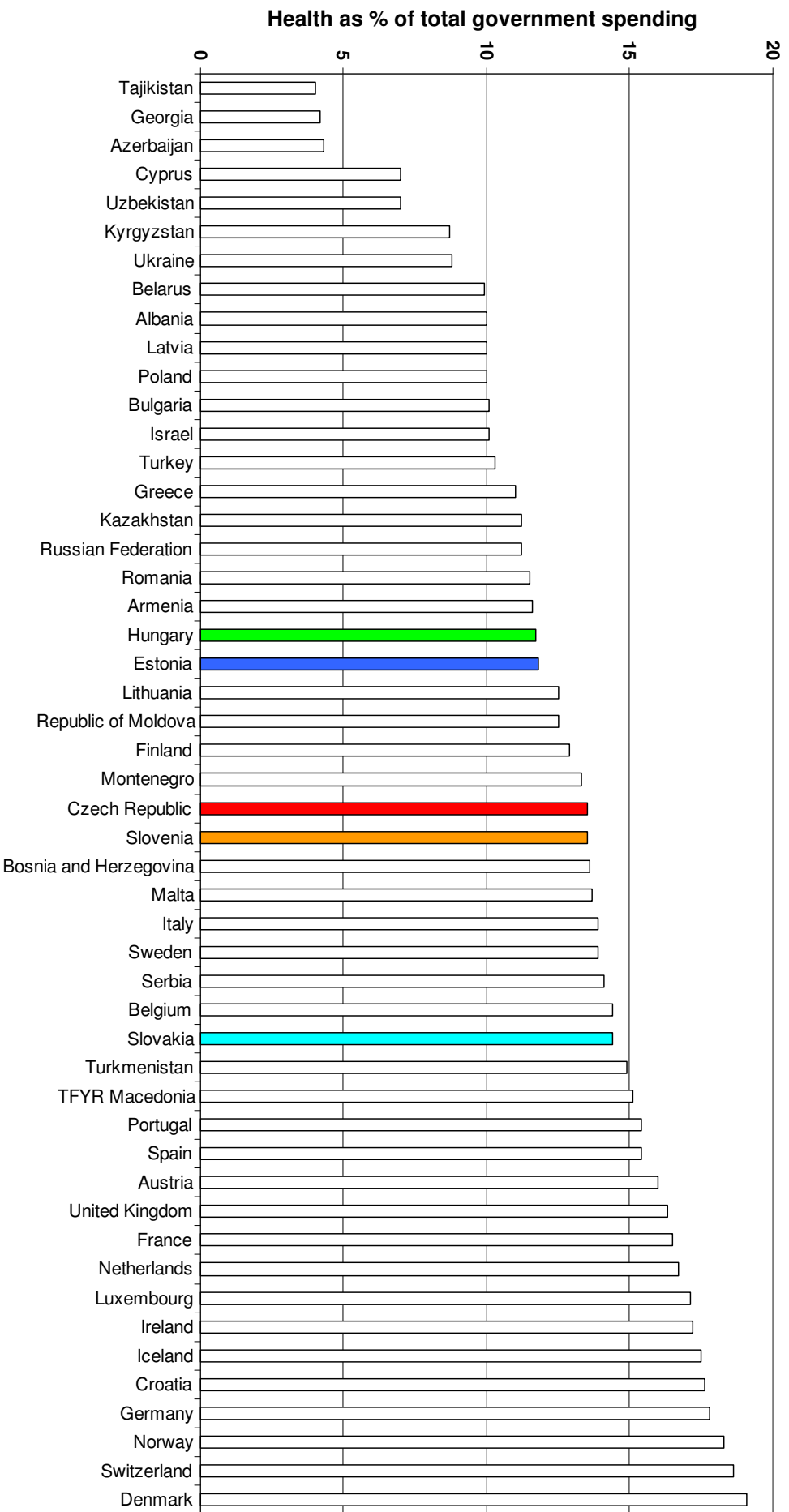
↑
Public policy priorities

Fiscal context: relative size of the government



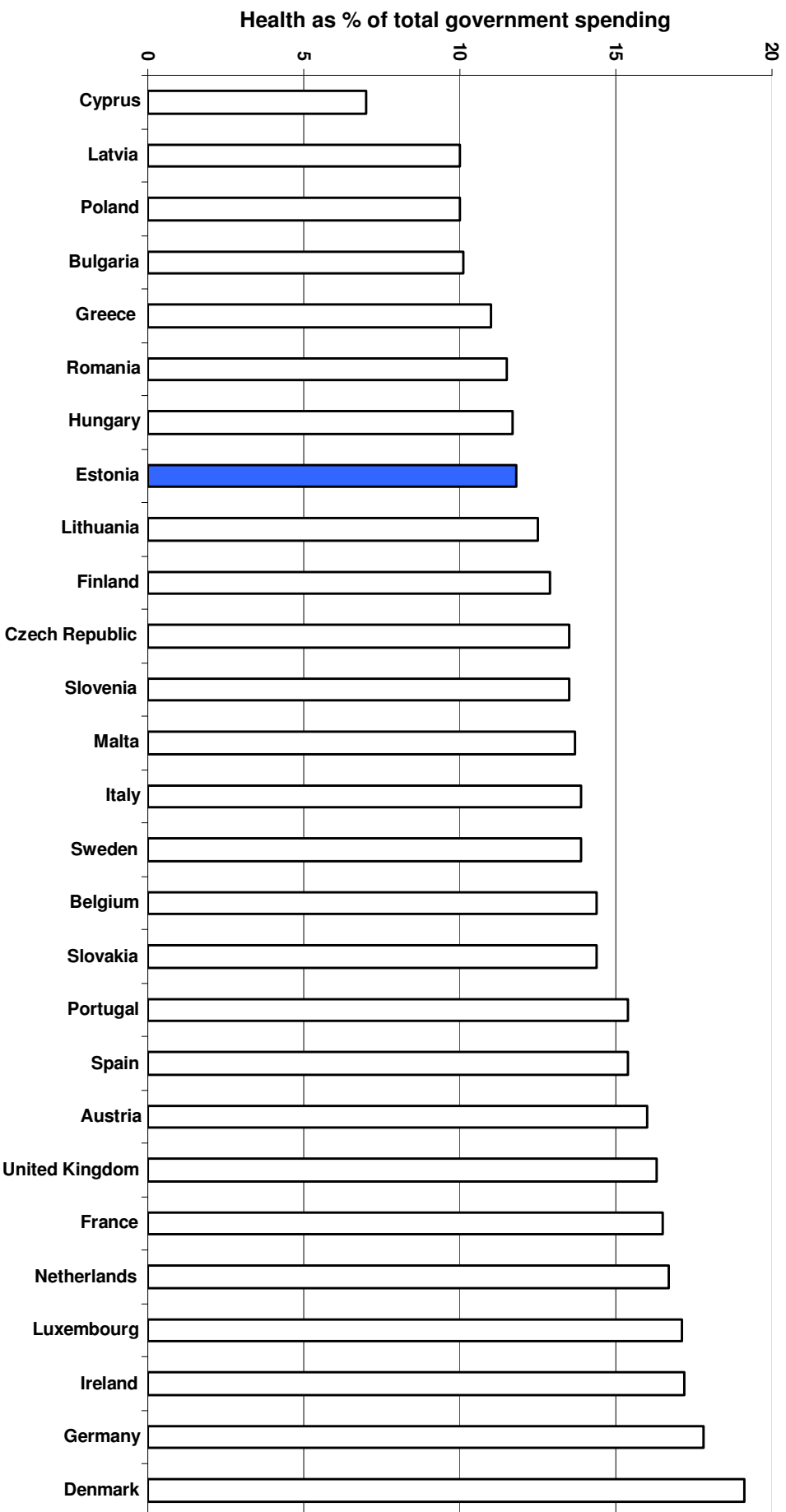
Source: WHO, 2009

Priority given to health in the European Region (2007)



