Health Service Financing and Delivery

GEK1900 Public Health in Action

Dr Joanne Yoong

WHO (November 2013)

- The WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being.
  - The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. even when you cannot pay
  - About 150 million people suffer financial catastrophe annually, and 100 million are pushed below the poverty line as a result of health care expenditure..

Health System Goals Are Embedded in Values

- Is health a human right or a privilege?
- Should individuals be entitled to receive a minimum level of health care services?
- Should rich and poor individuals pay the same amount for health care?

Health System Goals Are Embedded in Values

Should we pay for people who purposely makes his health poor?

"It's not fair that higher income groups should pay more than lower income groups. Some poor people are just lazy."

"Ideally, one should have a maximum level of service for all but if the government cannot afford it, they have to do what's feasible."

"Health care is not a commodity that can be bought. Some health conditions are out of people's control and affect rich and poor alike."

"It's not fair. Poor people are more vulnerable to ill health."

"Everyone should have access to the same standard of health care."

"It's OK if the basic health services provided are the same for the rich and poor, and those that can afford it pay extra for a higher standard of catering and accommodation."

"If some people can pay for better services they should get it."

The last mile

"Something is wrong. For the first time, public health has commitment, resources, and powerful interventions.
What is missing is this: the power of these interventions is not matched by the power of health systems to deliver them to those in greatest need, on an adequate scale, in time. In part, this lack of capacity arises from the failure of governments all around the world to invest adequately in basic health systems. It also arises, in part, from the fact that research on health systems has been so badly neglected and underfunded. The two go together. So long as investments in health systems are given low priority, research in this area will also be neglected. In the absence of sound evidence, we will have no good way to compel efficient investments in health systems."

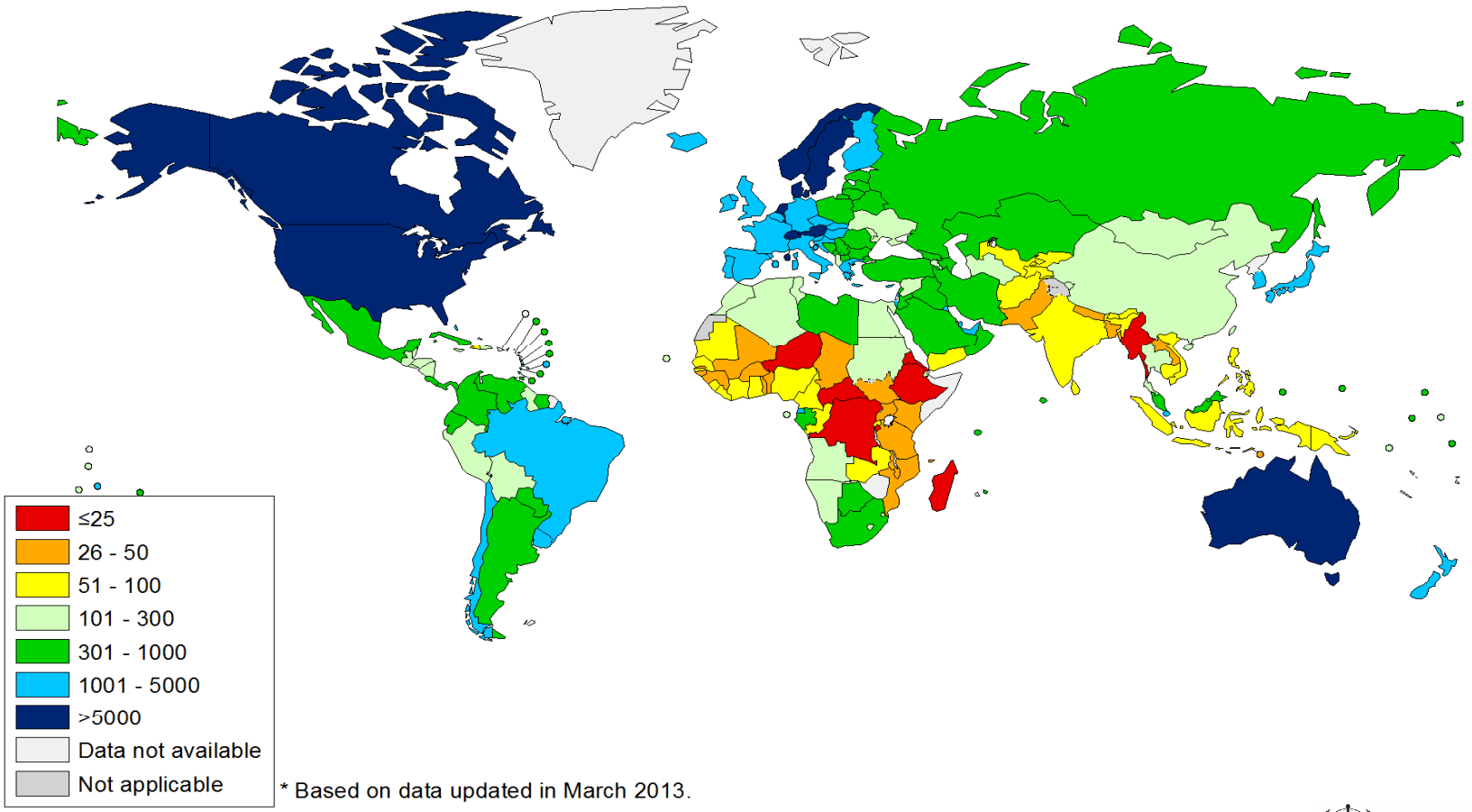
Dr. Margaret Chan, Director-General of the World Health Organization
Beijing, China, October 29, 2007

Wei Jia, Sancha, China


COUNTRY
DRIVING
A Chinese Road Trip
Peter Hessler

Money for health : total health $ per capita

Per capita total expenditure on health at average exchange rate (US$), 2011 *

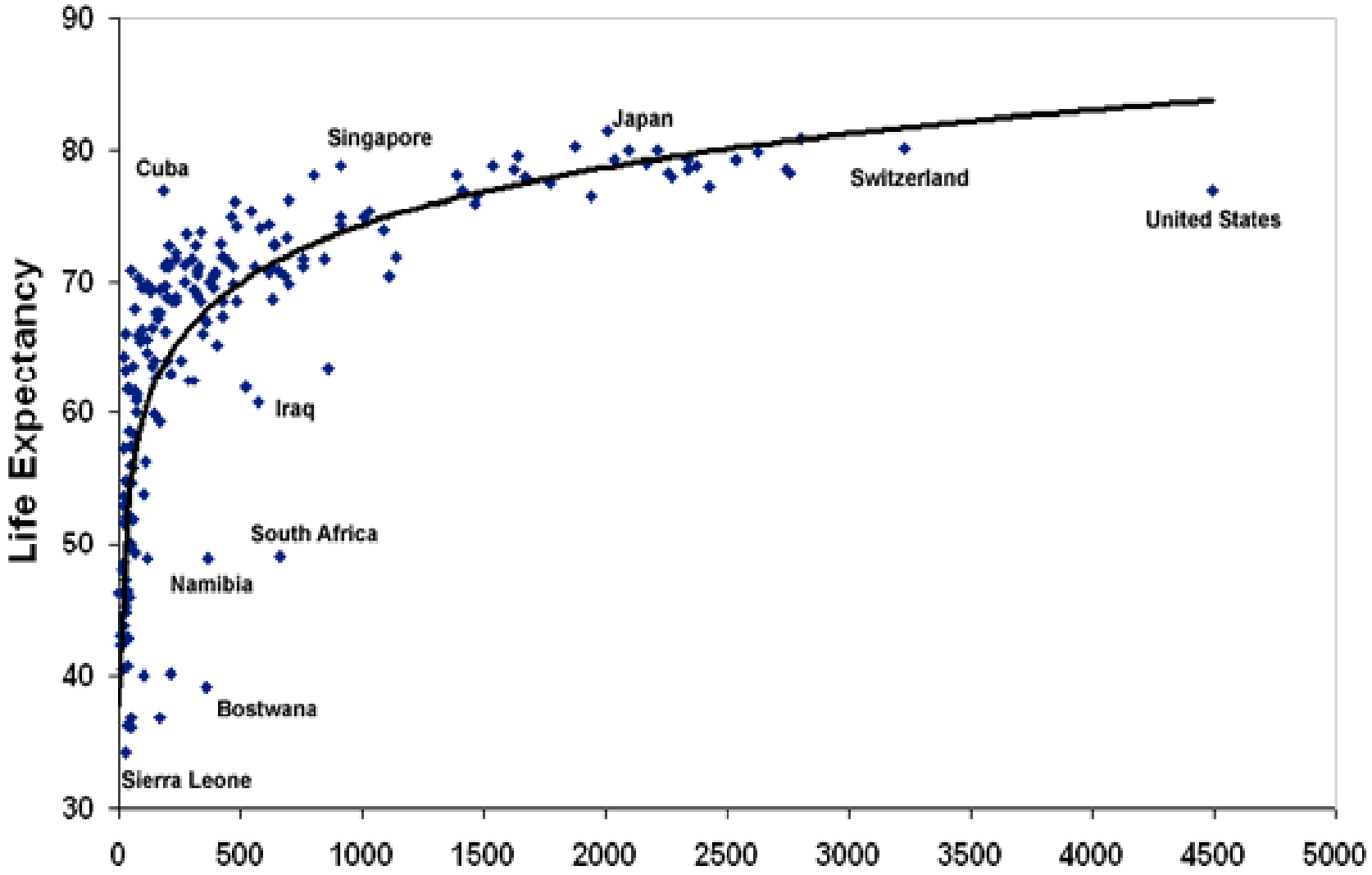


* Based on data updated in March 2013.

