Health Reforms

Statistical, Economic and Social Research and Training Centre for Islamic Countries-
SESRIC
Yemen MoH Training Program
June 24-25,2012

Prof. Dr. Adnan KISA

PROFESSOR OF HEALTH POLICY AND ECONOMICS
ZİRVE UNIVERSITY
GAZİANTEP-TURKEY

Classifications of Health Care Systems

Traditional sickness insurance:

- fundamentally a private insurance market approach with a state subsidy. (Germany)

National health insurance:

- a national-level health insurance system. (Canada, Finland, Norway, Spain, and Sweden.)

Classifications of Health Care Systems

National health services:

- state provides the health care. (Examples: Denmark, Greece, Italy, New Zealand, Portugal, Turkey, and the United Kingdom.)

Mixed systems:

- contain elements of both traditional sickness insurance and national health coverage. (Examples: Switzerland, and the United States.)

Common Reported System Deficiencies

- Health outcomes are mediocre with large regional disparities
- The organization and management of the system is fragmented and inefficient
- Too little is spent on health (curative care vs preventive care)
- Money is spent on health inefficiently and inequitably
- The system is financed inequitably (eg. over half the population have no health insurance coverage)
- Too many beds (hospital occupancy rate below eg 50%) and few physicians
- Serious shortages in some rural areas creating access problems
- Quality of care in public and private sectors are problematic
- Few incentives for efficiency
- Efficiency and quality problems in the pharmaceutical sector

Need for Reform

- Health outcomes needed to be improved
- Organizational structure and management of the system needed to be reformed
- The financing system needed to be more equitable and efficient
- The service delivery system needed to be restructured
- The distribution, efficiency, and quality of the human resource base needed to be improved
- The pharmaceutical sector needed to be more efficient and of higher quality

DEFINITION OF REFORM

- A process of making significant changes to overcome agreed weaknesses.

- It is different from a review.
  - A review might lead to significant changes. But we are unsure whether there are agreed weaknesses.

- It is different from a plan.
  - A plan is the product of an ongoing process to overcome weaknesses. It is therefore less likely to involve significant changes.

WHY REFORM IS COMMON IN THE HEALTH SECTOR

- Health sector needs reforms to a greater extent than in other sectors.
  - the problems are large and obvious (a review is not really needed)
  - there is no ongoing planning process that leads to continuous improvement (plans are not good)
  - change is so difficult to make

DIFFICULTIES IN THE HEALTH SECTOR

- Technical complexity.
  - Most other industries produce large volumes of a few different products.
  - Health sector produces small volumes of a very large range of products.
- Vested interests of powerful groups.
  - Politicians want short-term gains before the next election
  - Drug companies don't want rational prescribing.

ADDITIONAL CONSTRAINTS TO CHANGE

- It's unclear who has the power and the responsibility.
  - The minister for health?
  - The professional associations (medical association, nursing associations, dental associations)?
  - The health insurers?
  - The citizens?
- Power is divided among groups with different attitudes and interests.
  - Doctors want more freedom and more resources
  - Health insurers want more control and less spending
  - Ministers want quick changes, public health specialists want health promotion

THE MOST IMPORTANT CONSTRAINT?

- Consumers/patients have too little power and knowledge.
  - It is the citizens' money
  - It is the citizens' health
- But other people make decisions for them.
  - Who decides how much to spend on health?
  - Who decides the balance between hospital and community-based care?
  - Who decides whether to use care pathways?

DEFINITIONS OF HEALTH SECTOR REFORM

- Changes that affect at least two of these elements:
  - health financing
  - expenditure
  - organization
  - regulation
  - consumer behavior.

William Hsiao

If we only change regulation, it’s not reform.

DEFINITIONS OF HEALTH SECTOR REFORM

- Changes intended to affect the attitudes and behavior of clinicians and consumers.

- So that they become involved in continuous reform of themselves.

Don Hindle

If attitudes and behavior are the same, nothing has really been achieved. Nothing important has changed.

FEATURES OF SUCCESSFUL REFORM

- We create a 'purposeful system', one that continuously reforms itself without external pressures.

Russell Ackoff

- We create a 'learning organization', one where everyone is continually trying to learn from everyone else.

Peter Senge

- We establish 'continuous quality improvement', meaning that everyone is continuously committed to improving themselves and the system.