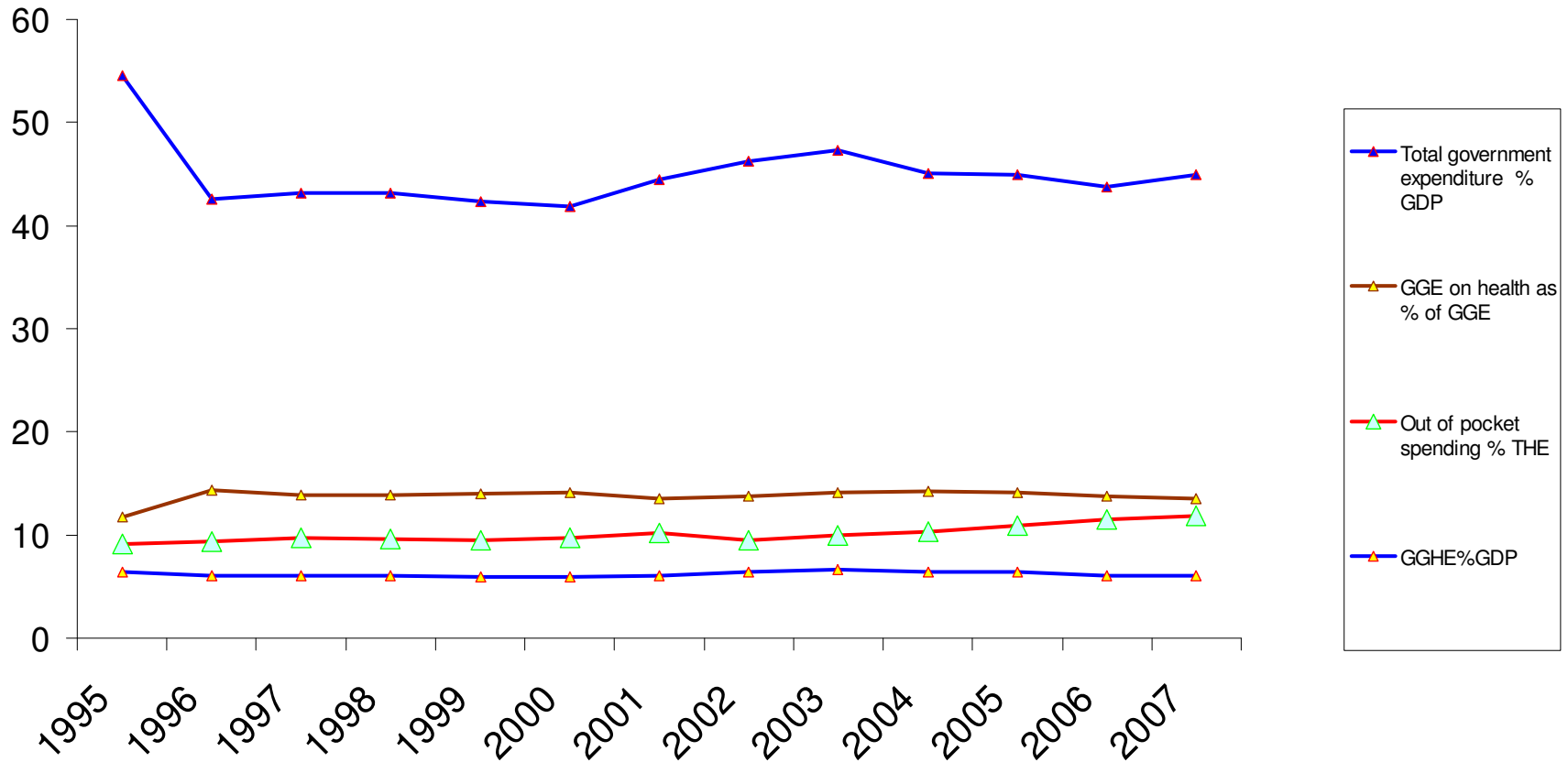
Source: WHO, 2009

Priority given to health in the EU countries (2007)



