

**Should providers be allowed to extra-bill
for uncovered services?
Debate, resolution and the future in Japan**

**Naoki Ikegami, MD, MA, PhD
Dept. of Health Policy & Management
Keio University School of Medicine
ikegami@sc.itc.keio.ac.jp**

Health insurance in Japan

- **Social insurance system covers virtually the entire population**
 - **No choice of plans**
 - **Employed: Plan provided by employer**
 - **Self-employed and pensioners: By municipalities**
 - **Over 5,000 insurance plans**
- **Plans having high ratios of low-income people enrolled subsidized by taxes**
- **Central pooling fund to spread evenly the cost of medical care for elderly**
- **Co-insurance rates relatively high but catastrophic coverage is provided to all**

Central role of the fee schedule

- **Applied to all payers and all providers**
 - Includes both physician and hospital services
 - For providers: Determines how much will be reimbursed and under what condition
 - Complaints on low fees, rigid conditions
 - For patients: Determines their benefit package
 - Very few aware of the regulations: regard health care as basic right
- **Providers prohibited from extra billing and balance billing: All or none rule**
 - Billing will result in the patient being forced to pay out of pocket for the entire costs of the treatment
- **Revised biennially: Fees decreased if volume expands on an item-by-item basis**

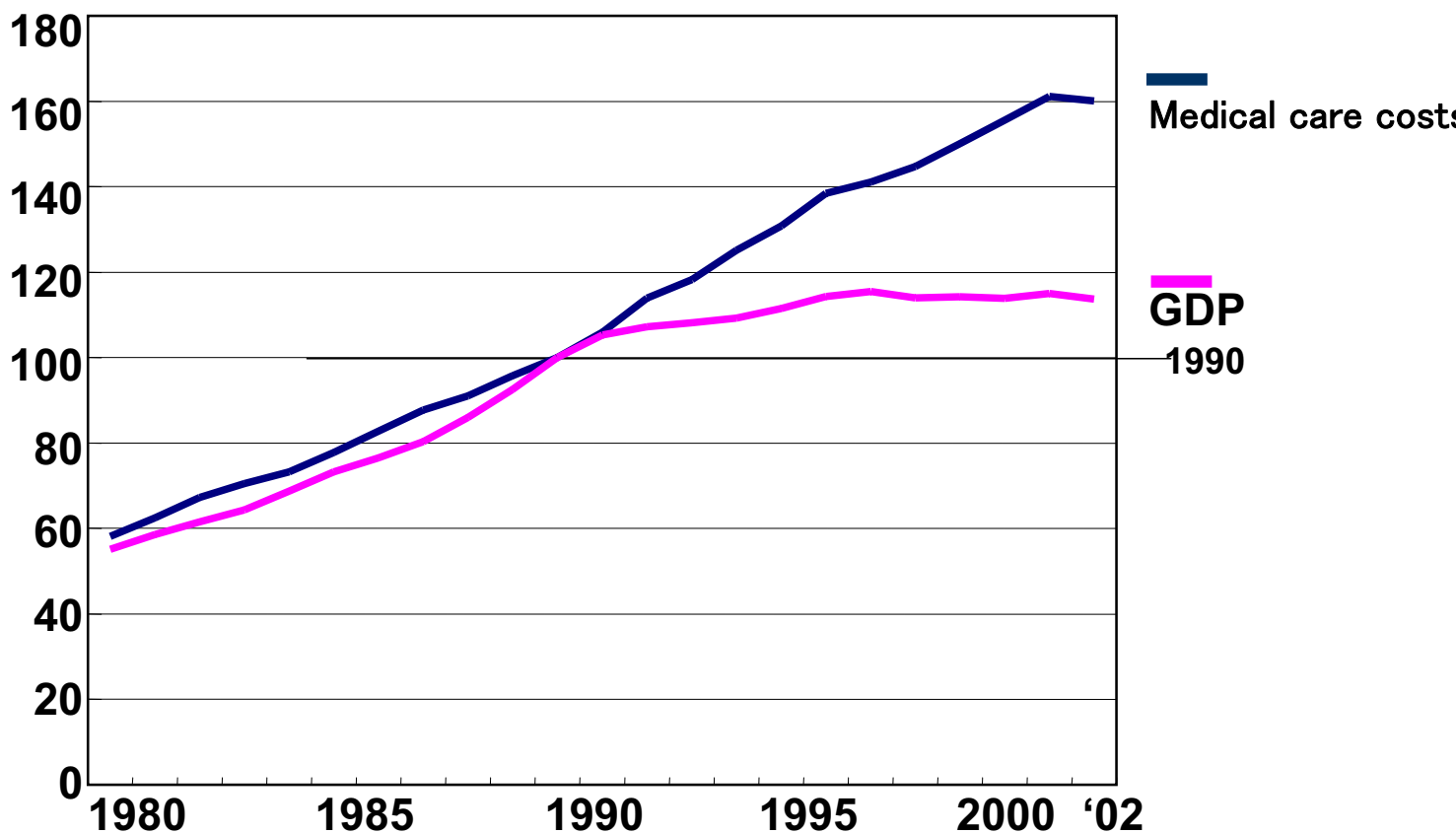
Targeted decreases in fees for imaging: Fee revision of April, 2002