Charles Deming

FEATURES OF UNSUCCESSFUL REFORM

- It is based on the assumption that more central control is needed.

  Doctors and nurses and citizens are not to be trusted.

  For example, the central planning model of norms and standards used in the former communist countries.

FEATURES OF UNSUCCESSFUL REFORM

- It is imposed top-down.

  For example, Margaret Thatcher's health sector reform policy in 1990 in the UK.

  (She personally chaired the committee designing the reform strategy.)

FEATURES OF UNSUCCESSFUL REFORM

- It is based on simple slogans.
  - We will centralize (command economies in the 1950s and 1960s)
  - We will nationalize (the UK in the late 1940s)
  - We will decentralize (many countries in the 1990s)
  - We will privatize (most countries in the 1980s and 1990s)
  - We will give citizens more choice (many countries since 2000)

FEATURES OF UNSUCCESSFUL REFORM

- There's confusion about objectives.
  - Some people think that equity of payment of care providers is a useful end in itself.
  - Some people think that it is always useful to increase citizens' choices of care provider.
  - Some people think it's possible to create additional health financing by having private insurance.

THEMES OF REFORM: THE INTERNATIONAL SCENE

- Ideas that are no longer popular:
  - Large-scale health planning (and instrumental rationalism in general)
  - Privatisation and corporatization of hospitals
  - Competition in the market place
  - Rationalisation of hospitals by top-down planning
  - Licensing and accreditation
  - Voluntary health insurance
  - Importation of ‘good managers’ from other industries
  - Employment of bad economists as business managers and contract negotiators
  - Decentralisation-centralisation

- Ideas that are popular right now:
  - Better output-based payment of care providers
  - Patient safety
  - Coordinated (integrated, seamless) care
  - Clinical practice guidelines
  - Care pathways (clinical pathways)
  - Referral guidelines
  - Utilisation review
  - Finding and managing standard costs

- Ideas that will be dominant in future:
  - Organisational culture
  - Clinical teamwork
  - Purposeful systems
  - Managing complexity
  - Social solidarity
  - Balancing evidence and attitude
  - Consumer empowerment

Health Reforms in Europe

Common Characteristics of European Health Systems

- A broad package of insured health care, embracing most mainstream health interventions (not always long term care)
- Universal coverage of all citizens, regardless of financial or health status;
- Low reliance on direct user charges
- Financial contributions according to ability to pay, independent of health status (tax or social insurance)
- High levels of regulation of providers
- A unifying principle of ‘solidarity’ - the health risks of all citizens are pooled, with contributions to the risk pool unrelated to health status

Four broad types of health system

- Social insurance: unreformed
  - France, Austria
- Social insurance: competitive
  - Netherlands, Germany
- Public sector: devolved
  - Sweden, Spain
- Public sector: centralized
  - United Kingdom, Italy

Preoccupations of European Health Systems

- 1980s: Cost containment
- 1990s: Efficiency and markets
- 2000s: Quality

1. Cost containment

- Gatekeeping
- Copayments
- Community care

1. GATEKEEPING

- Traditional feature of public European systems (UK, Scandinavia, Italy)
- In some respects, directed at enhancing quality of care
- Main focus is on containing costs
- Some evidence of success
- Social insurance countries seeking to encourage gatekeeping through payment mechanism (France, Germany)

1980s: Cost containment

Gatekeeping principles

- Limiting access to specialist care
- Persuading citizens to use preferred providers
- Potential lever to improve costs and quality
- Needs to be implemented alongside many other policies
- Very different effectiveness in different systems.

Copayments

- Traditionally low levels of copayment in European systems
- Widespread voluntary insurance against copayments in some systems, diluting incentive effect (France, Ireland)
- Tentative experimentation with copayments in public systems (Sweden, Netherlands)
- Reference pricing as a form of copayment for pharmaceuticals (Germany, Spain etc.)
- Differential copayments according to lifestyle? Not yet tried.