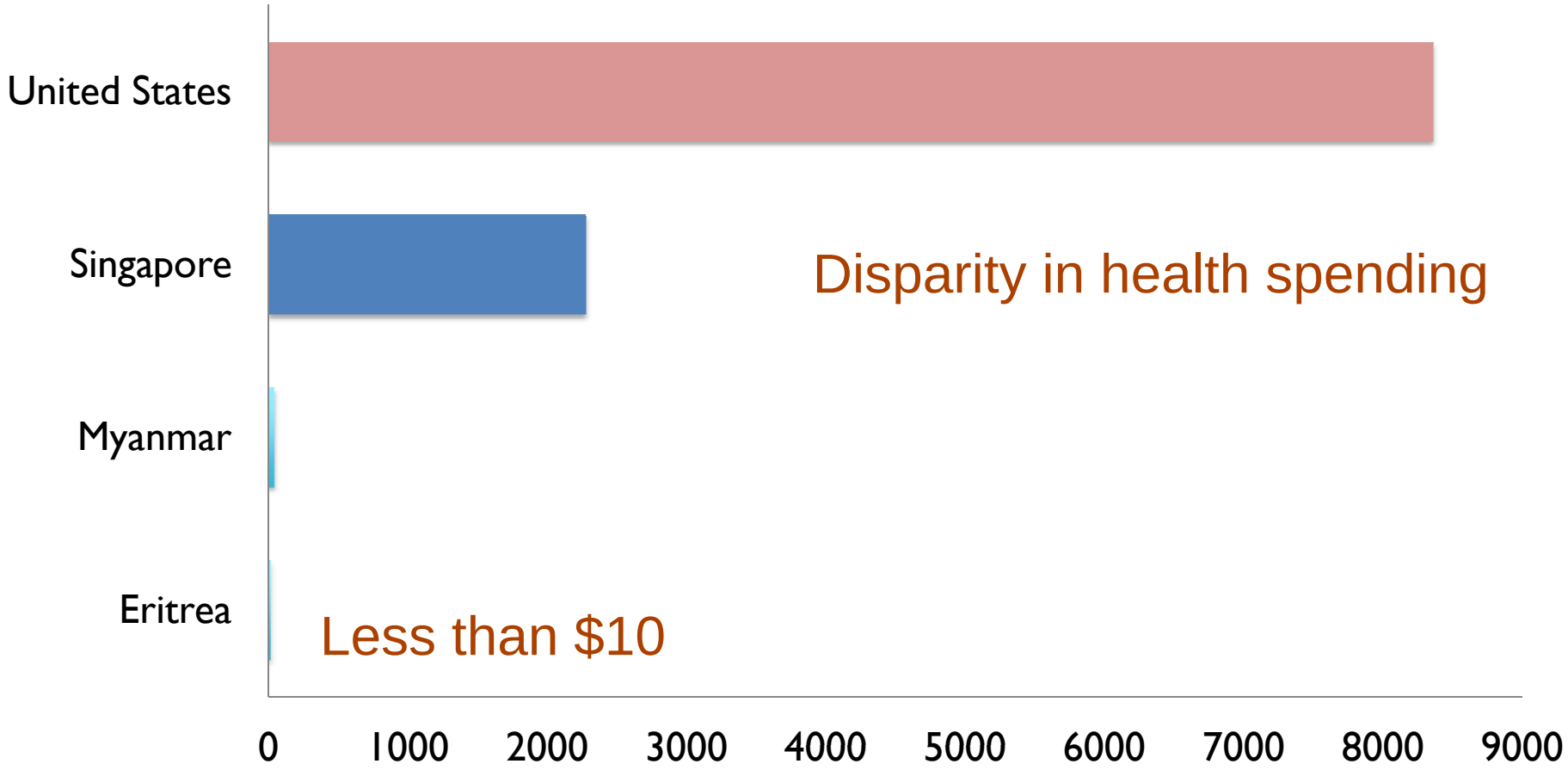
Data Source: Global Health Observatory, WHO
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization

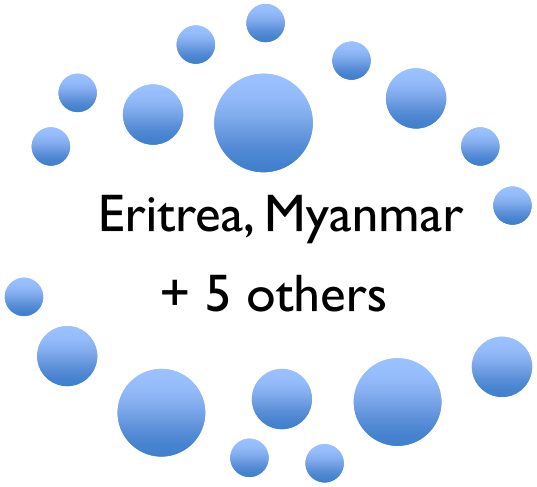
World Health Organization

Health $ Per Capita vs Life Expectancy, 2000



Total health $ per capita in USD 2010

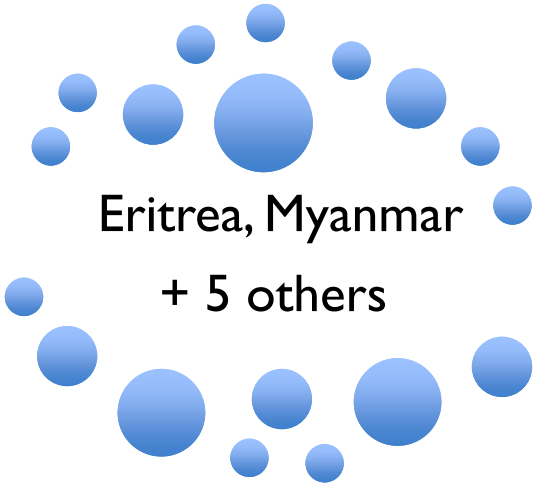




WHO estimate of per-capita $ for basic life-saving services

$16-$44

$44



WHO estimate of per-capita $ for basic life-saving services

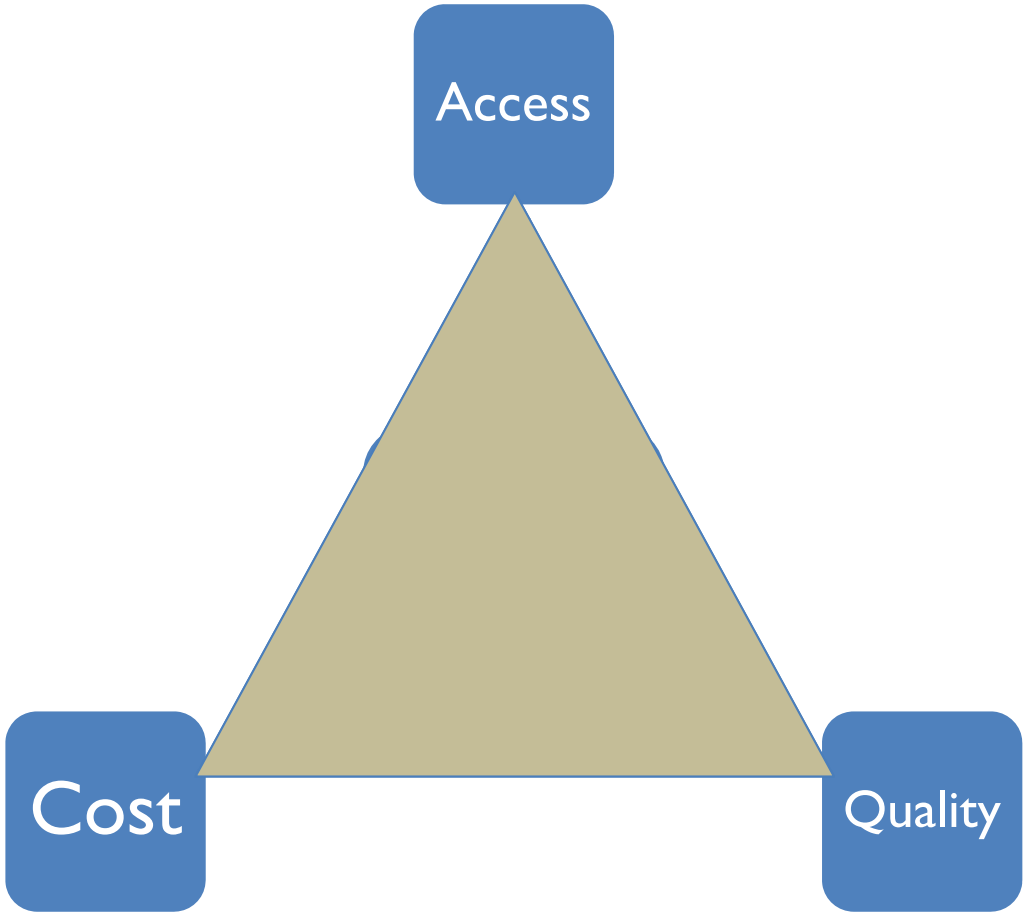
Average global health expenditure per capita

$16-$44

$44

$948

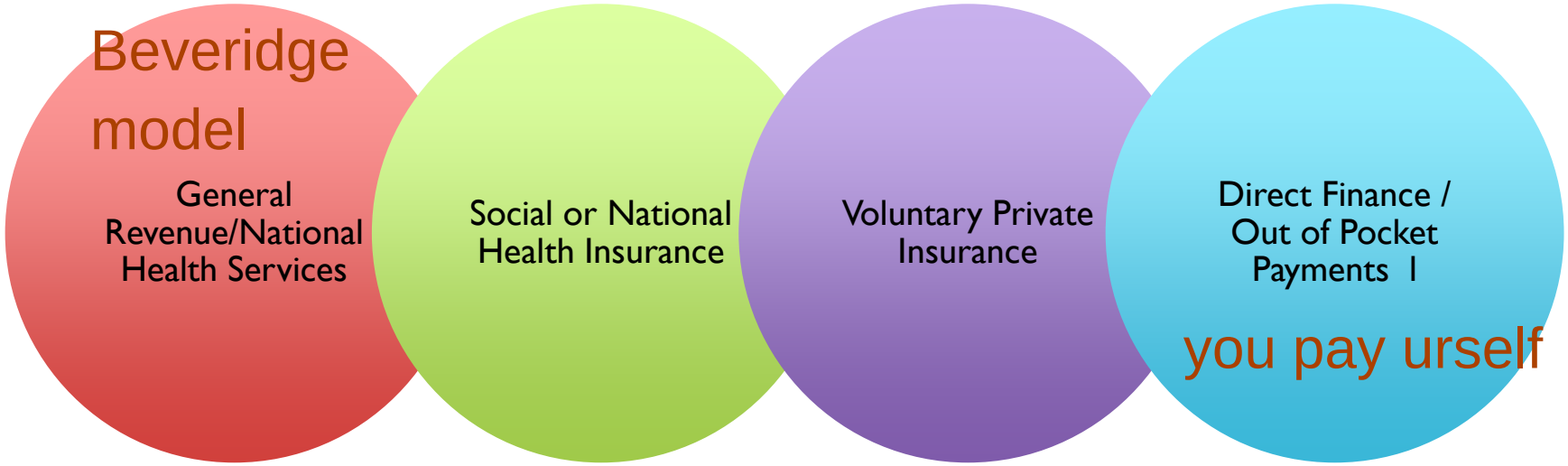
Is There An Iron Triangle?



Every financing system is defined by three functions

Revenue collection	• how is money raised?
Risk-pooling and prepayment	• how are households protected from financial risks?
Purchasing	• how are services from bought and paid for?

Archetypes for Healthcare Systems



United Kingdom – the Beveridge Model

- Based on the principle that healthcare should be available to all, regardless of wealth
- Revenue is collected from general (progressive) taxation
- Health services are provided by the public National Health Service free at point of care to any UK resident
- Providers are salaried employees of the NHS (with quality incentives)
- Parallel private sector operates (sometimes as subcontract to NHS) but relatively small

The NHS is one of the world's largest public healthcare systems

- Covers 63.2 million people
- Services 1 million patients every 36 hour

Healthcare is not free- the taxpayer pays for it.

msnbc

Society / Health

British celebrate national health care in Olympics opening ceremony

07/30/12 09:13 AM – UPDATED 08/22/13 04:23 PM

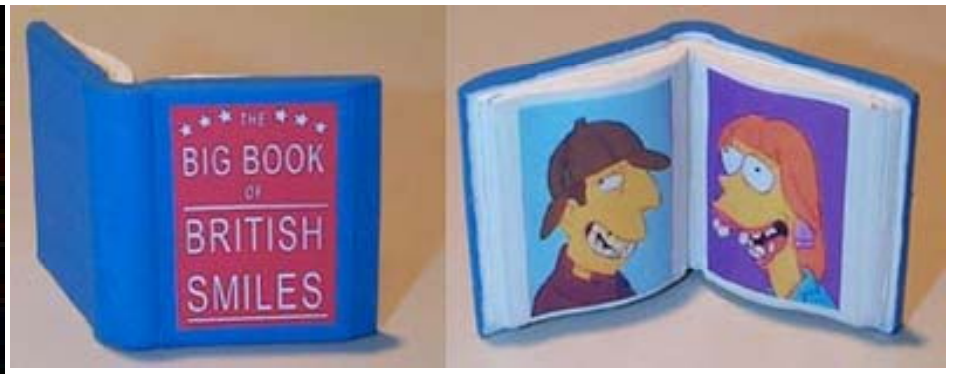
0 save share 3

While Republicans fight against against a Supreme-Court-upheld health care law in this country, the British celebrated their National Health Service (NHS) in the Olympics opening ceremony Friday.

