HEALTH SYSTEM REFORM AND THE DEMAND FOR HEALTH CARE

Lecture 8

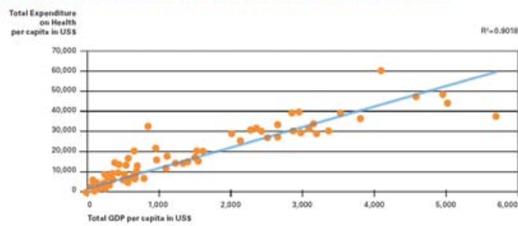
It has long been claimed that health spending has to be brought under control

'Health policy in Europe over the last two decades has been increasingly bedevilled by the growing cost of care. The aging of the population associated with higher levels of chronic disease and disability, the increased availability of new treatments and technologies, and rising public expectations have exerted an upward pressure on overall health related expenditures.' (WHO 1996, p.2)

How to control costs?

Privatization of management, funding and provision have been the main components of a reform movement that has relied heavily on the proposition that health care costs in developed and less developed countries are unaffordable. In less developed countries the World Bank and the WHO advise on health system reform in resource-poor contexts, in many cases advocating reforms similar to those in developed countries.

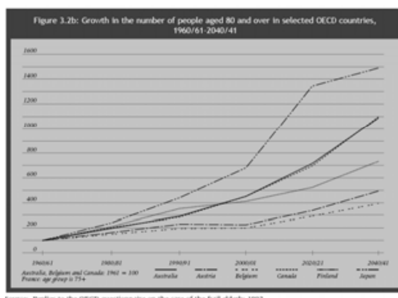
WHO financing fact sheet global overview – health spending rises with national income



Other cost pressures usually mentioned

- An ageing population (the 'demographic time bomb')
- Technological change
- Consumer demand

Examination of ageing (OECD data)



"Over the period 1960-2040 (or one average life span) the population aged 80 or over is expected to multiply by about three times in most northern European countries, rising by over 400% in Switzerland and over 600% in Finland. Even this rate of growth is dwarfed by that anticipated in the non-European industrialised countries, which is projected at a minium of around 500% in New Zealand, over 800% in the United States, over 900% in Australia and Canada and over 1,300% in Japan." (Royal Commission on Long Term Care. The costs of long term care now and in the future. Evidence chapter 1. London: HMSO, 1999)

UK Royal Commission

Table 3.5: Base case projections of long-term care costs for elderly people in the UK (1995/96 prices)

	1995 £ billions	2010 £ billions	2021 £ billions	2031 £ billions	2051 £ billions
NHS Continuing Care (1)	2.6	3.5	4.9	7.0	10.9
PSS net (2)	4.5	5.5	7.2	10.1	16.1
Private expenditure (3)	4.0	5.7	7.8	10.9	18.3
Total	**11.1**	**14.7**	**19.9**	**28.0**	**45.3**
% increase from 1995		32%	79%	152%	308%
GDP (total as percentage of GDP)	700 (1.6%)	980 (1.5%)	1,250 (1.6%)	1,560 (1.8%)	2,440 (1.9%)

Source: PSSRU and Royal 1995/96 PricesCommission

According to Figueras et al (2008): 'A European Commission (EC) study (26) based on the EU Member States belonging to the EU before January 2007 (EU25) predicts that the combined effects of health and long-term care will account for an additional 1.1–3.8% of European GDP…' Nevertheless, the authors add that the figures should be treated with some caution because not enough is known and utilization rates are hard to predict.

Types of cost containment method

- budget shifting (co-payments, treatment restrictions, public budget shifting)
- budget setting (administrative controls)
- direct and indirect controls (financial incentives or managed care)

But when is expenditure unnecessary?

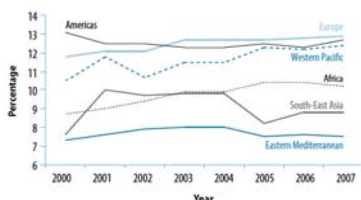
- Public expenditure above the basic care package
- Public expenditure on services used by the better off
- Expenditure on care that is not medically necessary

DOES INSURANCE LEAD TO UNNECESSARY EXPENDITURE?