(in Yen, 105 Yen=US\$1)

| | Old fee | New fee |
|------------------------|----------------|----------------|
| CT scan (head) | 6550 | 6200 |
| CT scan (body) | 8800 | 8300 |
| CT scan (limbs) | 6100 | 5700 |
| | | |
| MRI (head) | 16600 | 11400 |
| MRI (body) | 17800 | 12200 |
| MRI (limbs) | 16900 | 11600 |

***Japan has the highest per capita number of CTs, MRIs**

Growth in medical care costs and GDP, Indexed to 1990, Japan, 1970–2002



(Amount transferred to LTC Insurance added from 2000. MHLW and Cabinet Office. 2003)

Adjusting to economic stagnation: Use all means!

- **Fee schedule: Prices reduced globally 2.7% in 2002**
 - Has led to a 0.7% reduction in expenditures in 2002
- **Increases in co-insurance for employees:**
0%→10%(83)→20%(97)→30%(03)
- **Increases co-insurance for elders**
50%→0(73)→\$3(83)→10%(02) (20% for high income)
- **Increase in the premium rate of largest plan from 7.4% to 8.2% of total income from April, 2003**
- **Opening the Pandora's box: whether to allow extra-billing of services not covered and balance billing?**

Current regulations on extra-billing

- **Restricted to those listed in the “specified medical costs” (SMC) 特定療養費**
 - **High-tech services being developed**
 - Limited to 128 designated hospitals
 - 165 requests approved: 97 active (58 already listed, 10 discontinued)
 - **Services chosen by the patient**
 - Extra-charge rooms (16% of all beds)
 - Special consultations with appointments (97 hospitals)
 - Consultation fees in hospitals with 200 or more beds
 - Clinical trials of drugs and devices (paid by manufacturers)
 - Surcharge co-payment amounting to 15% of bed & board
 - Drugs approved but not yet listed in the fee schedule
- ⇒ Care has been taken to limit financial burden to patients**

Offensive by pro-market forces: July, 2001

- Health care should be financed by a mixture of public insurance and private pay (混合診療)
- Government should only be responsible for providing a “basic package” of services
- Current fee schedule regulations on extra-billing restrict free choice by patients, dampens competition, cripples efforts to establish Japan as medical hub
- Patients should be allowed to choose and pay for services not listed in the fee schedule
 - Current all or none rule on coverage puts unfair burden on patients
- Spearheaded by Regulation Reform Council within Cabinet Office with corporate CEOs and economists as members
 - Council chair: CEO of a private insurance company

Strategy taken by Regulation Reform Council

- **Publicity campaign highlighting the seeming absurdities and unfairness of the present regulations**
- **Patients must pay full costs of treatment, if:**
 - **A drug not listed is prescribed, or prescribed for off-label use**
 - **Issue: Drugs for treating cancer etc. already approved in other countries**
 - **3+ eradication courses of Helicobacter pylori provided**
 - **Only up to 2 courses are approved**
 - **Silicon transplants for breast reconstruction is used**
 - **Silicon transplants not approved**
 - **Influenza vaccination is given to inpatient**
 - **Social insurance does not cover prevention**
 - **Interpreters are hired for non-Japanese patients**

Critique of Council's argument (1)