The musically fueled ceremony took viewers through a dancing version of Great Britain's history from its farming days through the industrial revolution and on up through to today's digital age, pausing to celebrate literary, musical, and theaterical contributions (Mary Poppins, James Bond, J.K. Rowling!), as well as societal milestones, such as NHS, which was founded in 1948.

Actors lying on beds meant to represent Britain's National Health Service (NHS) perform during the 2012 Olympics in London. **Jae C. Hong / AP**

At the same time…



Long waiting time
Time cost instead of monetary cost.
If you got time you get, if you no time you don't get.

Welcome to PlacidBritain

Britain Medical Tourism

Getting affordable, high quality medical care at accredited medical facilities abroad is easier than ever! PlacidBritain helps hundreds of British citizens find the best medical option for them abroad.

British medical tourists seeking treatment overseas without sufficient information and advice

Posted on 4 February 2014

A team of researchers has found that British people travelling abroad for medical treatment are often unaware of the potential health and financial consequences they could face.

The researchers say this can, in some cases, have catastrophic effects for individual patients.

At least 63,000 UK residents travel abroad for medical treatment each year. However, the study led by the University of York, and involving the London School of Hygiene & Tropical Medicine, Royal Holloway University, the University of Birmingham and Sheffield Teaching Hospitals NHS Trust, concludes that many people are embarking on medical tourism without understanding the risks involved.

These include a lack of redress in many countries should things go wrong, and the

October 25, 2013 12:04 am

More medical tourists leave UK than come to country, says study

By Andrew Jack and Sarah Neville

More patients travel from the UK for treatment than come into the country to use the National Health Service, according to a new study.

The finding casts doubt on concerns over the costs of "medical tourism".

A team led by researchers at the London School of Hygiene and Tropical Medicine calculated that the number of UK residents seeking treatment elsewhere had risen sharply to 63,000 in 2010, compared with just 52,000 coming into the country – a figure that has grown far more slowly in recent years.

More

ON THIS TOPIC

Boy's case casts light on UK health policy

Hard choices

Guide to NHS waiting times

Part of the NHS pledge to put patients at the centre of everything they do involves making sure that you are diagnosed and start treatment as soon as possible, at a time that is convenient for you. The NHS Constitution says you have the right to access certain services commissioned by NHS bodies within maximum waiting times. Where this is not possible and you ask for this, the NHS will take all reasonable steps to offer you a range of suitable alternative providers.

This promise is made a legal right by NHS England and Clinical Commissioning Groups (CCGs) in the responsibilities and standing rules regulations 2012 (PDF, 259kb).

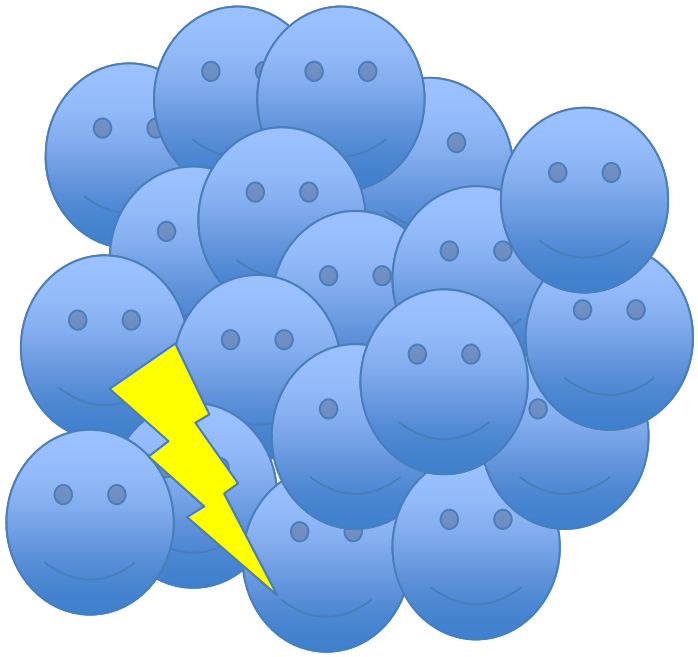
What are maximum waiting times?

You have the legal right to start your NHS consultant-led treatment within a maximum of 18 weeks from referral, unless you choose to wait longer or it is clinically appropriate that you wait longer.

Consultant-led treatment includes treatments where a consultant retains overall clinical responsibility for your treatment. This could include treatments provided by the service or team led by your consultant. The setting of your consultant-led treatment, whether hospital-based or in a community-based clinic, will not affect your right to start treatment within 18 weeks.

Only services commissioned by the NHS are included. Therefore, public health services commissioned by local authorities, such as sexual health services, are not covered by this right.

Risk pooling and insurance



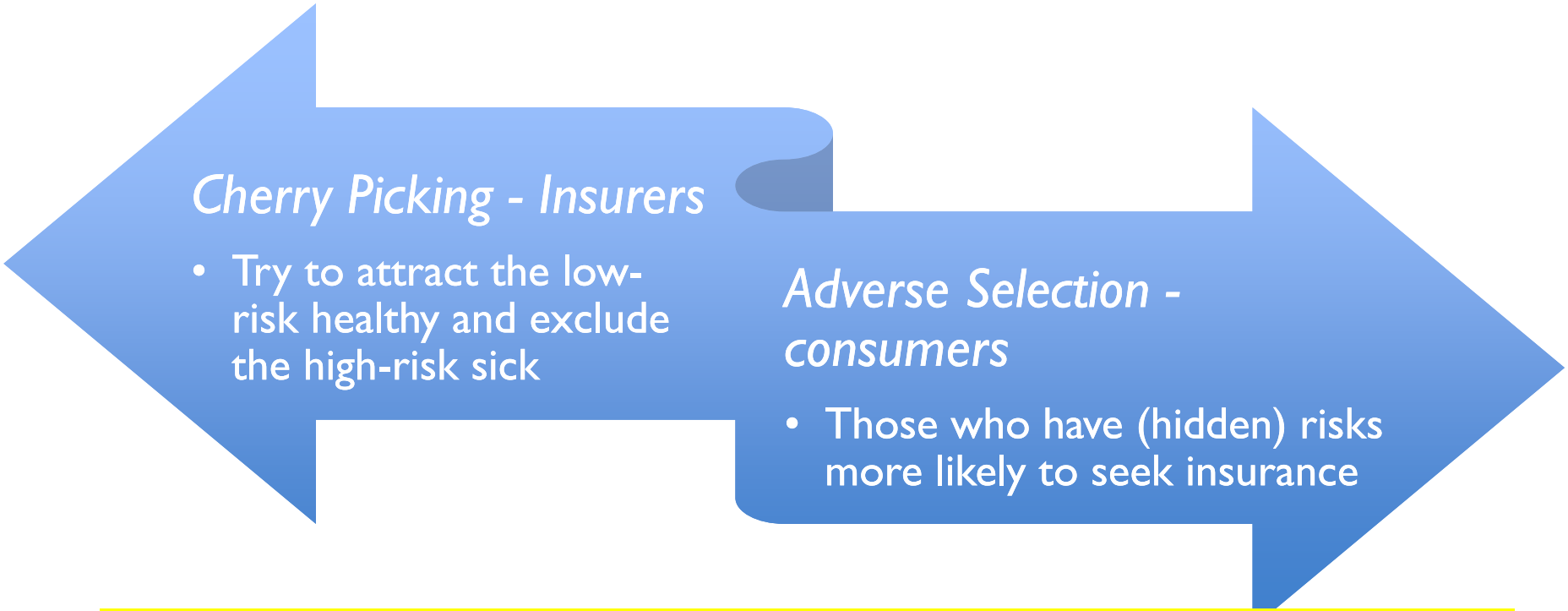
- Risk pooling means that we collect and distribute individual risks, transforming individual uncertainty into predictable population-level events
  - For an individual, suppose there is a 1% of having a catastrophic health-related medical event
    - If you do get hit, you'll need a lot of health services…
    - If you don't ?
  - In a population of 100 people, it is almost certain that 1 person will have such an event
- If we have a large enough population, everyone can make smooth *predictable* payments with certainty instead of a few chaotic unpredictable and possibly large payments

How does insurance stay sustainable?

- Actuarially fair premium = expected expenditure per head
  - Insurers charge each individual enough to offset the total expected payments for the group (including a fee for operations)

- Law of large numbers
  - "As the number of trials of a random process increases, the percentage difference between the expected and actual values goes to zero".
  - The more people are in the pool, the more likely it is that the insurer's predicted payouts will be on target

Problems in Insurance Markets



Solution : Make coverage mandatory for group

Moral Hazard

- Increasing risk: Taking more health risks after getting health insurance
- Overuse: Using (costly) services more often than necessary because the incremental cost is zero

- Solution: Copays discourage overuse
- However, RAND Health Insurance Experiment suggests that people forego both less and more valuable care

Now, I am covered. I am going to risk my life.

Germany – the Bismarck Model of SHI

- Employer-based health insurance, following Bismarck law of 1883, similar law in Japan in 1992, also other European countries
- Contributions to non-profit insurers funded by employees and employers via payroll tax
- Opt-out for wealthy, social funds cover unemployed/never employed
- Health insurers and providers are private but regulated: provide standard benefits and insure all applicants, negotiate prices

Removes problems of adverse selection

Many insurers, little coordination, rising costs?