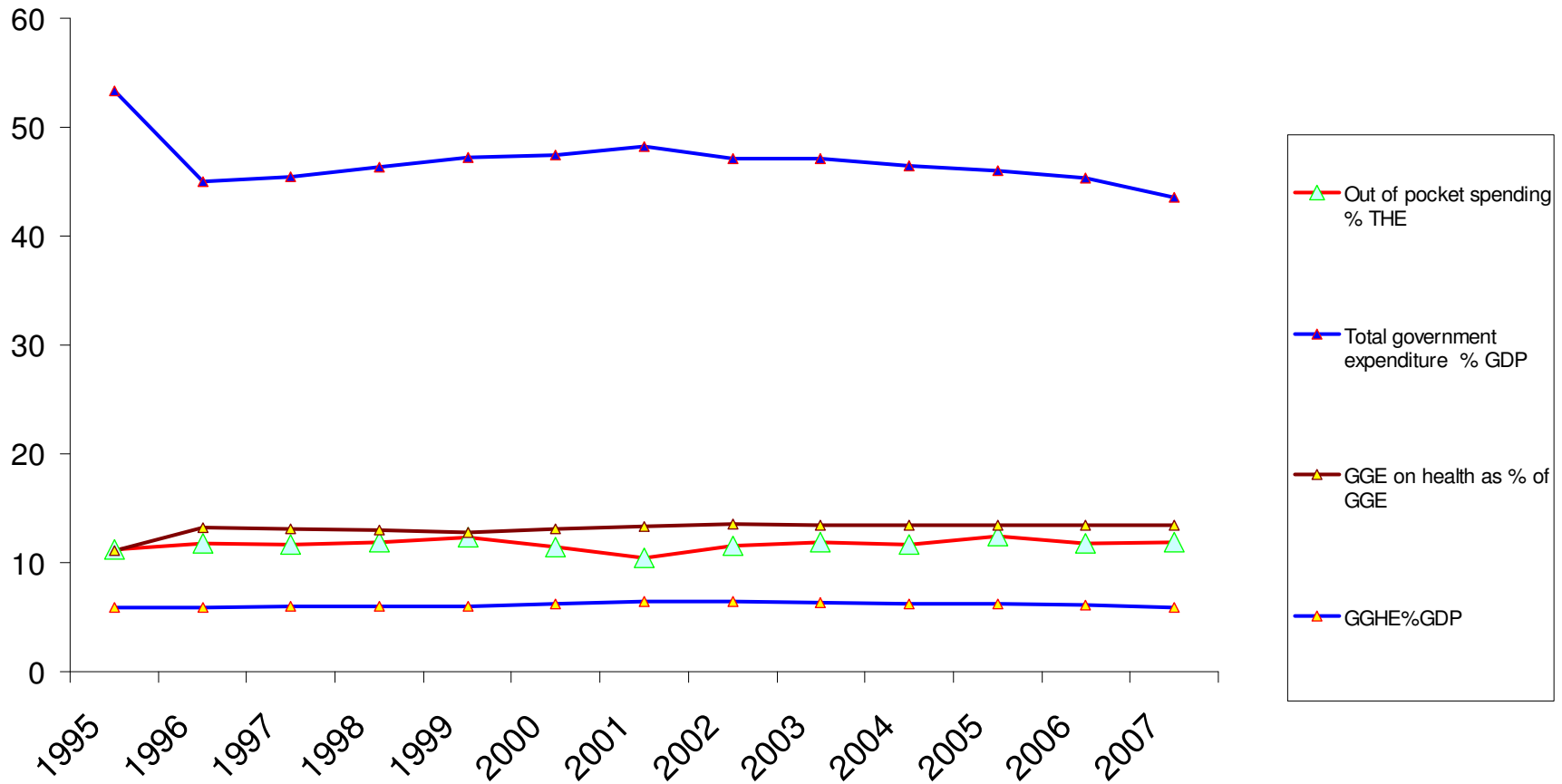
Source: WHO, 2009

CZE



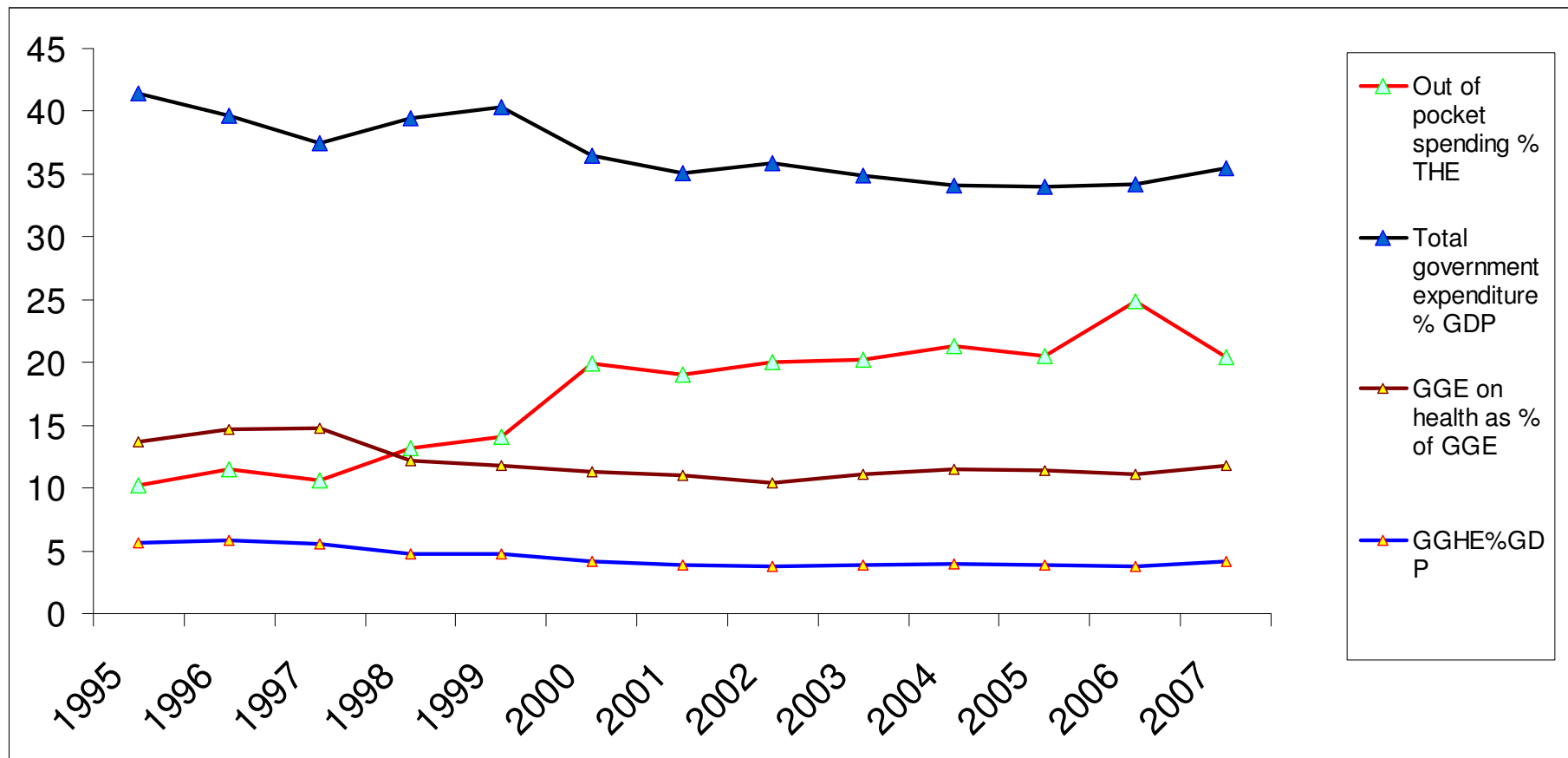
Source: WHO, 2009

SVN



Source: WHO, 2009

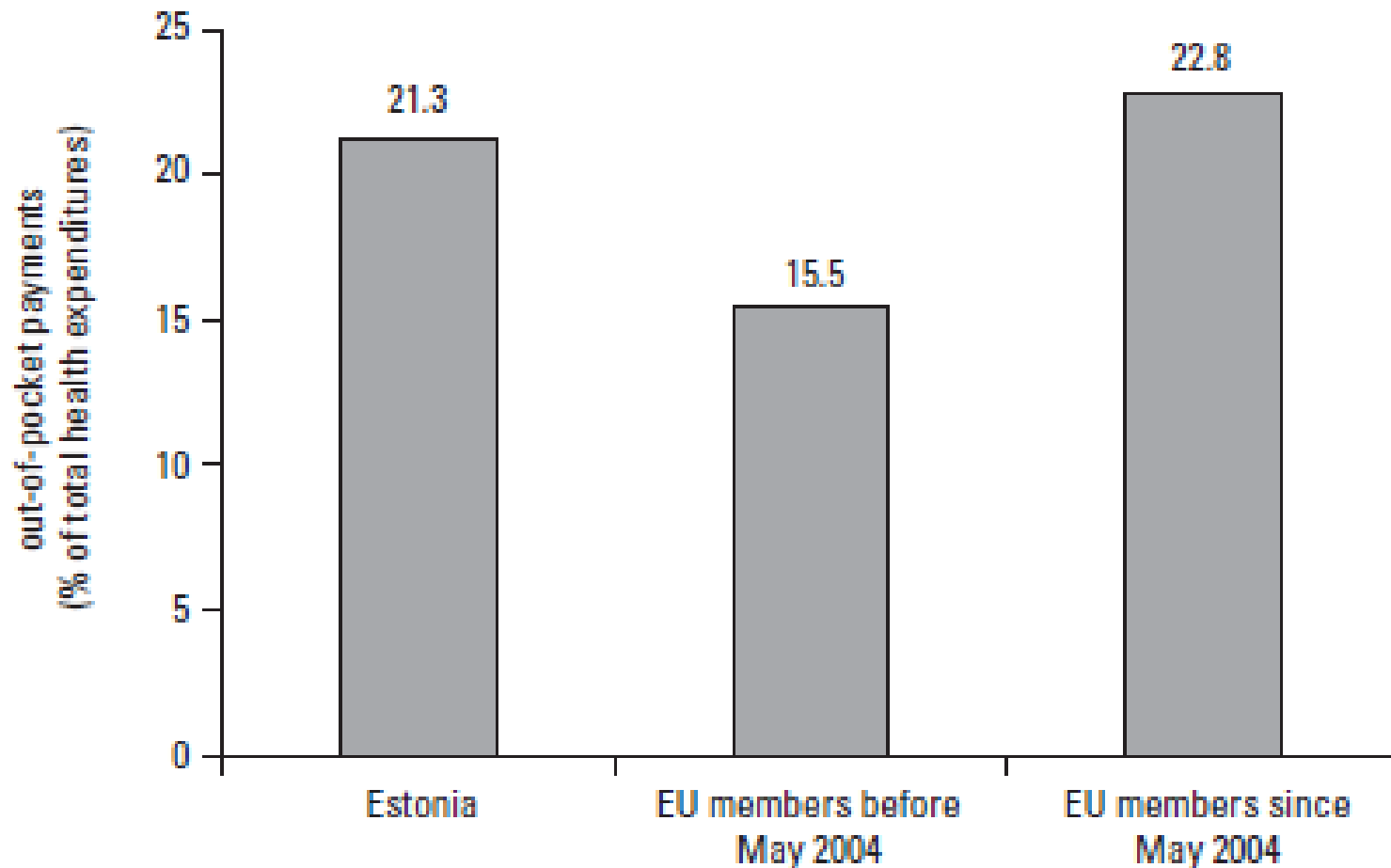
Estonia



Source: WHO, 2009

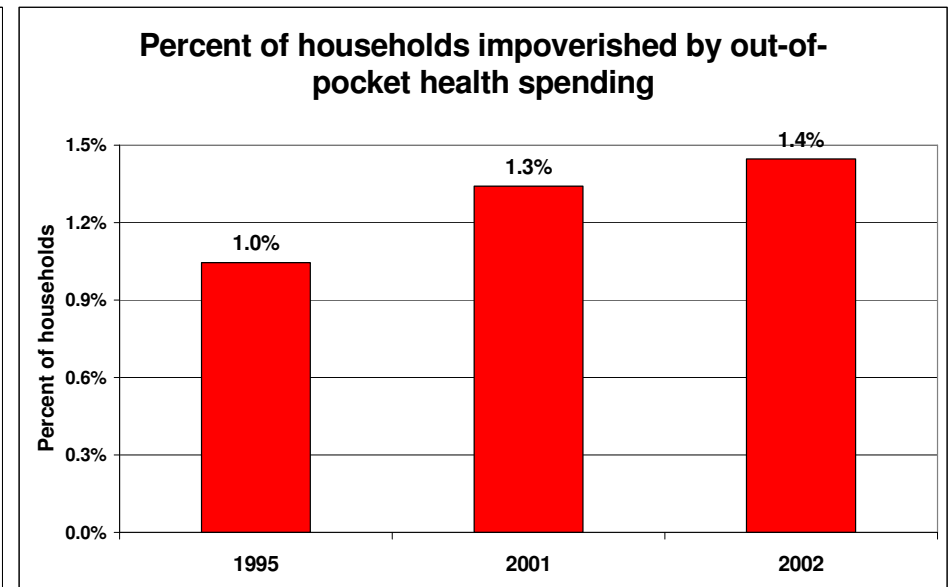
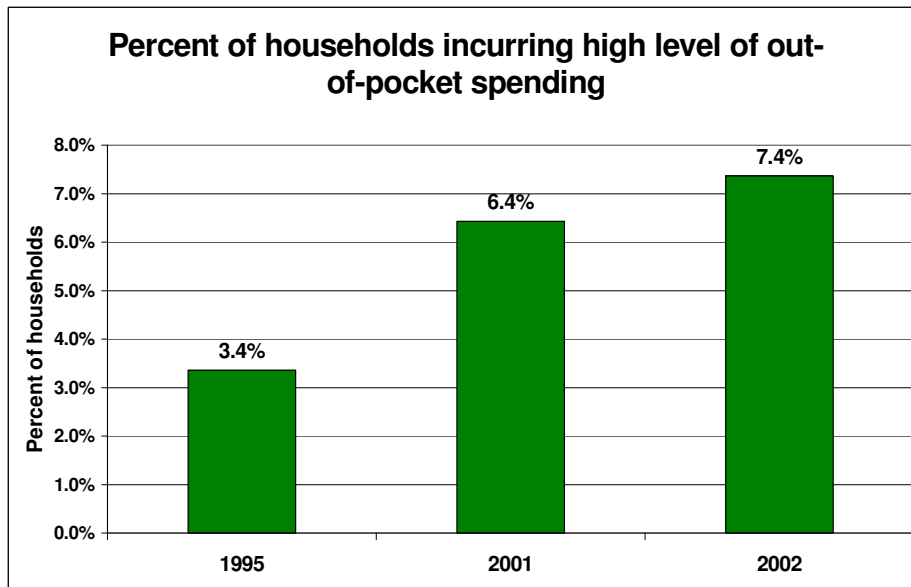
OOPs in EST in an EU perspective

Figure 9.5 Estonia: Out-of-Pocket Payments Compared with the EU, 2004



Source: Health for All Database 2006.

Measuring the objectives₍₁₎: changes in financial protection in Estonia