- **Is buying additional medical services not covered by the basic plan, the same as adding a CD player to the basic model when buying a new car?**
 1. Safety and effectiveness concerns
 2. Ethical concerns
 3. Practical concerns
- 1. **Safety and effectiveness concerns:**
 - **Should drugs be automatically approved if already approved in other countries?**
 - Iressa (lung cancer drug): After approval in Japan, was later found not to be effective, especially for Caucasians
 - The reverse could equally be true
 - **Some of the current restrictions are based on evidence**
 - Providing 3+ eradication courses for *Helicobacter pylori* increases risk of lung cancer, while not necessary increasing effectiveness

Critique of Council's argument (2)

2. Ethical concerns

- Does the public support deregulating health care?
 - Opinion polls show strong support for equality
- Does buying the extra-billed service make a difference?
 - Only increases statistical likelihood if that, not necessary tangible
 - If really effective, then should be covered by public insurance

3. Practical concerns

- Will physicians provide impartial information?
 - Not when it reflects on their income
- Will the patient be a prudent consumer?
 - Costs are likely to become covered by private insurance plans: “gap” insurance will become a profitable product
- Out-of-pocket costs may **decrease in the short run, but will increase in the long run**: Must pay premiums for both public and private insurance plans
 - Employers may have to pay both premiums to attract quality workers₁

Political compromise: December, 2004

- **Health Minister and Minister in Charge of Deregulation agreed to following:**
 - Drug approval process will be speeded up
 - Hospitals will be allowed to perform high-tech procedures not listed if they meet criteria to be set for each
 - Extra-billing of more than the prescribed eradication courses of *Helicobacter pylori* etc. permitted if patient requests based on information provided by physician
 - Clarification that the provision of influenza vaccines and interpreters will not lead to the patient being forced to pay for the entire costs of the treatment
- **Proponents did not achieve their goal of allowing the unconditional mixture of publicly and privately financed services**

Implications of the compromise

- **Health expenditures will increase more rapidly**
 - Approval process for listing in fee schedule has been made more transparent and faster: **Benefits will expand more quickly**
 - Increasing expenditures, heightening of fiscal crisis
- **Council will continue to pressure for deregulation**
 - In tandem with their other goal of allowing investor-owned hospitals to enter the market
 - Only round one is over
 - Next step is to push for balance billing (where real profits can be made)

Other options besides allowing extra-billing

1. Expand inclusive prospective payment

- Regulations are needed because of fee-for-service payment**
- But expansion would require time: DRG-PPS like payment introduced for tertiary hospitals only in 2003**

2. Cut the global fee schedule rate

- Politically difficult: 2004 revision compromised at 0%**

3. Increase both the fees and the co-insurance rate for hospitals evaluated to be of high quality

4. Raise premiums

- Current levels lower than Germany even with tax subsidies**

Conclusion

- **Japan provides reasonably egalitarian health care at relatively low costs**
- **Economic recession has increased pressures**
- **Pro-market forces tried to deregulate the restrictions imposed by the fee schedule**
- **They did not succeed but will keep trying**
- **Opening the door to a tiered system is likely to come under the banner of offering more choice, rather than explicitly stating that the ability and willingness to pay should determine the quantity and quality of health care**



Billing of Medical Services and the Financial Burden of Patients in Korea

Keio University, Tokyo
June 2005

Soonman KWON, Ph.D.
Head
Dept. of Health Policy & Management
Seoul National University, Korea



➤ **OUTLINE of Presentation**

- 1. Health Care Financing in Korea**
- 2. Billing of Medical Services**
- 3. Empirical Evidence on the Out-of-Pocket Payment by Patients**
- 4. Impact on Equity**
- 5. Concluding Remarks**