Aging happily (no longer paying in)…

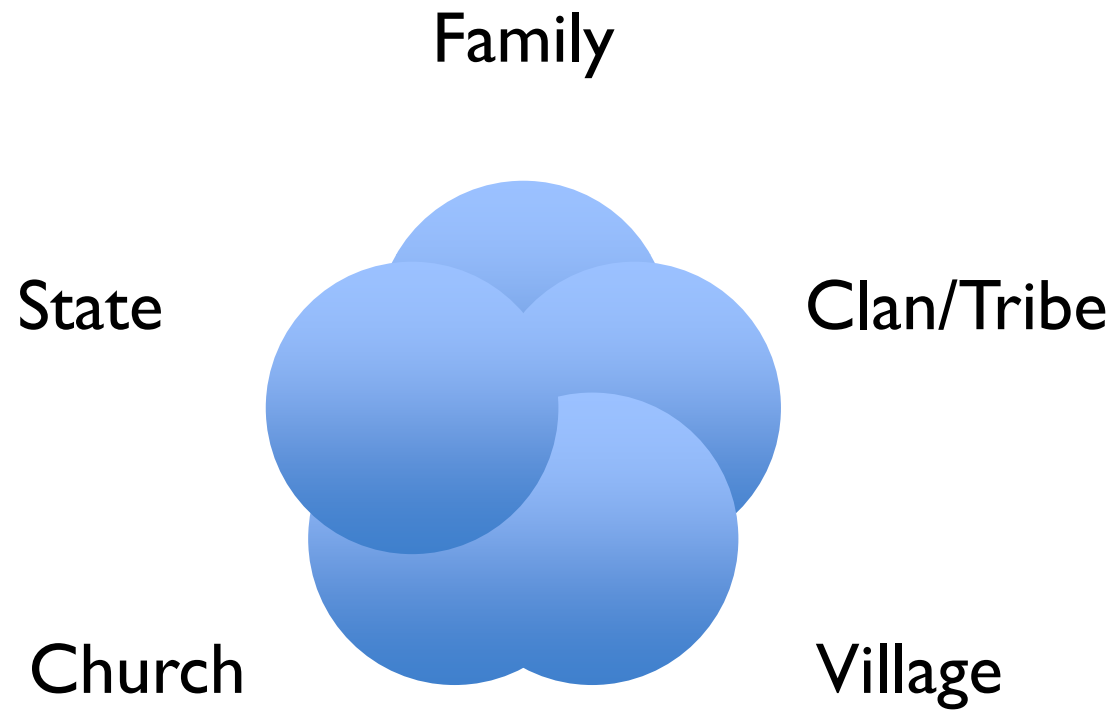
Taiwan – National Health Insurance

- Established in 1995
- All legal residents of Taiwan eligible to join, almost all 23 million have
- Single health insurance scheme administered by government
- Patients choose services from a mix of public and private healthcare providers contract with the NHI
- Financed through a mix of payroll contributions and taxes

Simple administration = lower costs

The doctor will see you now (for 2-5 minutes)

Social Insurance – Community/Microinsurance



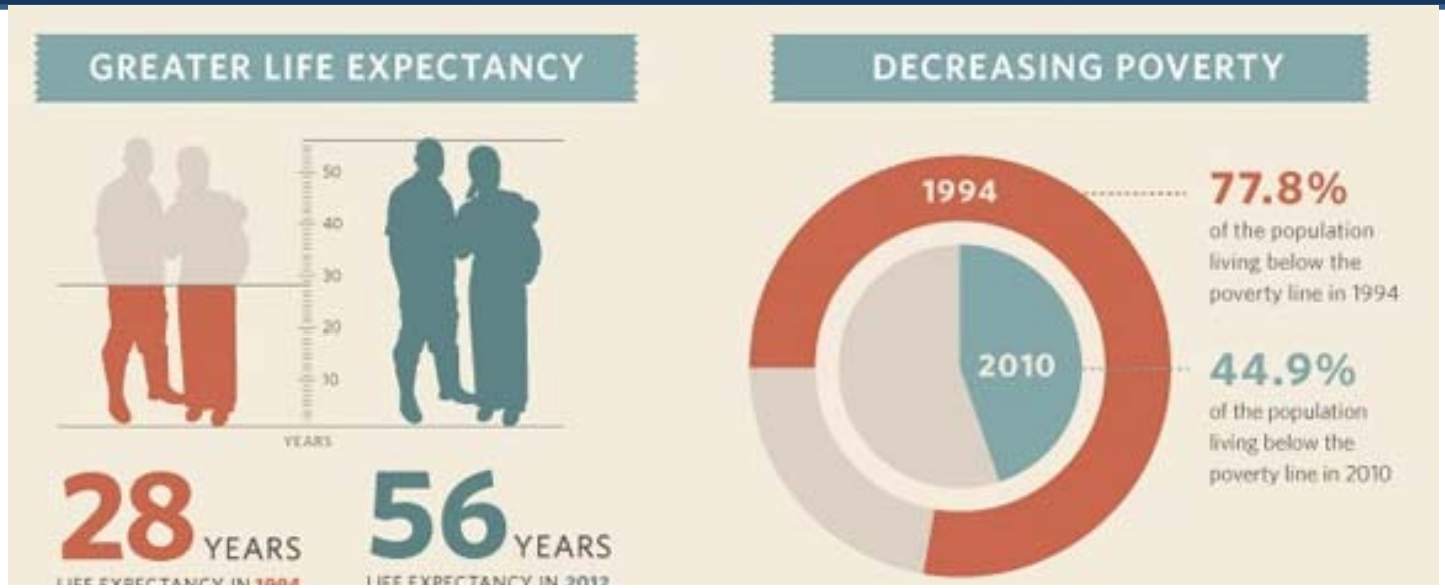
Community-based insurance programs build risk pools based on shared resources within pre-existing social structures

Rwanda – Community Based Insurance

- **Population**: 11.2 million (UN, 2012) **Capital**: Kigali
- **Area**: 26,338 sq km (10,169 sq miles)
- **Major languages**: Kinyarwanda (official), French (official), English (official), Swahili
- **Life expectancy**: 54 years (men), 57 years (women) (UN)
- **GNI per capita**: US $570 (World Bank, 2011)

*Community Health Insurance, almost 95% of population have insurance by paying $3USD per year.

Return from the 1994 Genocide



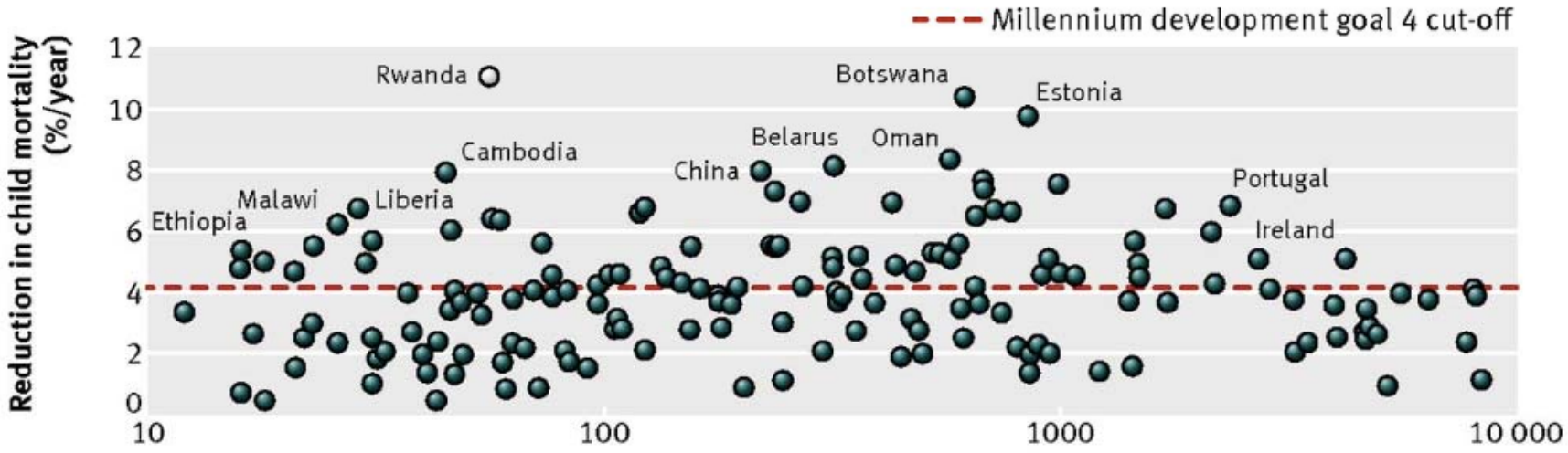


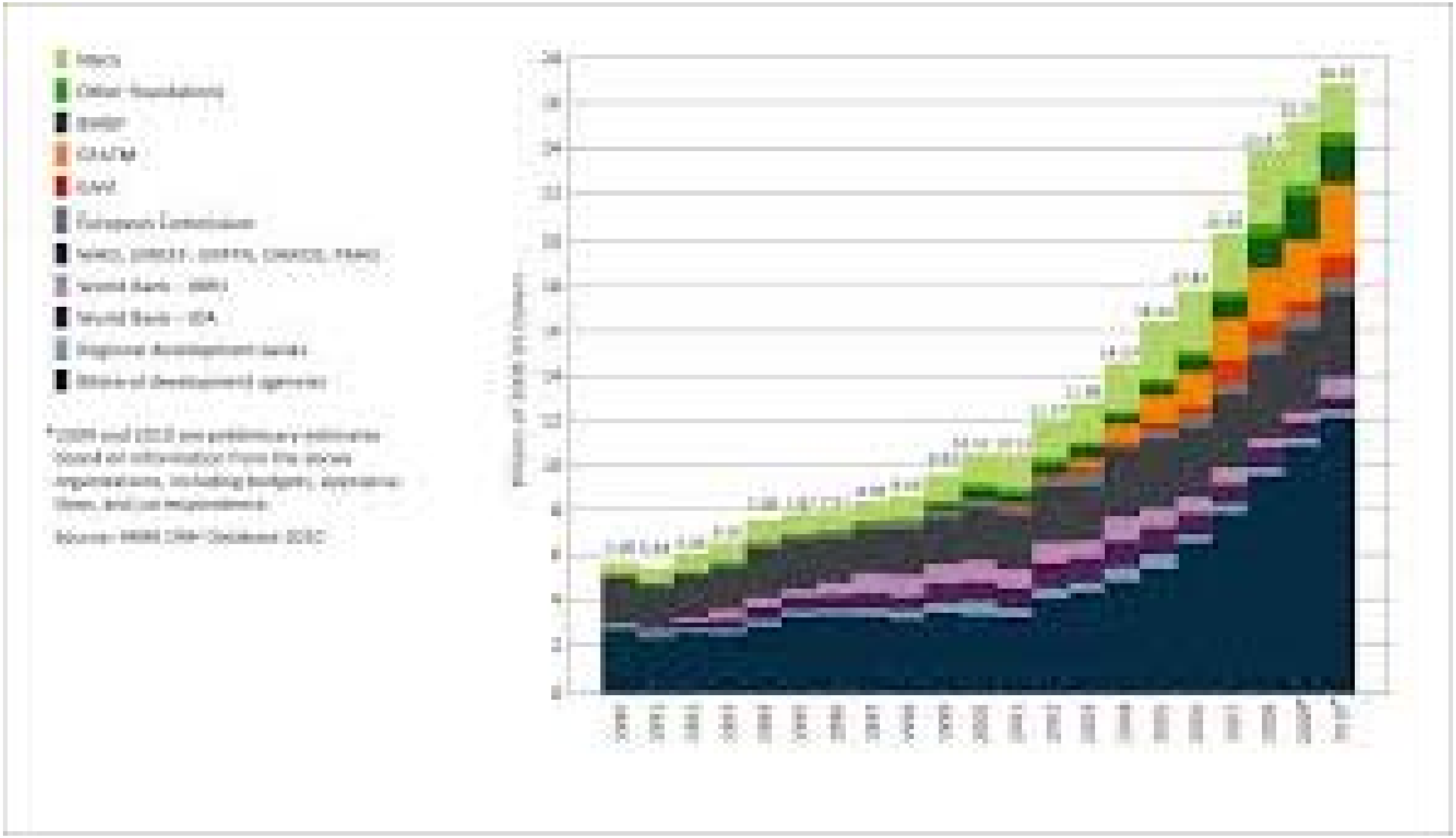
Figure 3


RECEPTION
MUTUELLE DE SANTE
KIBUYE

New Innovations in Health Financing

- Corporate levies
- Sin Taxes eg Thailand
  - Alcohol taxes
  - Cigarette Taxes
- Tourism Taxes
  - Currency levies
  - Airplane ticket taxes