Source: Habicht et al. (2006). “Detecting changes in financial protection: creating evidence for policy in Estonia.” *Health Policy and Planning* 21(6): 421-31.

Reducing the ability to sustain financial protection in Estonia (by choice?)

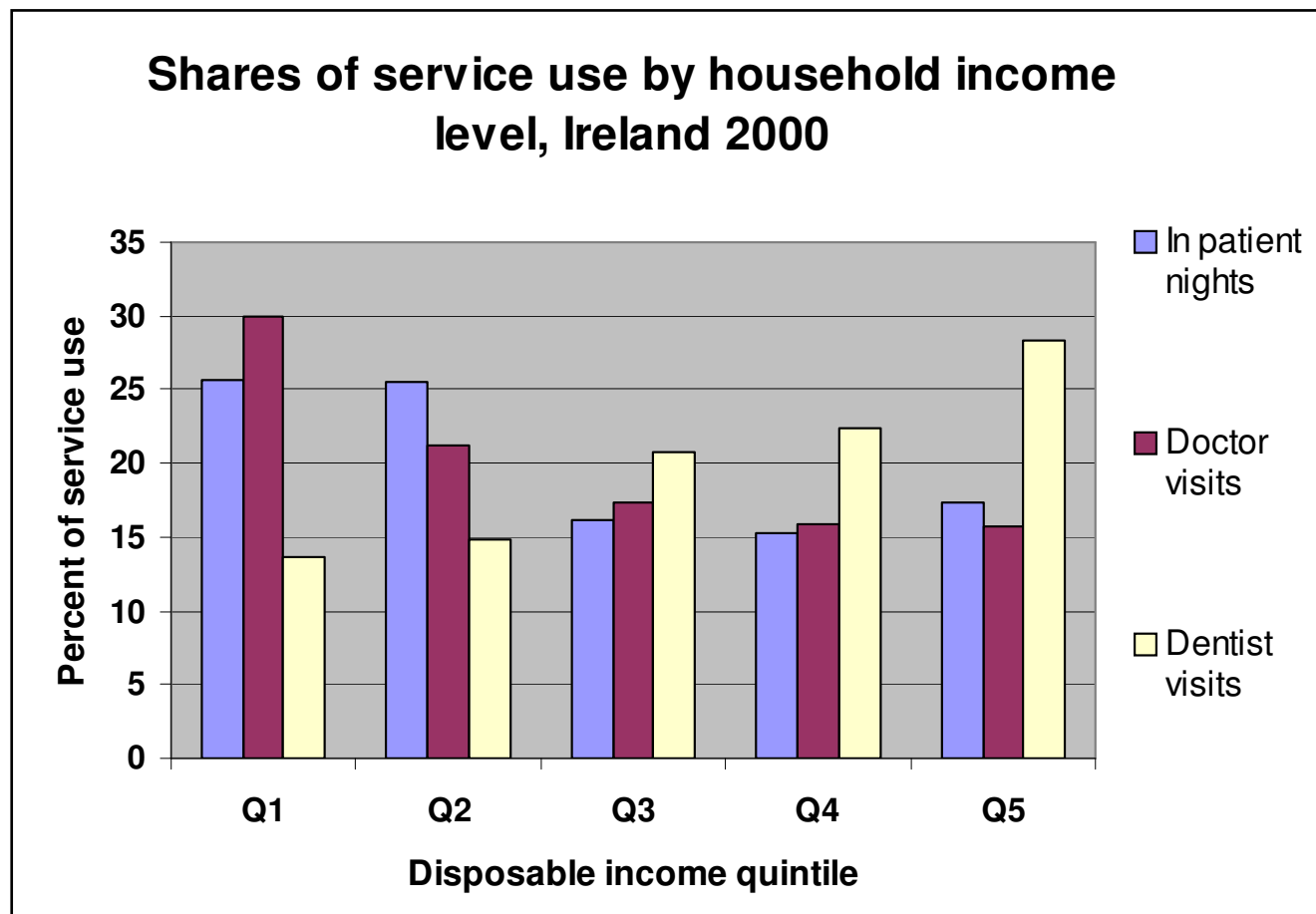
Actual and simulated health spending patterns in Estonia

	Total public spending as % GDP	Health as % total public spending	Public spending on health as %GDP	OOPS as % total health spending
1996	42.3%	14.0%	5.9%	11.5%
2003	36.7%	11.2%	4.1%	20.3%
2003 with 1996 priorities	36.7%	14.0%	5.1%	13.8%