I. Health Care Financing

Universal Coverage of population since 1989

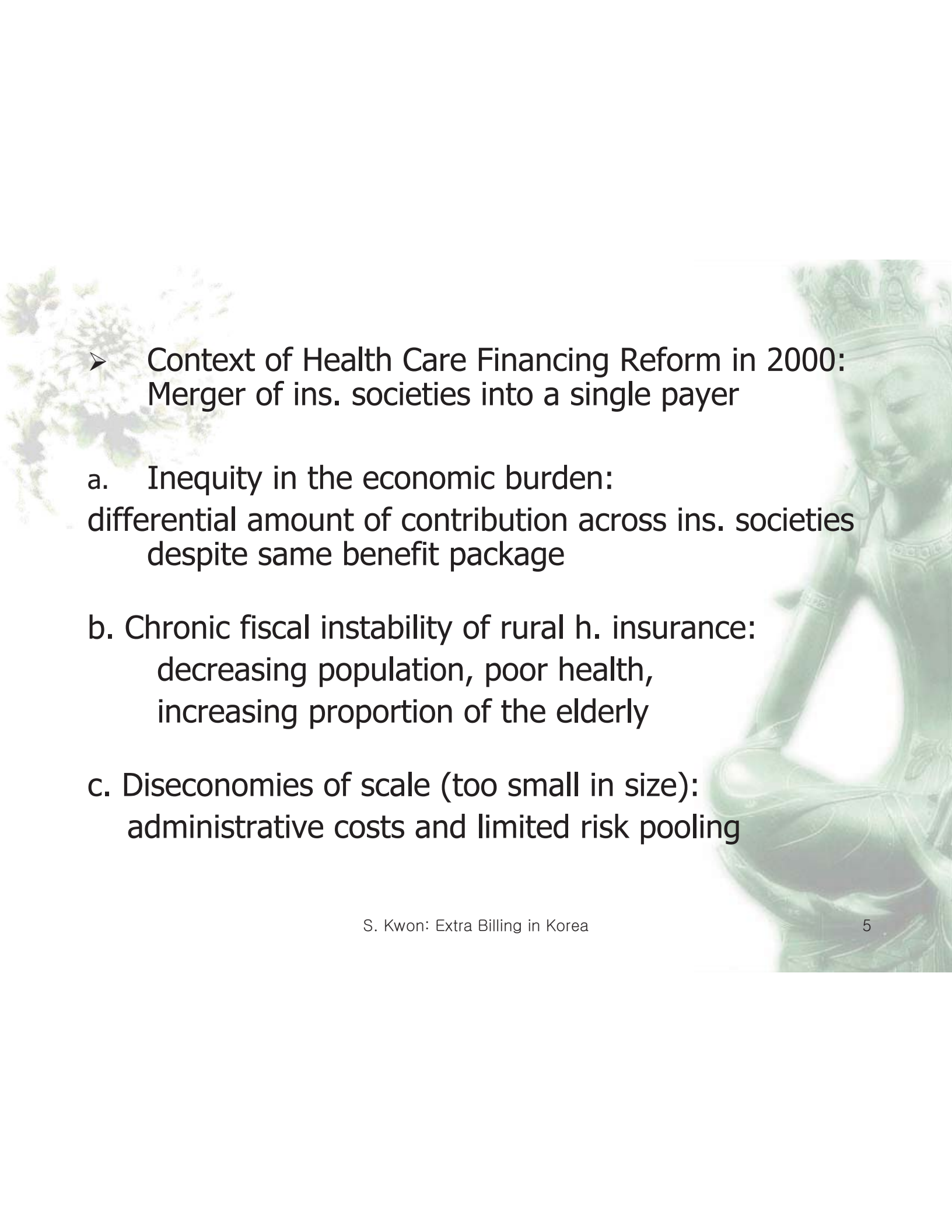
- Before 2000, NHI consisted of over 350 insurance societies (no consumer choice) for
 - industrial workers (36.0% of pop) : based on employment (firm-based)
 - self-employed (50.1%) : based on regions (regional)
 - public and school employees (10.4%): nationwide