Development Assistance for Health



Many Paths to Coverage

- https://www.youtube.com/watch?v=dJP4IkL1xT4

Universal Health Coverage

Universal health coverage means that

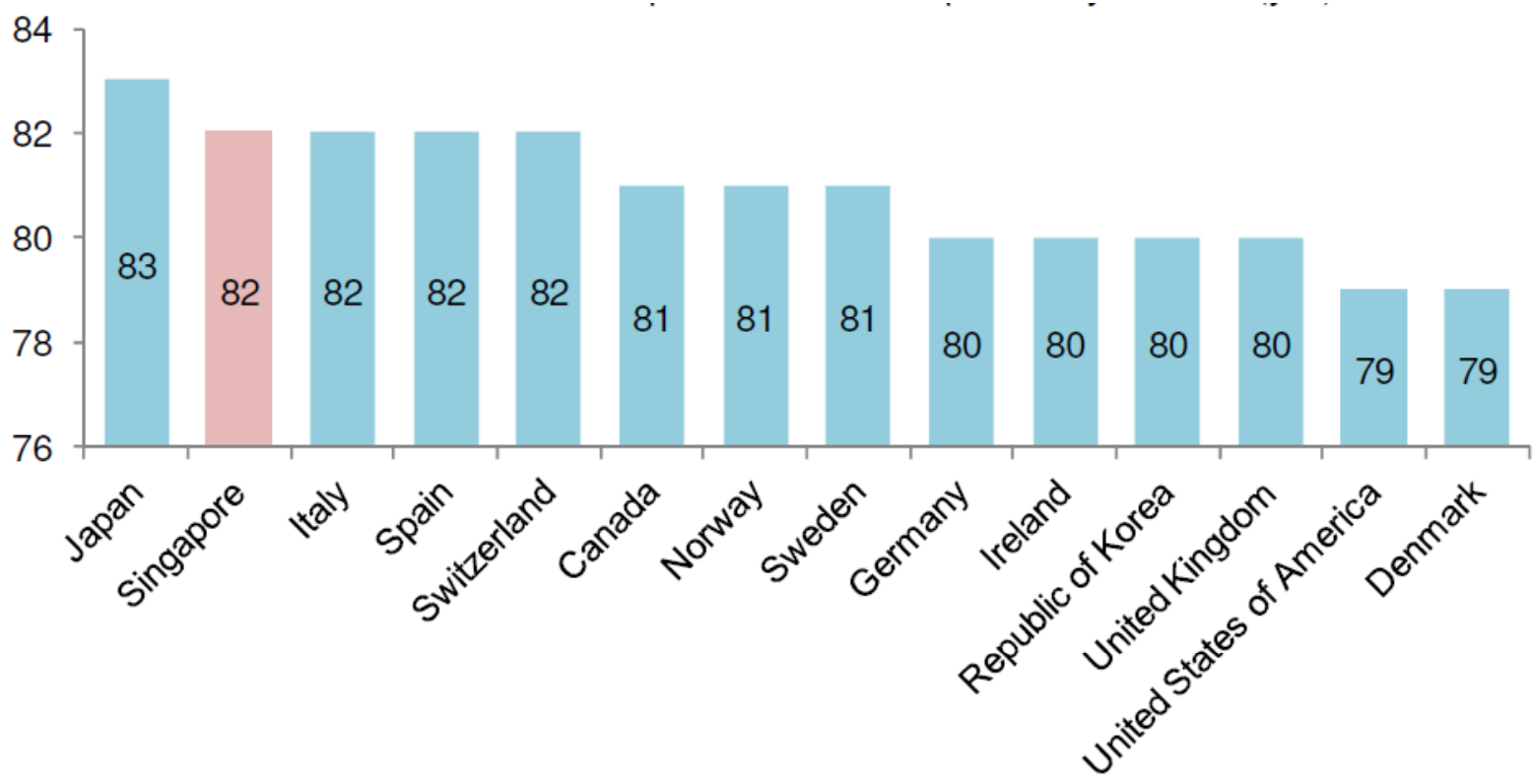
"all people have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them"

WHO 2010

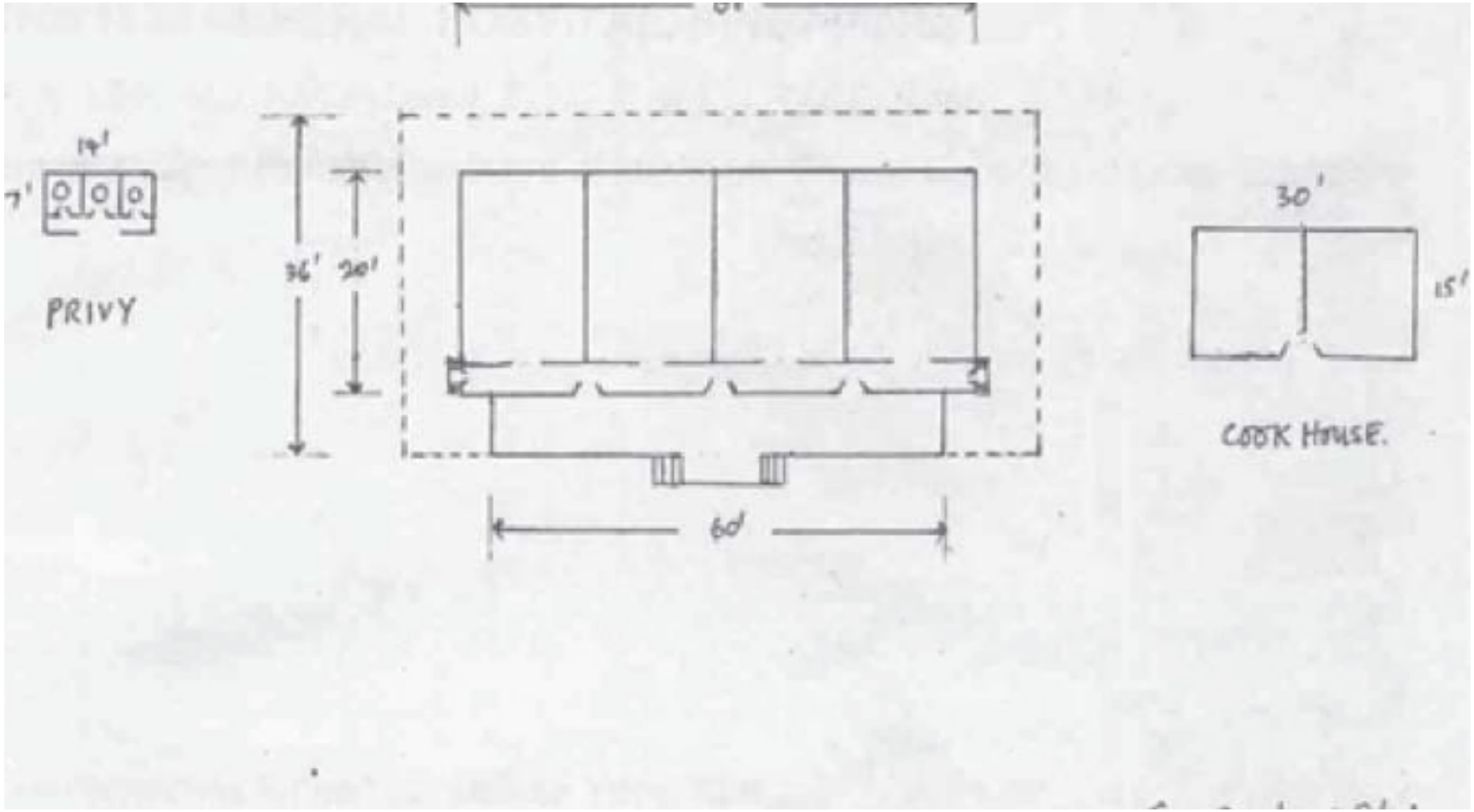
Another quiz!

- How long do you expect to live ?
- 50 years ago, what was the fee imposed for attending an outpatient clinic (if not a public holiday)?
- How much of your first paycheck will go to Medisave?

Singapore's Life Expectancy Rates are High



1827 : From a shed



Three key evolutionary stages

Pre-independence

- Beveridge model (similar to NHS)

Post-Independence

- Introduction of user fees
- Limited focus on private sector, continued traditional medicine

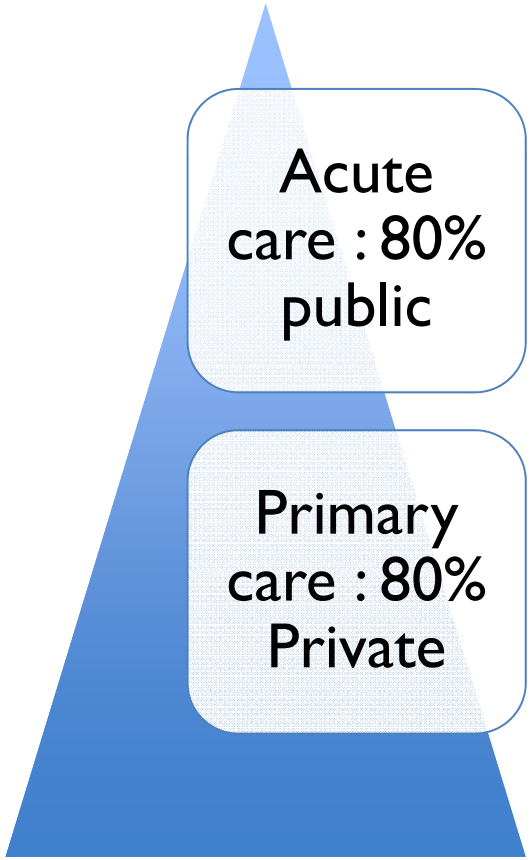
1983 National Health Plan

- "Restructured" hospitals to increase autonomy
- Introduction of 3M financing system