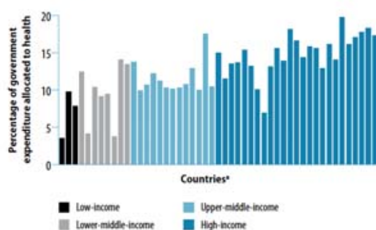
THE RAND EXPERIMENT AND MORAL HAZARD

(i.e. prepayment and pooling insulate consumers from the full economic cost of their consumption decisions)

Cost pressures on budget or size of budget? WHO report 2010



WHO report 2010 Governments of richer countries allocate more spending to health



In poorer countries demand side policy linked to wider economic development policy

'In 2001, high-income countries spent an average of 7.7 percent of their GDP on health, MICs spent 5.8 percent, and LICs spent 4.7 percent… In LICs, private and out-of-pocket spending and external assistance account for the bulk of all health spending.' (Schieber)

Nonetheless, OOPs were advocated from the 1980s as a means of avoiding tax increases that might otherwise affect export performance. (UNRISD)

Demand side policies managed care

Managed care:

- In the 1970s the USA began adopting the managed care or HMO model to improve cost efficiency in health services. These plans 'served as gatekeepers to both hospital and specialist services. […] At the same tome, insurance companies and other for-profit health care entities entered into the direct provision of services through this type of organization. […] By 1998 this type of plan insured more than 30% of the population…'
- There were fundamental changes in provision following vertical integration of those providing care and those financing it: *'From a European point of view, a striking characteristic of these new MCOs is their active and constraining influence on the extent and type of health care offered and provided to their subscribers.'* These arrangements are associated with a system of user charges, co-payments or deductibles, all of which are demand side controls.

(Erdmann, 2001)

Demand side policies
Targeting and rationing

- Cost effective treatment: The State of Oregon in the USA attempted in the 1990s to introduce rationing based on cost effectiveness. The attempt had to be abandoned because of the public controversy it caused.
- NICE and the Global Burden of Disease both involve economic evaluation of interventions
- Latter may be used for targeting services on the poor

Demand side policy
Cost sharing

- In the private insurance and managed care market OOP takes the form of deductibles or copayment. Deductibles refer to the portion of an insurance claim that is not covered by the insurance plan. Copayment is a capped personal contribution when medical services are accessed (sometimes referred to as a top-up fee).
- User fees are similar to copayments. The term is often used to refer to OOPs payments for public health care. User fees or direct out-of-pocket payments have been introduced or extended in many developing countries as an alternative form of health care financing.
- James (2006)) distinguishes between user fees (‘official fees charged by public health providers for basic as well as higher level services as used in one form or another in most countries and contexts) and out-of-pocket (OOP) payments, which may include charges by private, NGO and community-managed services.
- Informal or unofficial payments are payments that do not have an official sanction. Payments can be made for medical supplies, accommodation or to augment clinical salaries. They are associated with, but not limited to, health systems where major public budget cuts have been made (e.g. the transition economies).

Critical examination cost sharing

- Charges remain the main method of funding health care in low and middle income countries. In eastern Europe, for example, user charges have been increased substantially in the last 10-15 years. According to Figueras et al (2008: 40), in 2004, ‘out-of-pocket spending constituted over half of total health spending in Armenia, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan *(176)*. More recently, cost sharing has been extended elsewhere, including in several EU Member States (Austria, the Czech Republic, Estonia, France, Germany, Hungary, the Netherlands, Portugal and Romania).
- User fees have been widely criticized as inequitable and counter-productive (Creese, 1997). The Bamako Initiative adopted by several African countries in 1987 provides an example of the mixed results of user fees.

Bamako findings

- the revenue generated feel well short of expectations
- exemption policies for the poor were inefficient (in Ghana, for example, 'less than 1 in 1000 surveyed was granted exemption when an estimated 15-30% lived in poverty' (Singh A (2003) Building on the user fee experience: the African case. Geneva: WHO)
- revenue in most cases did not remain at the community level for which it was intended
- one third of countries reported a fall in primary care utilization and one third reported an increase (Elgazzar, 2007).