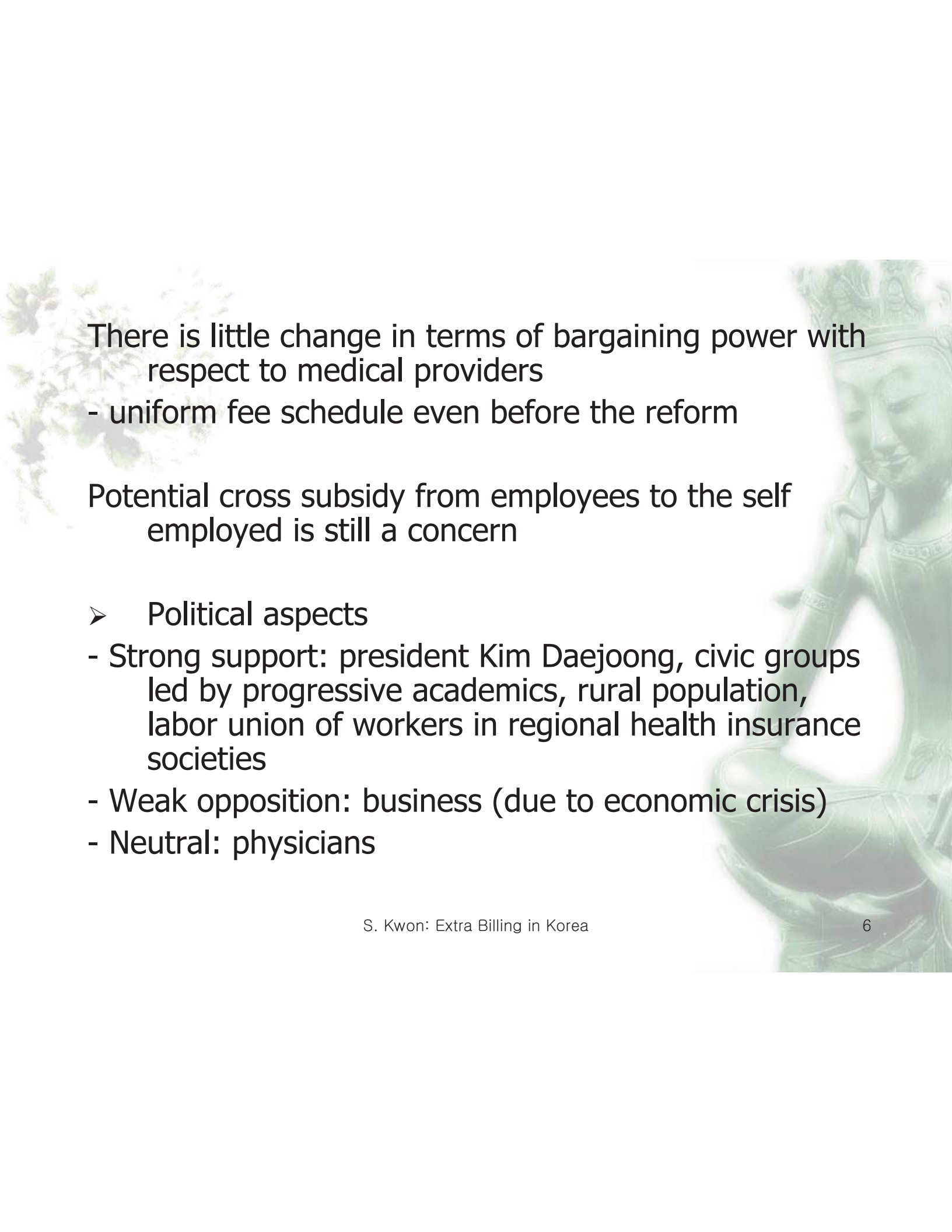
Public-Private Mix in the National Health Expenditure

(Unit: %)

| | 1989 | 1991 | 1993 | 1995 | 1997 | 1999 | 2000 | 2001 |
|----------------------|------|------|------|------|------|------|------|------|
| Government | 8.4 | 7.9 | 8.1 | 9.7 | 10.5 | 11.6 | 11.1 | 10.9 |
| Soc. Ins. | 24.7 | 26.2 | 27.0 | 28.4 | 32.9 | 34.2 | 36.5 | 43.5 |
| Public Total | 33.0 | 34.1 | 35.1 | 38.1 | 43.4 | 45.9 | 47.6 | 54.4 |
| Household | 58.3 | 57.7 | 55.7 | 52.2 | 47.4 | 44.6 | 43.0 | 37.3 |
| Priv. Ins. | 2.9 | 2.8 | 2.9 | 2.6 | 2.5 | 2.7 | 2.9 | 2.2 |
| Others | 5.7 | 5.4 | 6.3 | 7.1 | 6.6 | 6.8 | 6.5 | 6.1 |
| Private Total | 67.0 | 65.9 | 64.9 | 61.9 | 56.6 | 54.1 | 52.4 | 45.6 |

Source: OECD, OECD Health Data 2004

- 
- Context of Health Care Financing Reform in 2000:
Merger of ins. societies into a single payer
 - a. Inequity in the economic burden:
differential amount of contribution across ins. societies
despite same benefit package
 - b. Chronic fiscal instability of rural h. insurance:
decreasing population, poor health,
increasing proportion of the elderly
 - c. Diseconomies of scale (too small in size):
administrative costs and limited risk pooling



There is little change in terms of bargaining power with respect to medical providers

- uniform fee schedule even before the reform

Potential cross subsidy from employees to the self employed is still a concern

➤ Political aspects

- Strong support: president Kim Daejoong, civic groups led by progressive academics, rural population, labor union of workers in regional health insurance societies
- Weak opposition: business (due to economic crisis)
- Neutral: physicians