Reference pricing

- Designed to encourage use of cheaper generic substitute drugs
- Involves setting a fixed ‘reference price’ for all drugs within a cluster
- Patients must pay difference between drug price and reference price
- Complex technical issues (choice of clusters, choice of referenceprice)
- Widespread use in Europe (Sweden, Germany, Spain, Italy)

COMMUNITY CARE

- Objective is to keep patients out of unnecessary hospital care, and to minimize length of stay
- Some crude attempts to limit very long lengths of stay (bed blocking) (Belgium)
- Some discussion of introducing ‘no claims’ insurance premium discount (Netherlands)
- Incentives for local government to arrange for community care (England)

2. Markets and efficiency

a) Provider markets
b) Payment mechanisms
c) Purchaser markets
d) Information and markets
e) Health technology assessment

2a) Provider markets

- Major efforts to make provider markets more competitive and contestable
- Clearly relevant to some aspects of acute care, but concerns at implications for chronic care
- Little evidence on effectiveness of provider markets
- Little evidence on relevance of ownership of providers

2b) Payment mechanisms

- Almost all systems reimburse providers according to some sort of DRG payment
- Most DRG fee schedules are set passively, according to expected average costs
- DRG systems are augmented by numerous other payment mechanisms
- Payment mechanisms less well developed in ambulatory care
- Key issue is sharing risk within the health system.

Adjustments to payment mechanisms

- In Norway, funding of local governments is partly on the basis of DRGs (that is, actual activity) and partly on the basis of risk-adjusted capitation (that is, expected activity).
- In the Netherlands, some cost-sharing between the payer and the provider occurs once provider costs on a particular patient exceed some threshold.
- Many systems augment the pure DRG payment with other sources of finance, such as local government subsidies for capital resources (Austria) and tax subsidies (Belgium).
- In Germany, patients in registered chronic disease programmes attract additional capitation payments for sickness funds [23].

2c) Purchaser markets

- Payers for health care (local governments or insurance funds) have tended to reimburse passively
- Major efforts to make sickness funds competitive in social insurance systems (Netherlands, Germany, Belgium)
- Early experience suggests the a concern with the risk adjustment process, needed to create a fair market and prevent cream skimming of rich, healthy patients
- Little evidence of benefits in terms of quality or efficiency
- Key issue: how to reconcile active purchasing with the patient's traditional freedom to use any provider and fixed fee schedule.

2d) Markets and information

- Information is a key resource in the functioning of health care markets
- Traditionally poor level of information on costs and quality
- Great opportunity to enhance information base for patients and collective purchasers
- Concern about distortions induced by public reporting.

Performance ratings – key targets 2002

1. no patients waiting more than 18 months for inpatient treatment
2. fewer patients waiting more than 15 months for inpatient treatment
3. no patients waiting more than 26 weeks for outpatient treatment
4. fewer patients waiting on trolleys (gurneys) for more than 12 hours
5. less than 1% of operations cancelled on the day
6. no patients with suspected cancer waiting more than two weeks to be seen in hospital
7. improvement to the working lives of staff
8. hospital cleanliness
9. a satisfactory financial position

Plus…

… a satisfactory quality inspection.

Effect of performance ratings

- Positive impact on ‘key targets’
- Some concern that gaming or fraud has distorted the information provided by organizations
- Also concern about unintended side-effects on unmeasured aspects of health care

2e) Health technology assessment

- Universal move towards defining an ‘essential’ package of care
- Principal criterion for inclusion in package is cost-effectiveness of interventions
- Experience at a very early stage
- An enormous task, with numerous methodological and practical complexities
- Many countries setting up health technology assessment institutes (England, Finland, Germany, Sweden)

3. Quality improvement

a) Professional improvement
b) Patient empowerment
c) Incentives for quality

3a) Professional improvement

- Two distinct perspectives:
  - Supporting professional best practice (Netherlands, Sweden)
  - Identifying unsafe practitioners (England)

3b) Patient empowerment

- Contradictory pressures within Europe
- Some public systems seeking to enhance patient choice (Denmark, England)
  - Purpose is to enhance quality (principally waiting times)
- Some social insurance systems seeking to circumscribe patient choice (France, Germany)
  - Purpose is to encourage use of ‘preferred providers’ (quality and cost)
- Information for patients is a key resource in promoting choice
- Notion of giving a voucher (or cash payment) to chronic patients – some tentative experiments.

3c) Incentives for quality

- Increased evidence of wide variations in clinical quality
- New ability to measure quality
- Publication of quality data not enough to secure improvement in clinical performance
- Direct incentives needed to secure improvement.

Some other European concerns

- Sustainability of finance sources
- Manpower
- Pharmaceutical regulation
- Aging population