Source: WHO health expenditure estimates and analysis

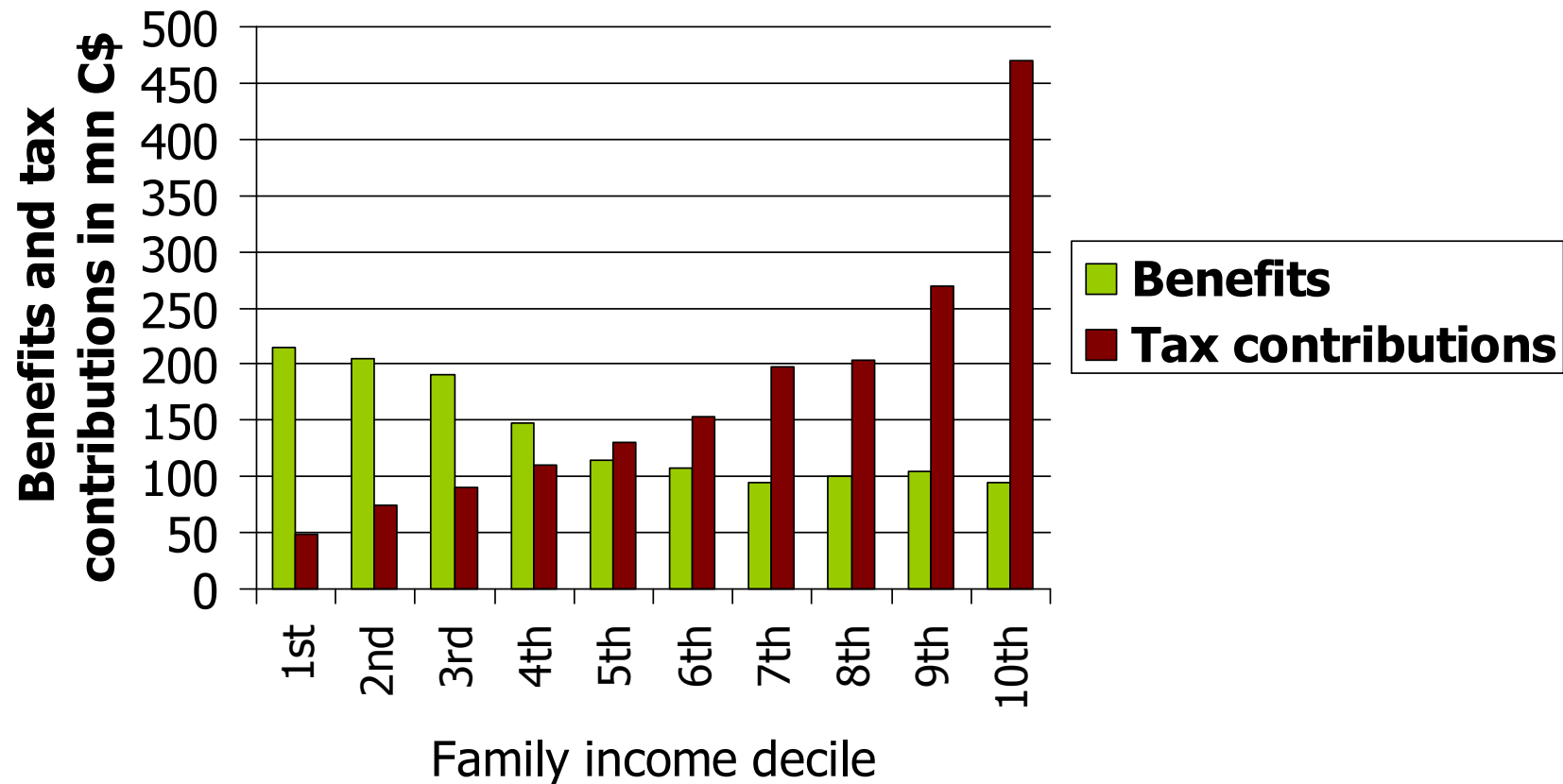
Government health spending fell and out-of-pocket spending increased in part due to overall fiscal contraction but mostly due to a shift in priorities away from health. In a sense, the government decided (implicitly) to have a lower level of financial protection.

Measuring the objectives₍₂₎: equity in service use in Ireland



Source: Layte R, Nolan B (2004). "Equity in the utilization of health care in Ireland." Dublin: Economic and Social Research Institute.²⁸

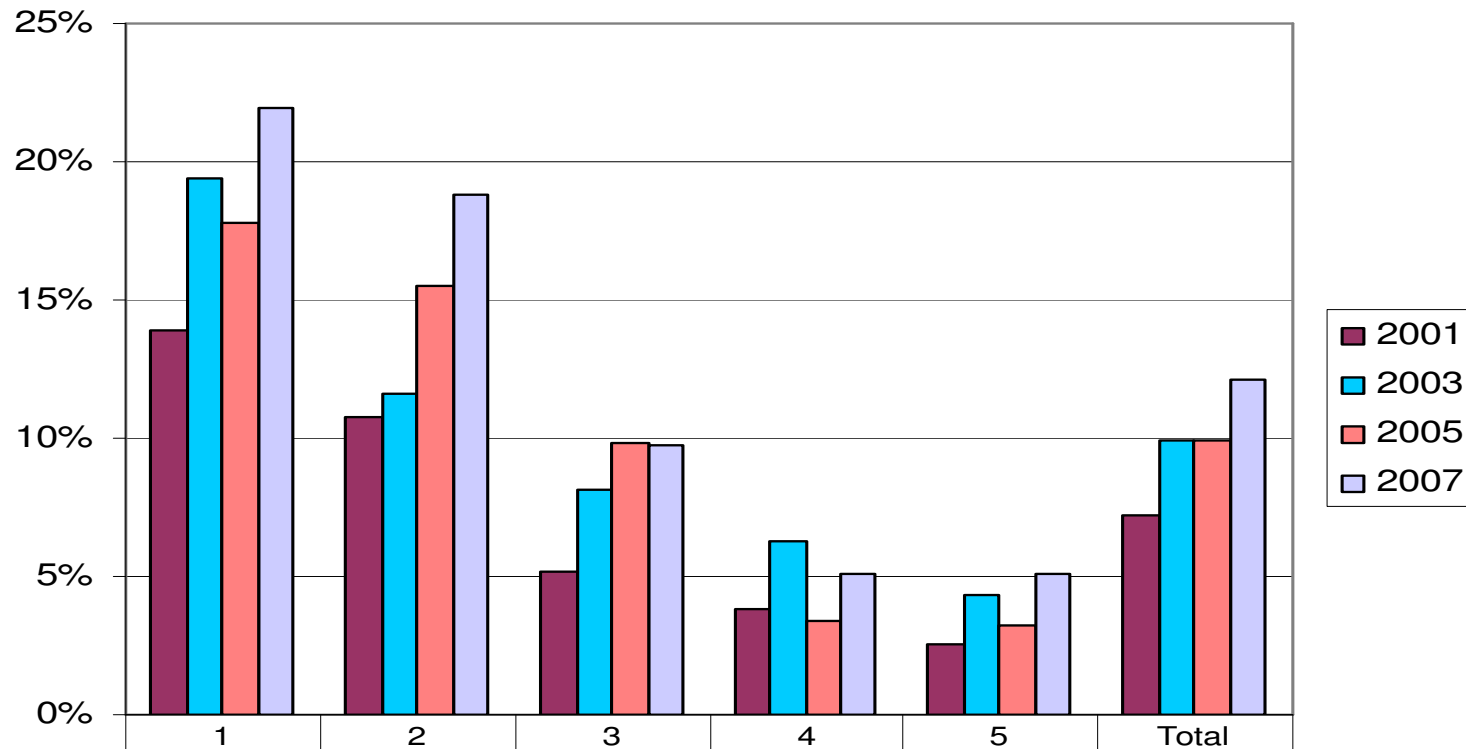
One of the few: Canada



Source: Mustard et al (1998); Evans (2002)

Is this desireable/acceptable?

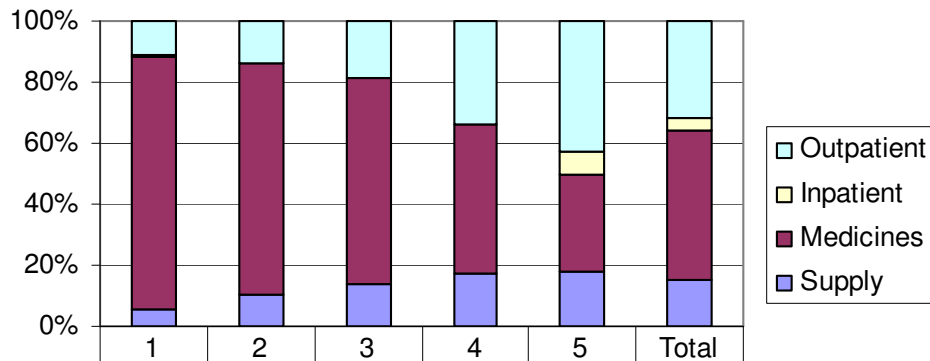
**Proportion of households with high health payments
(above 20% of capacity to pay)**



■ 2001	13.9%	10.7%	5.2%	3.8%	2.5%	7.2%
■ 2003	19.4%	11.6%	8.2%	6.2%	4.3%	10.0%
■ 2005	17.8%	15.5%	9.8%	3.4%	3.2%	9.9%
■ 2007	21.9%	18.8%	9.7%	5.1%	5.1%	12.1%

quintile (poor-rich)

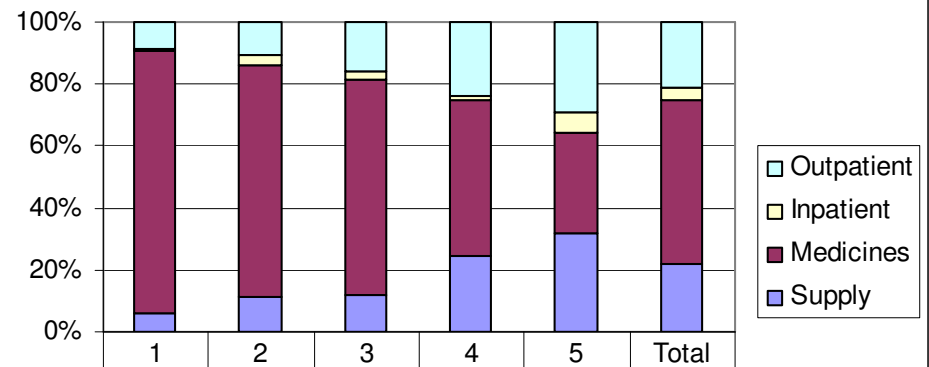
Which one is Estonia?