II. Billing of Medical Services

- For covered services, coinsurance rate is uniformly
 - 20% for inpatient care
 - 40-50% for outpatient care in hospitals
 - 30% for outpatient care [\$3] in physician clinics when total expense per visit is above [below] \$15

Discounted copayment for outpatient: elderly, patients with chronic and catastrophic conditions

Exemptions of copayment: poor people in the Medical Aid program

Ceiling on out-of-pocket payment for covered services: \$2,500 for 6 months


- 
- Physicians can *extra bill* patients for uncovered medical services and drugs

Patients pay copayment for NHI-covered services and full payment for uncovered services within a same episode of medical care utilization

-> Existence of private market (uncovered services)

Informed choice by consumers on different types of covered and uncovered services is difficult

- Information asymmetry, consumer ignorance
- Financial incentive (under Fee-for-service) of physicians

- 
- Extension of benefit coverage by NHI has often been accompanied by a rapid introduction of new (and uncovered) services by providers
 - > Expansion of private market, in which physicians are not subject to fee regulation

Physicians can easily persuade patients to use more of uncovered services by distorting information on cost effectiveness

Government policy on NHI has limited impact because physicians substitute uncovered services for covered ones, when regulation on covered service is tightened



➤ Typical types of uncovered services

- Uncovered medical services and drugs
- Meals
- Extra charge for rooms with less than 6 persons
- Some high-tech services (e.g., ultrasound)
- Extra charge for hospital specialists with more than 10 years of experience after board certification

III. Empirical Evidence on Out-of-Pocket Payment

- Out-of-pocket (direct) payment 43.6% on average: copayment for covered services 22.3%, payment for uncovered services 20.2%, full payment for covered services 1.1%

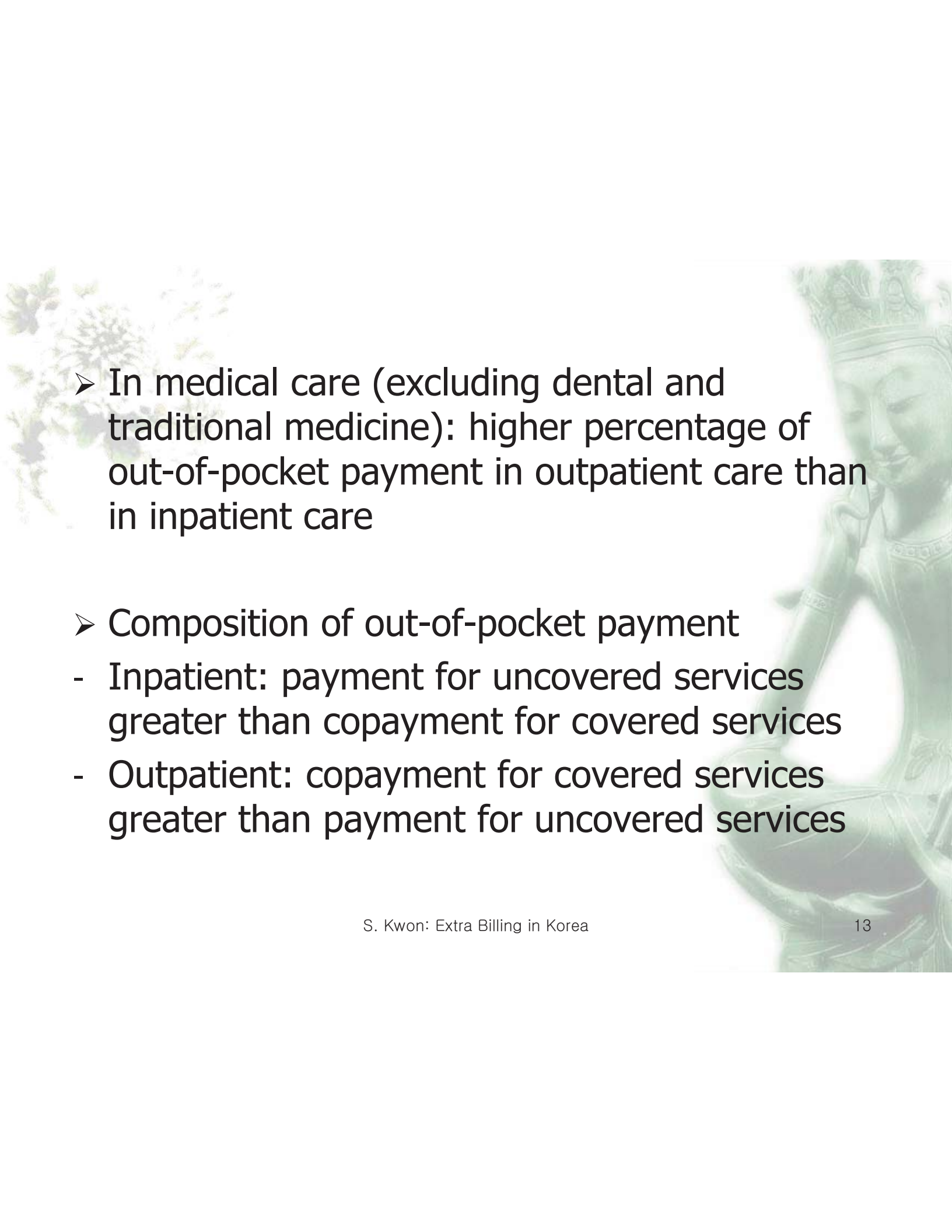
Higher proportion of direct payment in dental care and traditional medicine