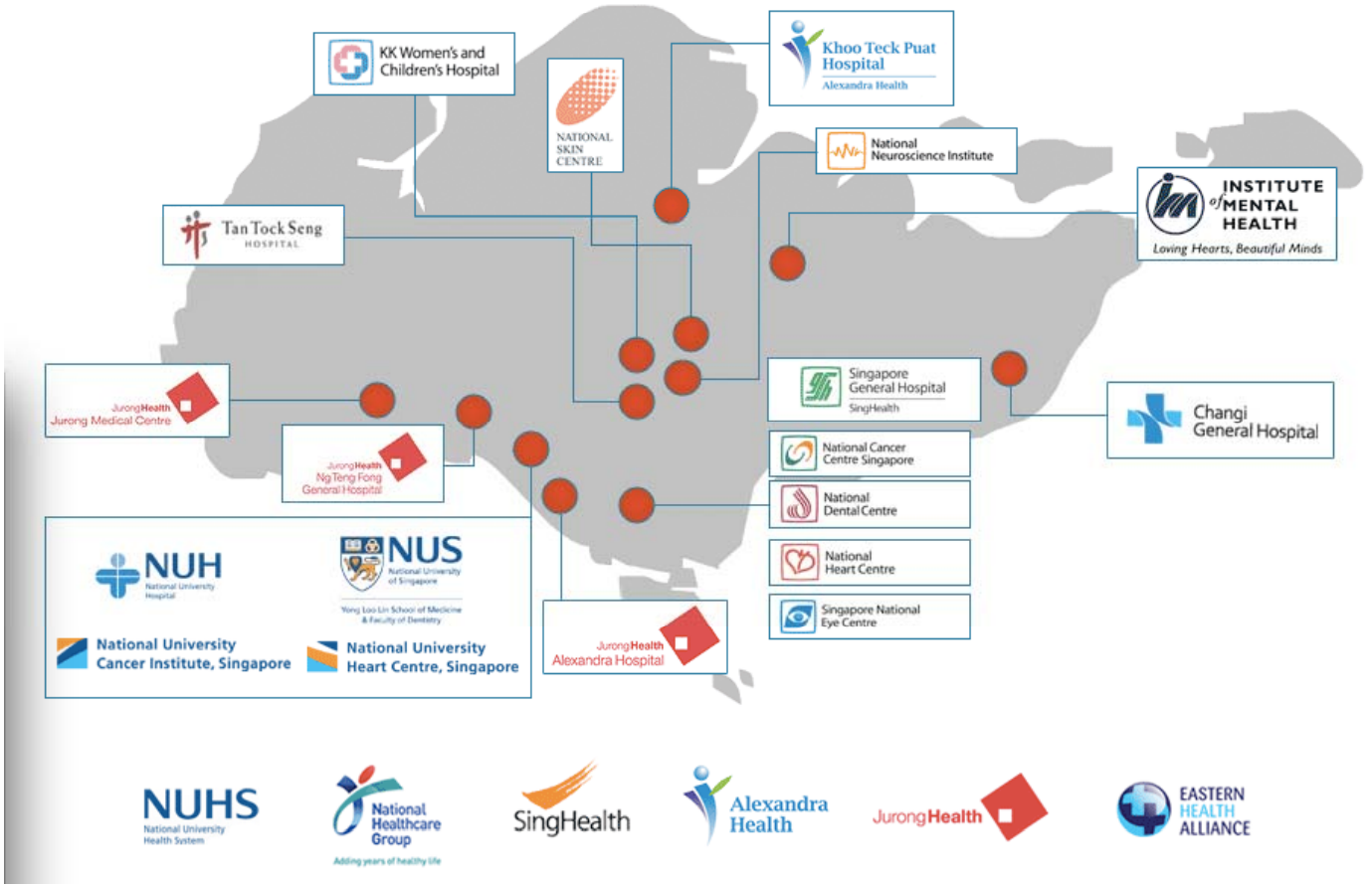
In Singapore, personal responsibility still matters.

Today: Mixed Healthcare Delivery

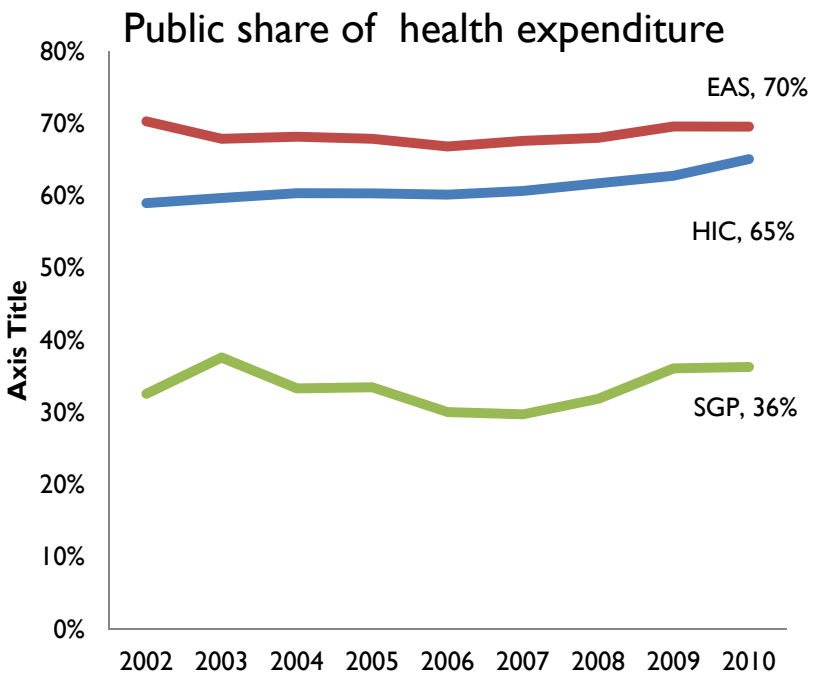
- Public hospitals and clinics
  - 18 outpatient polyclinics
  - 6 'restructured" general hospitals, women/children's hospital, psychiatry hospital
  - 6 national specialty centres for cancer, cardiac, eye, skin, neuroscience and dental care.
  - Residential/community based healthcare services including intermediate and long-term care
- Private sector hospitals and clinics
  - 2000 + private clinics
  - 10 hospitals
- Government subsidizes public healthcare, while private healthcare operates as a free market (no guideline fees since late 2000s)
- Ministry of Health is the primary regulator



A Regional Model For Public Sector



Healthcare Financing is Largely Private

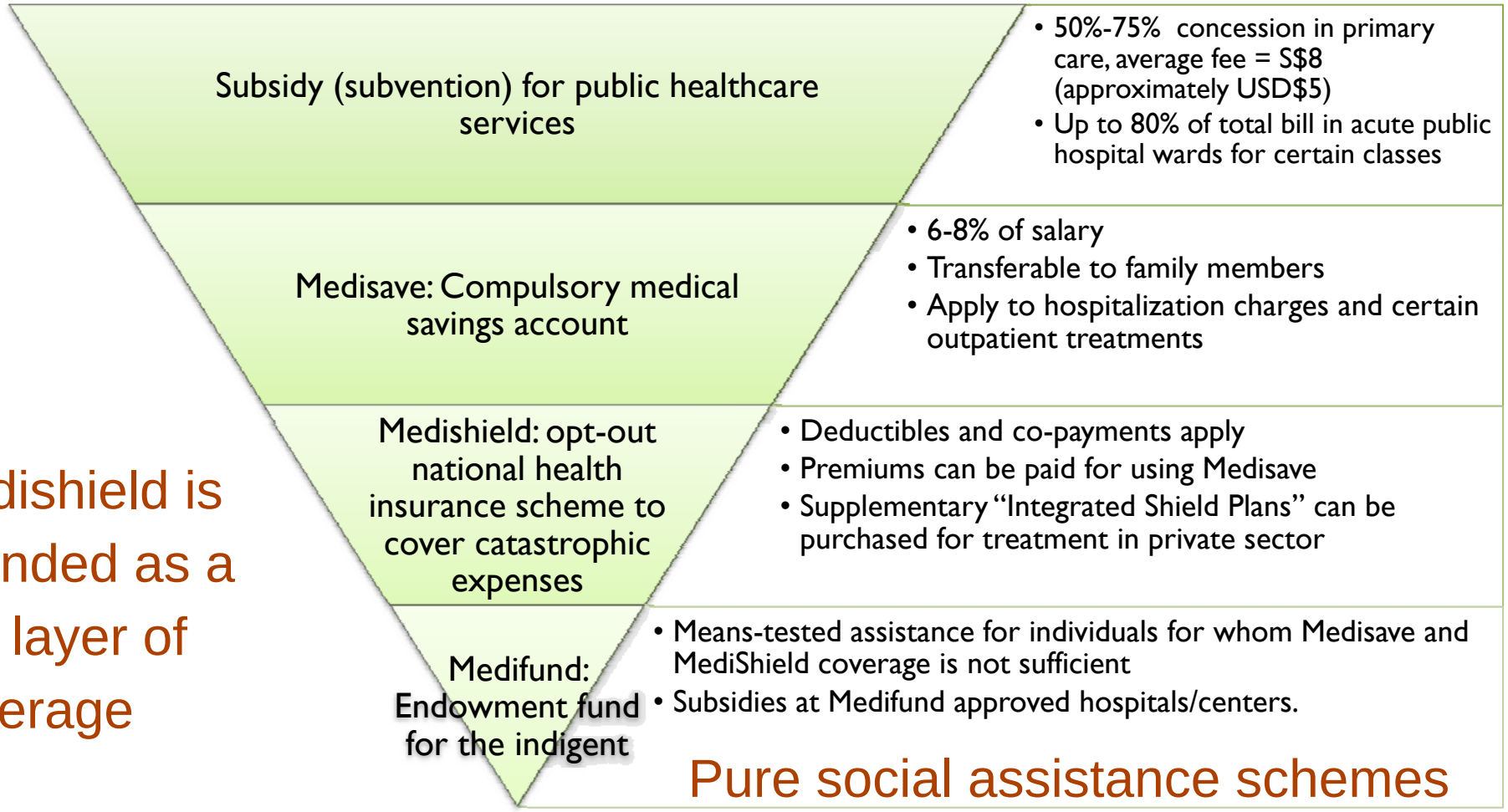


Philosophy is based on individual responsibility, with the government providing support and cost-containment

- Private funds come from individuals and/or employers
  - Medical savings accounts
  - Opt-out national catastrophic insurance and private health insurance
  - Employer benefits
  - Out-of-pocket payments for deductibles, copayments, drugs and expenses not covered by other financing sources
- Public expenditure comes out of general tax
  - Subsidies for public healthcare providers
  - Subsidies for health promotion
  - Public assistance programmes