	1	2	3	4	5	Total
Outpatient	11%	14%	19%	34%	43%	32%
Inpatient	0%	0%	0%	0%	8%	4%
Medicines	83%	76%	68%	48%	32%	49%
Supply	5%	10%	14%	18%	18%	15%

quintile (poor-rich)

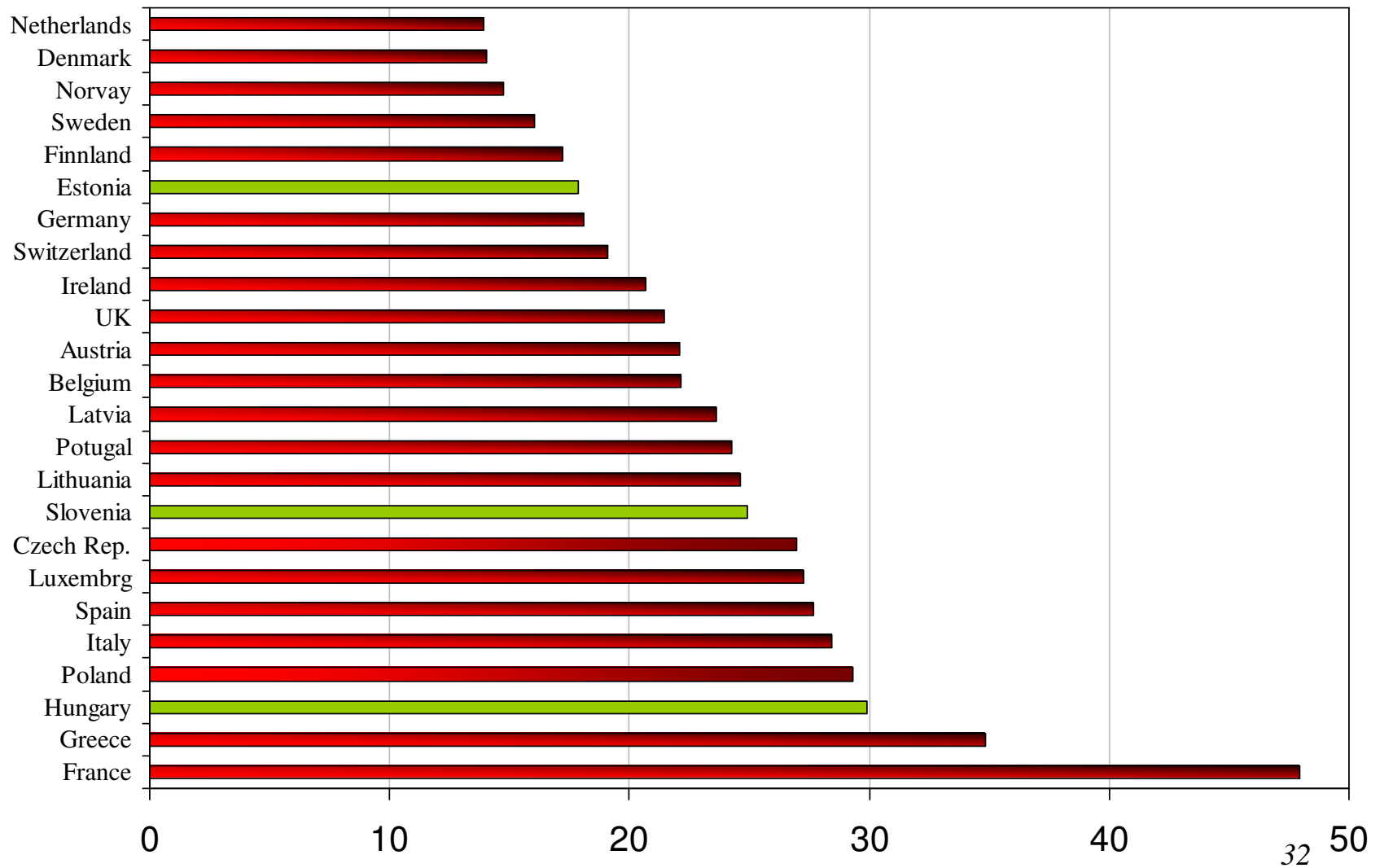
Distribution of OOPs across medical services and goods per quintiles



	1	2	3	4	5	Total
Outpatient	9%	10%	16%	24%	29%	21%
Inpatient	1%	3%	3%	1%	7%	4%
Medicines	84%	75%	69%	50%	33%	53%
Supply	6%	11%	12%	24%	32%	22%

quintile (poor-rich)

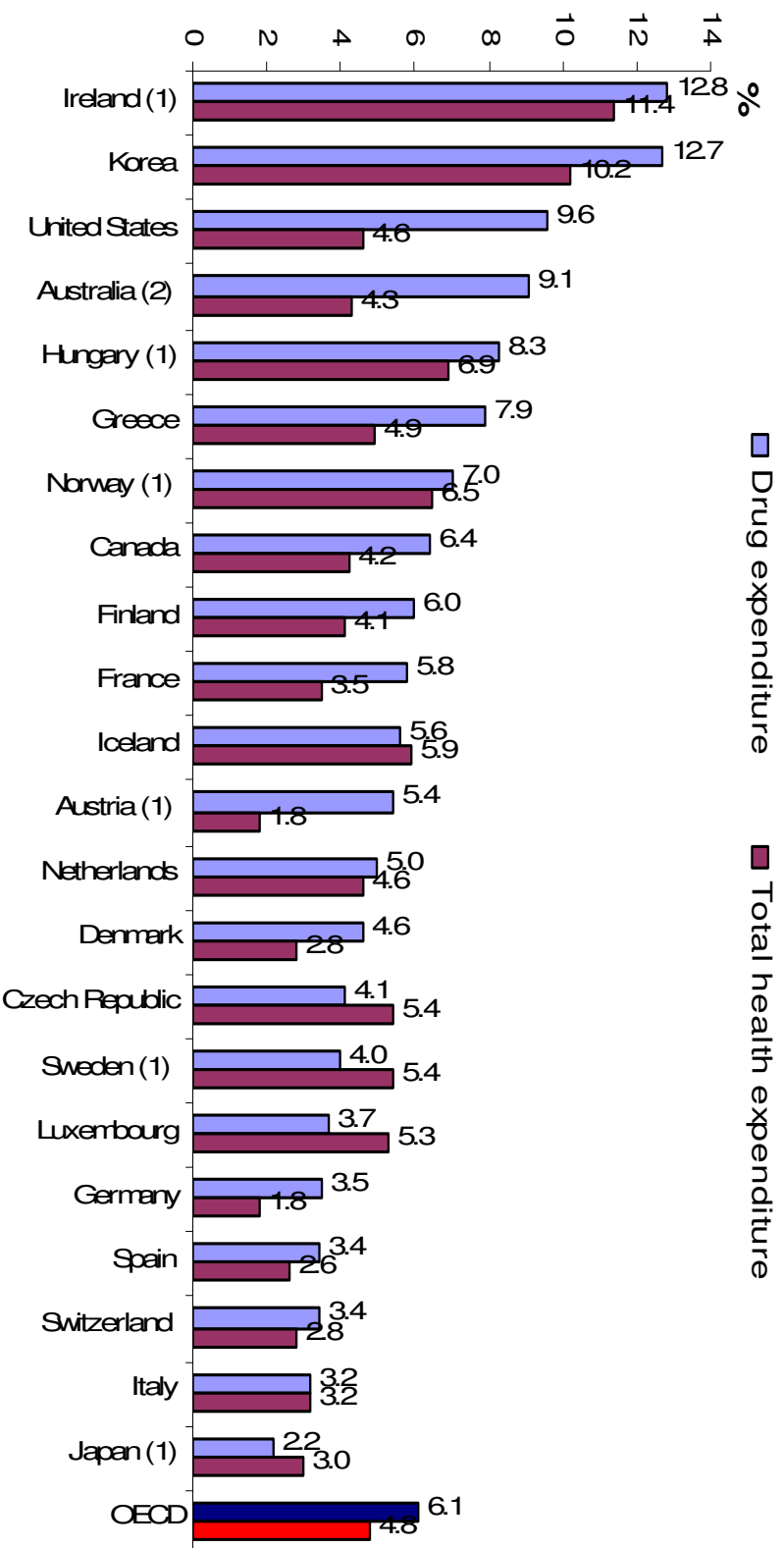
Drug consumption is boxes (2004)