The larger the type of health care organization, the greater the percentage of out-of-pocket payment by patients

Out-of-Pocket Payment by the Type of Health Care Institutions (All)

(Unit: %)

| Type of Health Care Institutions | Paid by the Insurer | Out-of-pocket Payment by the Patient | | | |
|----------------------------------|---------------------|--------------------------------------|--------------------------------|----------------------------|-----------------------------|
| | | Sub total | Copayment for Covered Services | Payment Uncovered Services | Full Copay Covered Services |
| AVERAGE | 56.4 | 43.6 | 22.3 | 20.2 | 1.1 |
| Tertiary Care Hospital | 43.8 | 56.2 | 20.8 | 32.7 | 2.7 |
| General Hospital | 51.7 | 48.3 | 22.6 | 23.9 | 1.8 |
| Hospital | 51.6 | 48.4 | 22.8 | 24.0 | 1.6 |
| Clinic | 67.5 | 32.5 | 24.3 | 8.1 | 0.1 |
| Dental Hospital | 22.2 | 77.8 | 16.9 | 60.9 | 0.0 |
| Dental Clinic | 38.3 | 61.7 | 15.6 | 45.8 | 0.3 |
| Trad Med Hosp | 20.6 | 79.4 | 9.4 | 69.7 | 0.3 |
| Trad Med Clinic | 66.4 | 33.6 | 19.5 | 14.1 | 0.0 |

- 
- In medical care (excluding dental and traditional medicine): higher percentage of out-of-pocket payment in outpatient care than in inpatient care

 - Composition of out-of-pocket payment
 - Inpatient: payment for uncovered services greater than copayment for covered services
 - Outpatient: copayment for covered services greater than payment for uncovered services

Out-of-Pocket Payment by the Type of Health Care Institutions (Inpatient)

(Unit: %)

| Type of Health Care Institutions | Paid by the Insurer | Out-of-pocket Payment by the Patient | | | |
|----------------------------------|---------------------|--------------------------------------|--------------------------------|--------------------------|-----------------------------|
| | | Sub total | Copayment for Covered Services | Payment Uncov'd Services | Full Copay Covered Services |
| AVERAGE | 54.9 | 45.1 | 16.3 | 26.5 | 2.3 |
| Tertiary Care Hospital | 48.0 | 52.0 | 14.0 | 34.7 | 3.3 |
| General Hospital | 57.0 | 43.0 | 17.5 | 23.4 | 2.1 |
| Hospital | 54.3 | 45.7 | 18.8 | 25.3 | 1.6 |
| Clinic | 72.1 | 27.9 | 17.8 | 9.6 | 0.5 |
| Trad Med Hosp | 31.4 | 68.6 | 11.4 | 57.2 | 0.0 |

Out-of-Pocket Payment by the Type of Health Care Institutions (Outpatient)