Source: World Bank Databank

The 3M Financing Framework

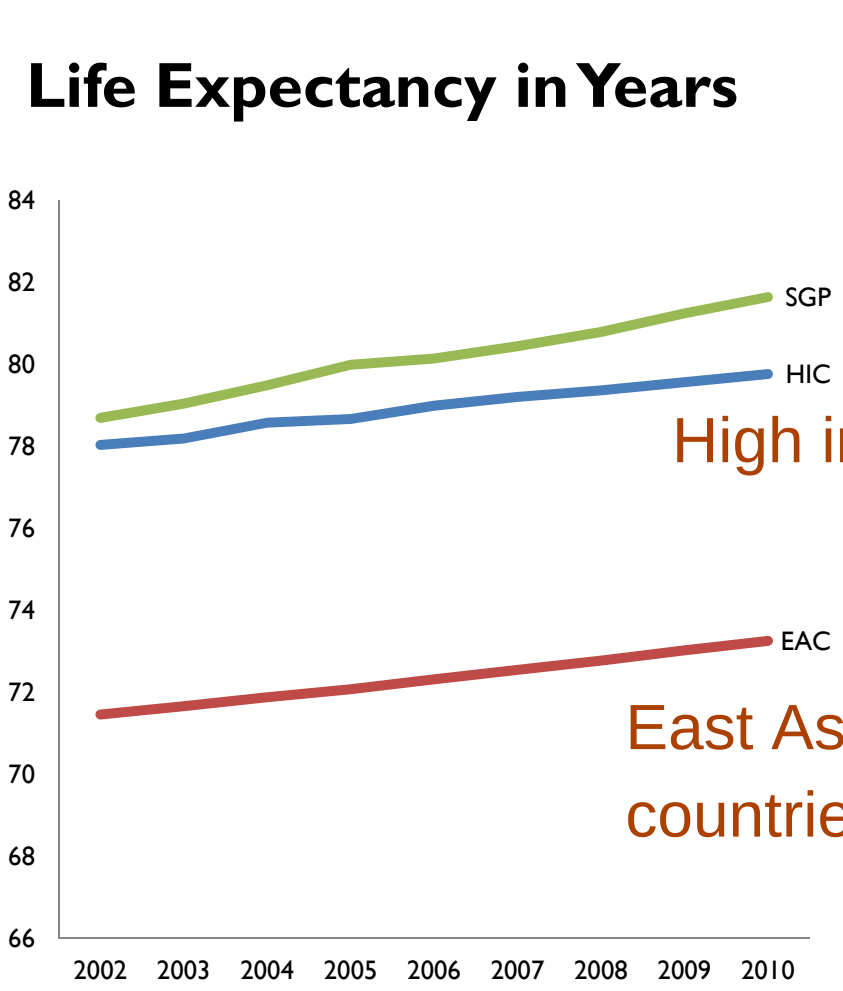


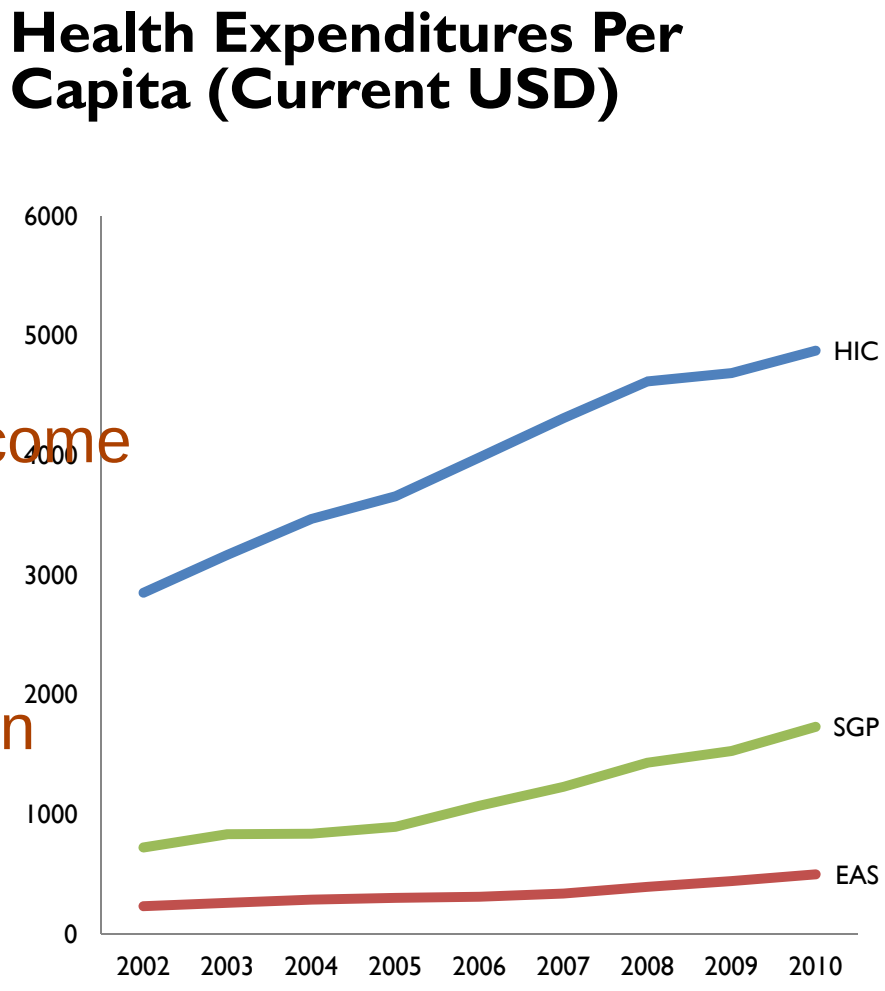
Medishield is intended as a last layer of coverage

Assistance for specific at-risk groups

Eldershield	• Opt-out national insurance scheme, payouts in the case of severe disability
Interim Disability Assistance	• Benefit for those excluded from ElderShield due to age /pre-existing disabilities
Community Health Assist Scheme	• GP treatment (including NCD) for low income and 40+/disabled
Intermediate & long-term care (ILTC) subsidies	• Up to 80% of bill for intermediate and long-term care service at government care facilities based on means testing + clinical eligibility
Medical Fee Exemption Card	• Fee exemption at government facilities for those in LTC/disability homes
Medical Assistance Fund	• Up to 75% drug subsidy for non-standard drugs for qualifying patients at public institutions

Positive Outcomes At Low Cost (So Far)





Source: World Bank Databank

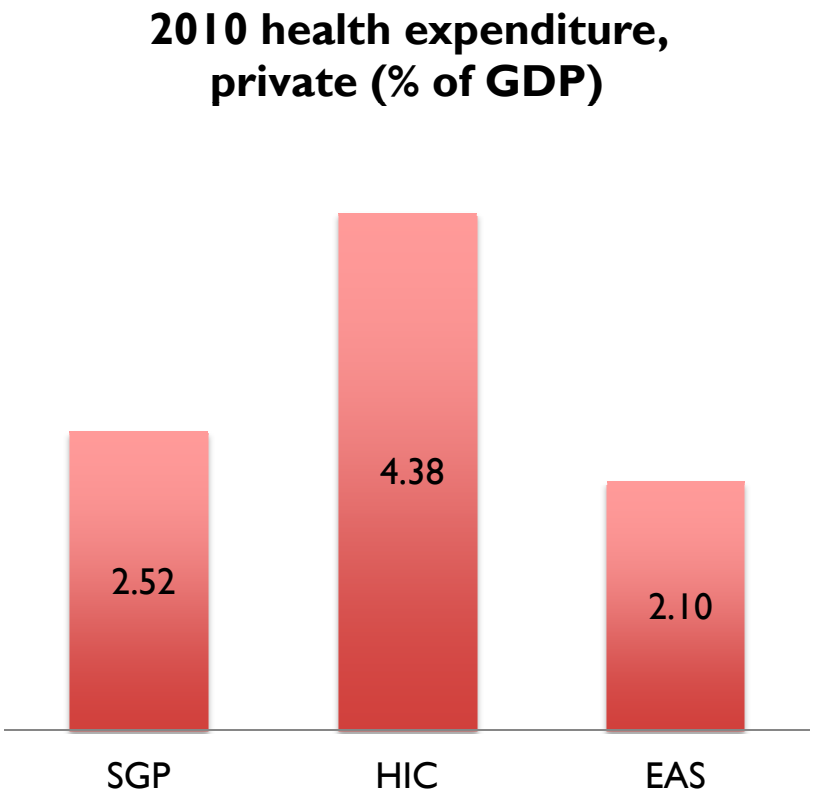
Universal Coverage?

	2008	2009	2010
Medisave			
► No. of Accounts (million)	2.9	2.9	3.0
► Total Medisave Balance ($billion)	42.4	45.8	50.2
► Average Balance per Account ($)	14,900	15,700	16,900
► Amount Withdrawn for Direct Medical Expenses ($million)	588	661	732
MediShield & Integrated Shield Plans			
► No. of MediShield Policyholders ('000)	3,076	3,299	3,390
► No. of MediShield Policyholders with Private Integrated Shield plans ('000)	1,790	1,930	2,068
ElderShield			
► No. of ElderShield Policyholders ('000)	835	882	921
► No. of ElderShield Policyholders with Supplements ('000)	76	127	189

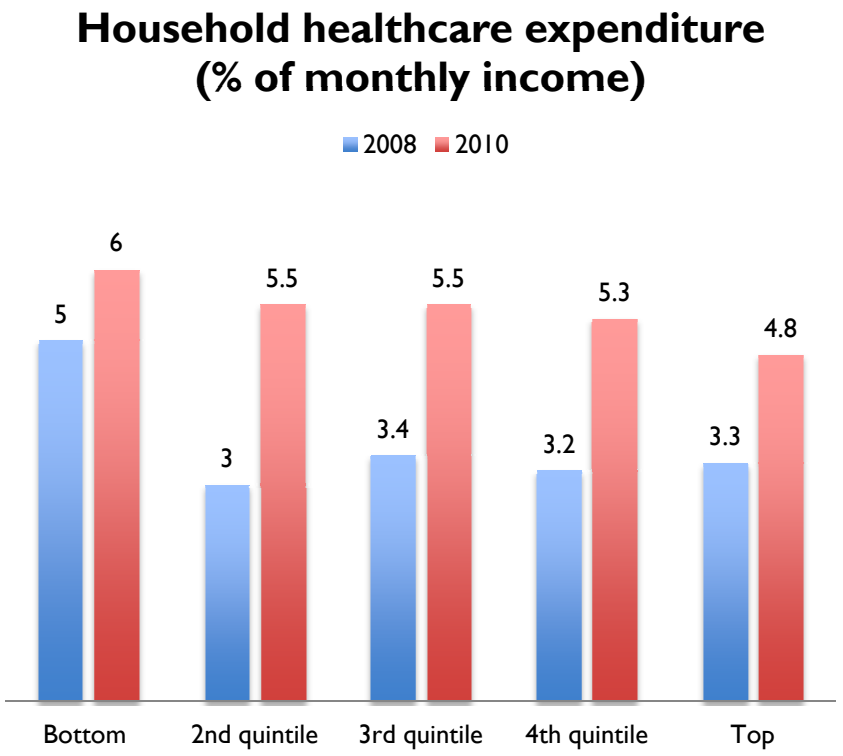
	FY08	FY09	FY10
Medifund			
► No. of Applications Approved ('000)	370	410	481
► Grants Disbursed to Institutions ($million)	73.7	75.0	80.0

Burden of Private Health Expenditure

Across Countries:



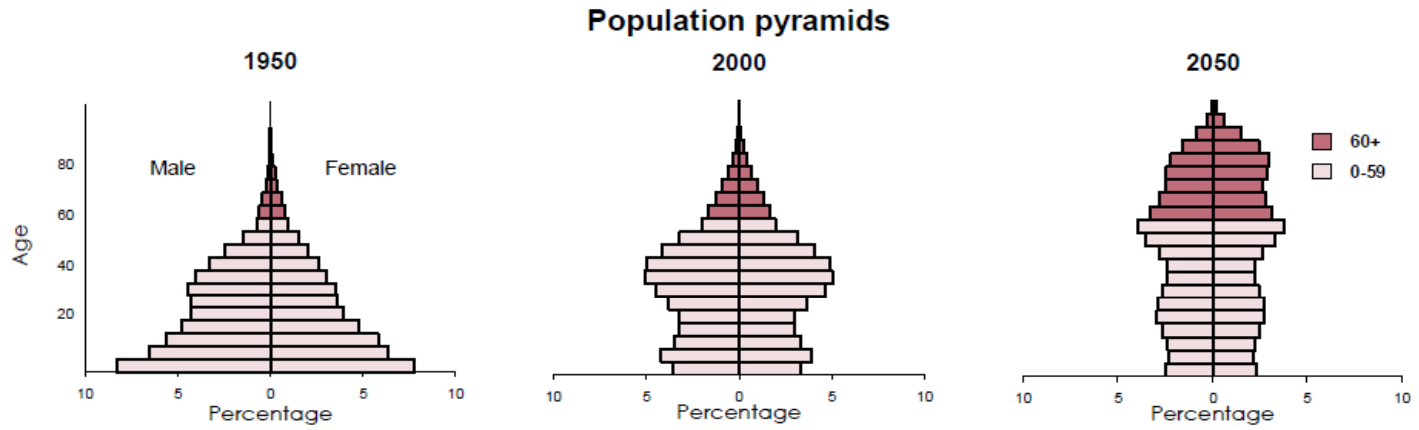
Within Singapore:



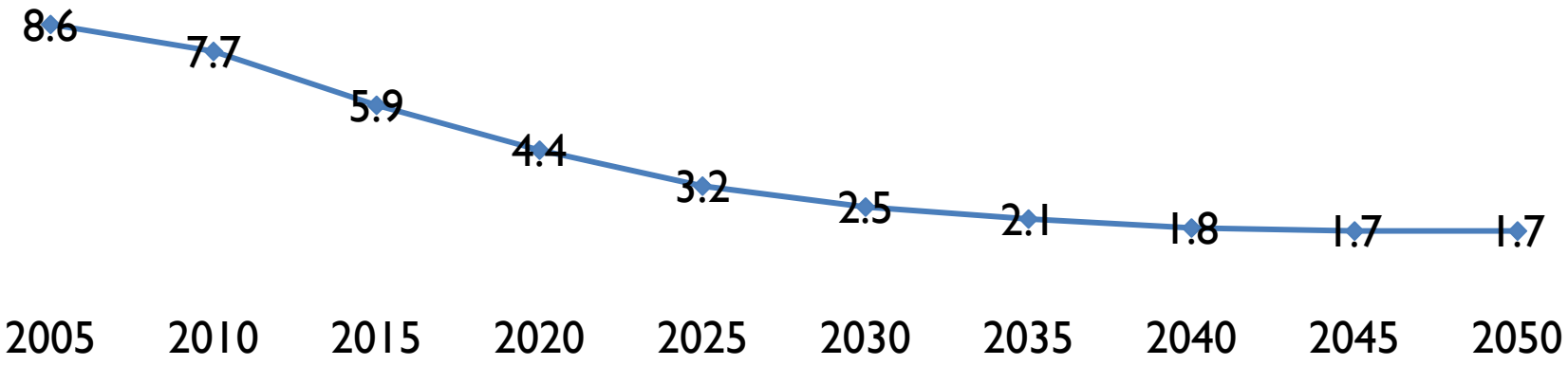
Source: World Bank Databank, Ministry of Health

Today's Challenges : Individual Vulnerability

Tomorrow's Challenges : Rapid Aging

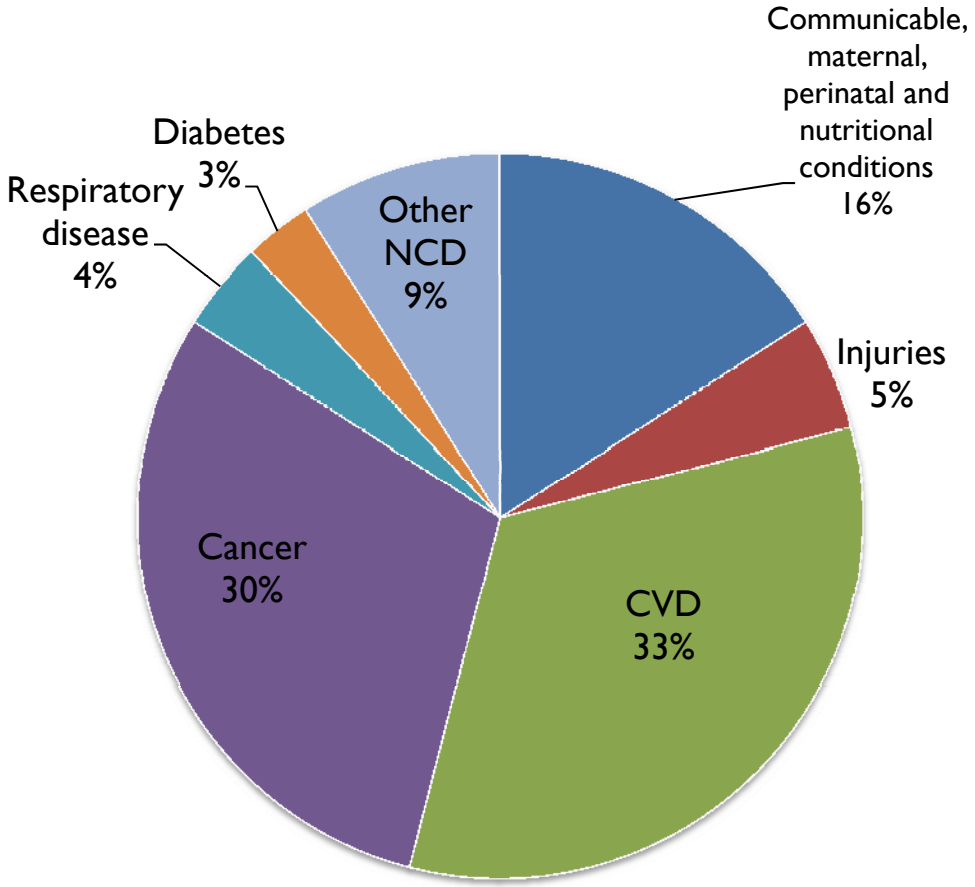


Projected Old Age Support Ratio 2005-2050



Source: UN DESA, Population Division, "World Population Aging : 1950-2050"

Tomorrow's Challenges : Rise of NCDs



Live long but sick

In the last 10 years

Ongoing 3M reforms

- Medisave liberalization eg Chronic Disease Management Programme expansions
  - Since 2006, covers outpatient treatments of increasing number of chronic diseases (now 10) at private clinics including diabetes, high blood pressure, stroke, depression
  - Private GPs commit to a care management and monitoring programme, while patients can use family member's or own Medisave
- Medishield expansions

Exploration of integrated public/private care models

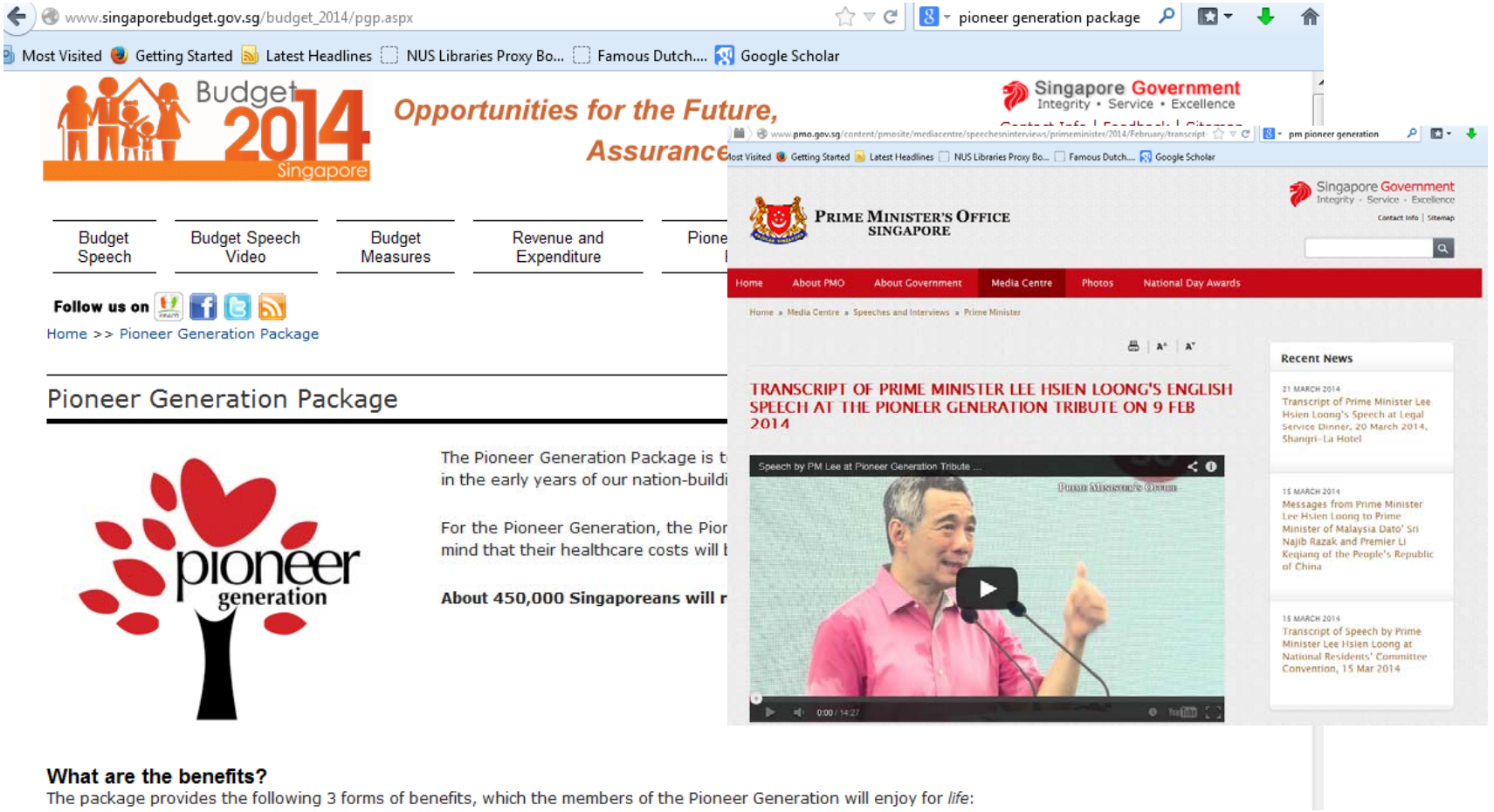
- Expansion of regional healthcare clusters eg. SingHealth Delivering on Target Programme for co-management of stable diabetic patients
- Community Health Centers and Family Medicine Clinics

Other moves to extend the social safety net

- CHAS expansion subsidies for chronic care, increased Medisave subsidization for outpatient expenses from $300 - $400
- Raising Medishield coverage limits,increased IDAPE coverage/payouts, and active discussion around ElderShield benefits
- Medifund expansions to cover non-residential ILTC services

In the last 10 months

In the last 10 months



MediShield Life premiums a hot topic at Facebook chat

PM Lee announced details for the new national insurance scheme, MediShield Life during the Pioneer Generation Tribute event held at the Istana on 9 February 2014.