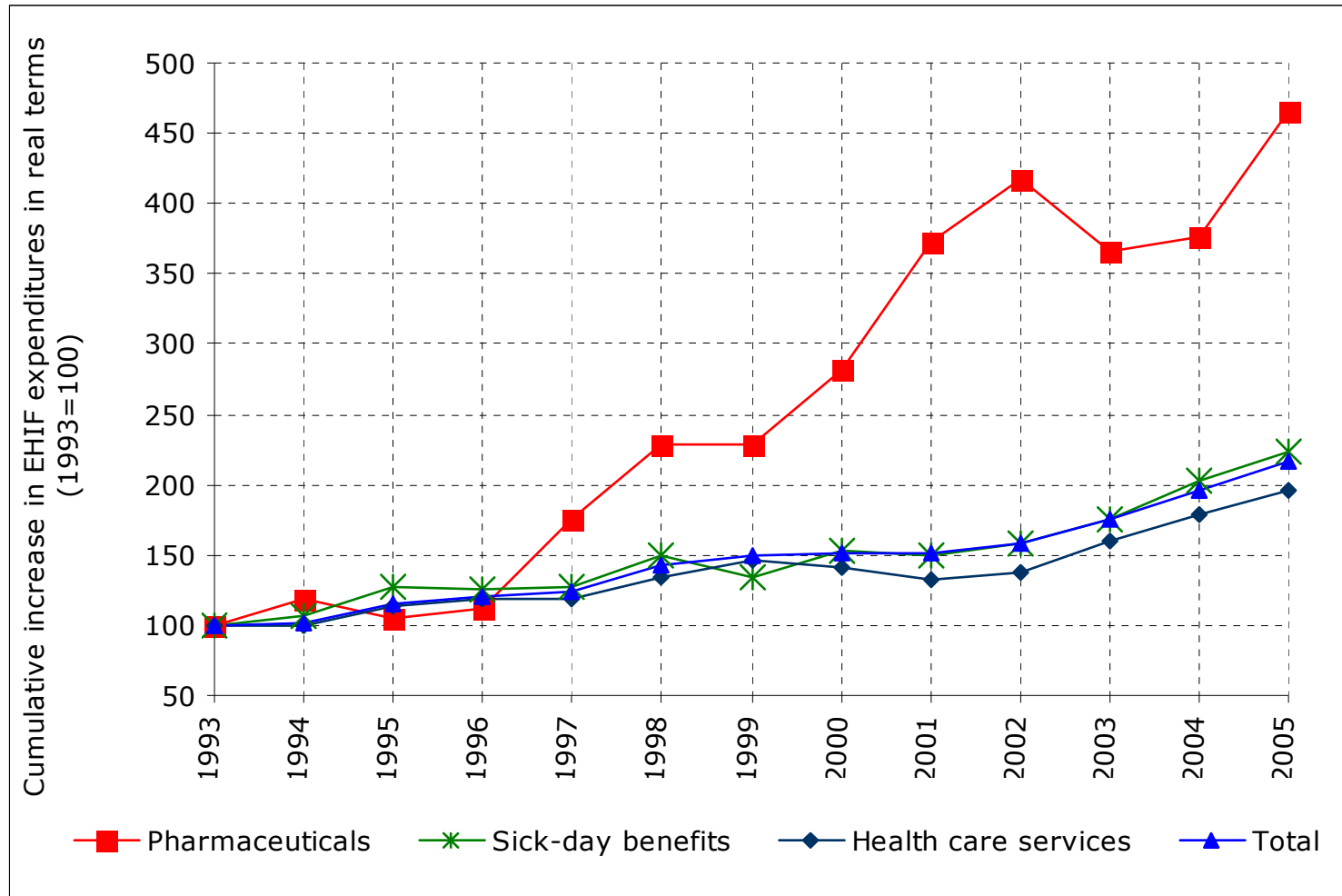
Source: OECD

Pharmaceuticals are the single largest cost driver in almost all countries

Annual growth in drug expenditure and in total health expenditure, 1998 to 2003

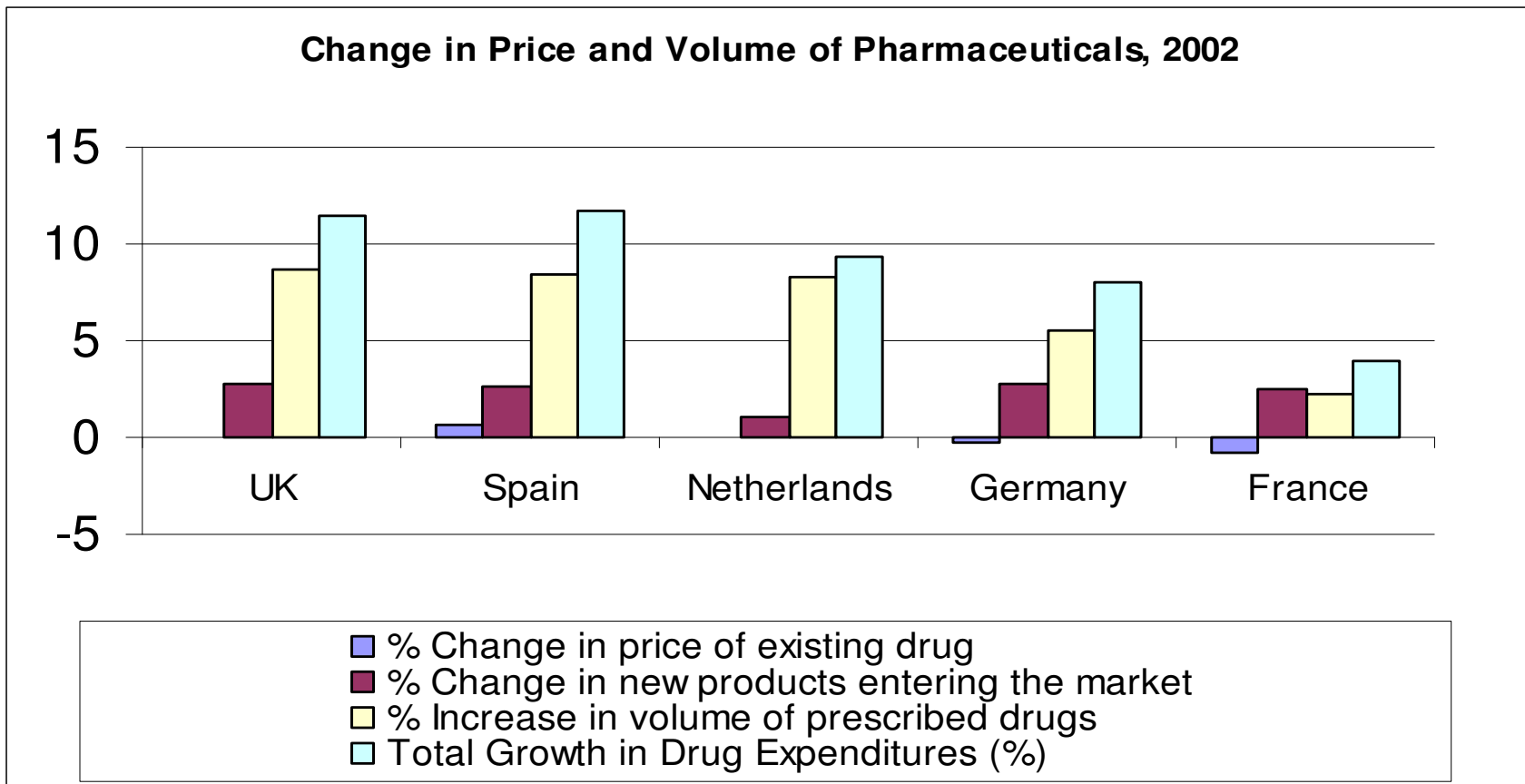


Increase of health insurance expenditures in Estonia 1993-2005

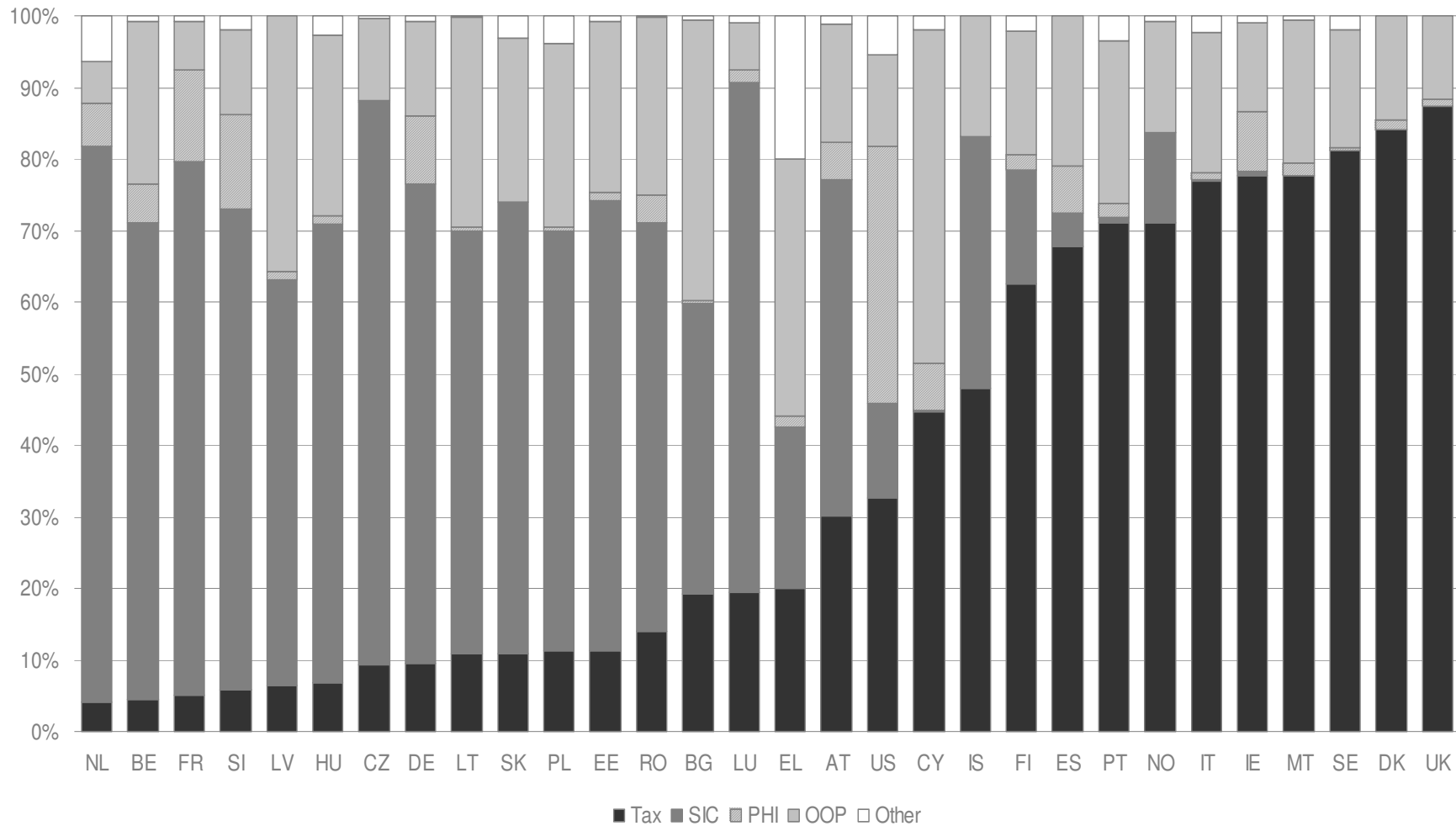


Source: Estonian Health Insurance Fund annual reports and statistics (various years), authors calculations ³⁴

One reason for rising pharmaceutical costs is increase in volume of drug use



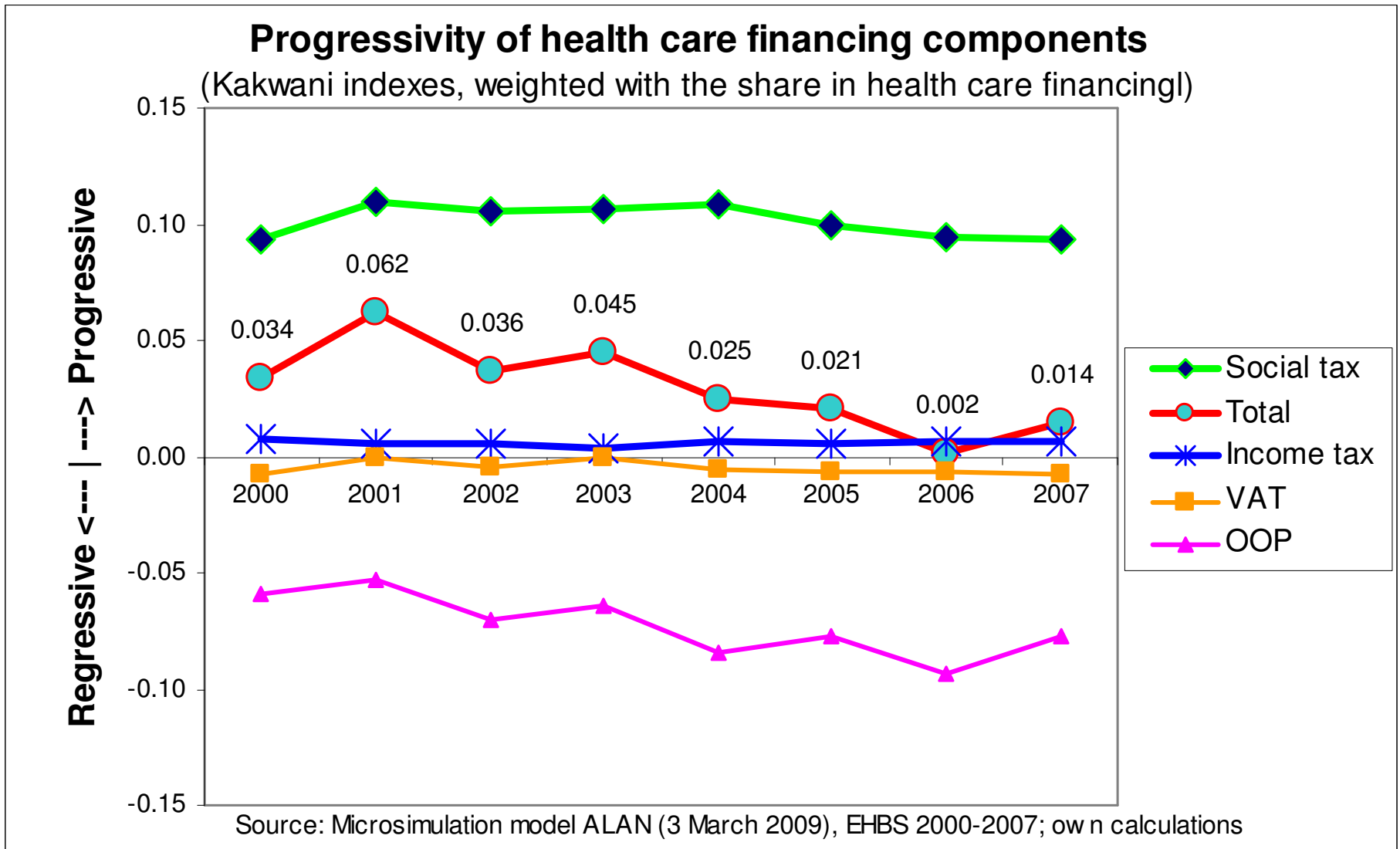
Breakdown of the mechanisms used to finance health care by country, 2006



Note: SIC = social insurance contribution; PHI = private health insurance; OOP = out of pocket payments. SIC refers to all funds channelled through health insurance funds, which may include substantial amounts of tax revenue

Source: WHO, 2009

Options for revenue collection and equity consequences



Source: Vork, 2009 (forthcoming)

Closing remarks in light of the financial crisis

- The real challenge is balancing the budget in a way that cause less than proportional decrease in the attainment of policy objectives, especially:
 - Financial protection
 - Health gain
- It is always more difficult to withdraw benefits that have already been provided therefore preventing unrealistic expectations pays off on the long run
- Act before it gets worse! Be proactive and prevent emergency interventions, which tend to produce more damage (apparently Estonia does not need this advice)!