(Unit: %)

| Type of Health Care Institutions | Paid by the Insurer | Out-of-pocket Payment by the Patient | | | |
|----------------------------------|---------------------|--------------------------------------|--------------------------------|--------------------------|-----------------------------|
| | | Sub total | Copayment for Covered Services | Payment Uncov'd Services | Full Copay Covered Services |
| AVERAGE | 56.9 | 43.1 | 26.0 | 16.7 | 0.4 |
| Tertiary C. Hosp | 36.0 | 64.0 | 33.5 | 28.9 | 1.6 |
| General Hospital | 40.1 | 59.9 | 33.6 | 25.0 | 1.3 |
| Hospital | 48.7 | 51.3 | 27.2 | 22.6 | 1.5 |
| Clinic | 66.4 | 33.6 | 25.9 | 7.7 | 0.0 |
| Dental Hospital | 22.2 | 77.8 | 16.9 | 60.9 | 0.0 |
| Dental Clinic | 38.3 | 61.7 | 15.6 | 45.8 | 0.3 |
| Trad Med Hosp | 14.2 | 85.8 | 8.1 | 77.3 | 0.4 |
| Trad Med Clinic | 66.4 | 33.6 | 19.5 | 14.1 | 0.0 |



➤ Payment for Uncovered Services

Inpatient: extra charge for rooms, pay for meals, specialist charge

Outpatient: medical technology, tests

Big financial burden of patients due to specialist charge in tertiary care hospitals

Payment for Uncovered Services in the Inpatient Care

(Unit: %)

| | Extra Chg Room | Meals | Injection | Surgey | Test | M | Ultra Rsound I d | Materials | Special ist Chg | Othe r | Total |
|---------------------------|----------------|-------------|------------|------------|------------|------------|------------------|------------|-----------------|-------------|--------------|
| AVERAG E | 23.5 | 20.7 | 6.7 | 3.6 | 5.2 | 5.4 | 11.0 | 5.1 | 13.1 | 5.8 | 100.0 |
| Tertiary Care Hosp | 28.8 | 9.9 | 6.2 | 2.3 | 5.6 | 6.4 | 5.4 | 6.0 | 25.4 | 3.8 | 100.0 |
| General Hospital | 23.4 | 27.3 | 8.0 | 3.1 | 3.5 | 5.9 | 5.3 | 6.9 | 10.2 | 6.5 | 100.0 |
| Hospital | 22.3 | 33.8 | 6.6 | 8.2 | 7.2 | 6.2 | 2.2 | 3.1 | 0.0 | 10.3 | 100.0 |
| Clinic | 9.2 | 19.5 | 4.9 | 3.0 | 5.9 | 0.0 | 54.9 | 0.5 | 0.0 | 2.1 | 100.0 |
| Trad Med Hospital | 17.1 | 23.7 | 1.0 | 3.5 | 0.6 | 0.7 | 0.1 | 0.2 | 6.8 | 46.4 | 100.0 |

Payment for Uncovered Services in the Outpatient Care

(Unit: %)

| | Drug | Injection | Test | Radiology | CT | MR I | Ultrasound | Materials | Specialist Charge | Others | Total |
|--------------------------|-------------|-------------|-------------|------------|------------|-------------|-------------|-------------|-------------------|-------------|--------------|
| AVG | 5.1 | 10.3 | 18.8 | 3.3 | 3.7 | 5.6 | 24.4 | 9.3 | 3.2 | 16.3 | 100.0 |
| Tert. Hosp | 0.9 | 4.5 | 11.1 | 1.6 | 0.3 | 18.3 | 25.1 | 5.9 | 23.3 | 9. | 100.0 |
| General Hospital | 1.0 | 3.5 | 11.7 | 1.4 | 1.9 | 27.1 | 34.3 | 5.3 | 4.3 | 9.6 | 100.0 |
| Hospital | 0.3 | 13.2 | 21.3 | 2.0 | 1.8 | 18.3 | 20.4 | 0.9 | 5.3 | 16.4 | 100.0 |
| Clinic | 1.6 | 15.6 | 27.4 | 5.1 | 5.9 | 0.0 | 30.6 | 0.9 | 0.0 | 12.8 | 100.0 |
| Dental Hospital | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 76.6 | 0.0 | 23.2 | 100.0 |
| Dental Clinic | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 84.5 | 0.0 | 15.4 | 100.0 |
| Trad Med Hospital | 62.8 | 0.0 | 1.8 | 0.0 | 0.0 | 0.0 | 0.4 | 0.0 | 3.8 | 31.0 | 100.0 |
| Trad Med Clinic | 43.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 10.9 | 100.0 |

Source: Kim, J. and J.-C. Chung, 2005

IV. Impact on Equity

1. Financial Risk Protection

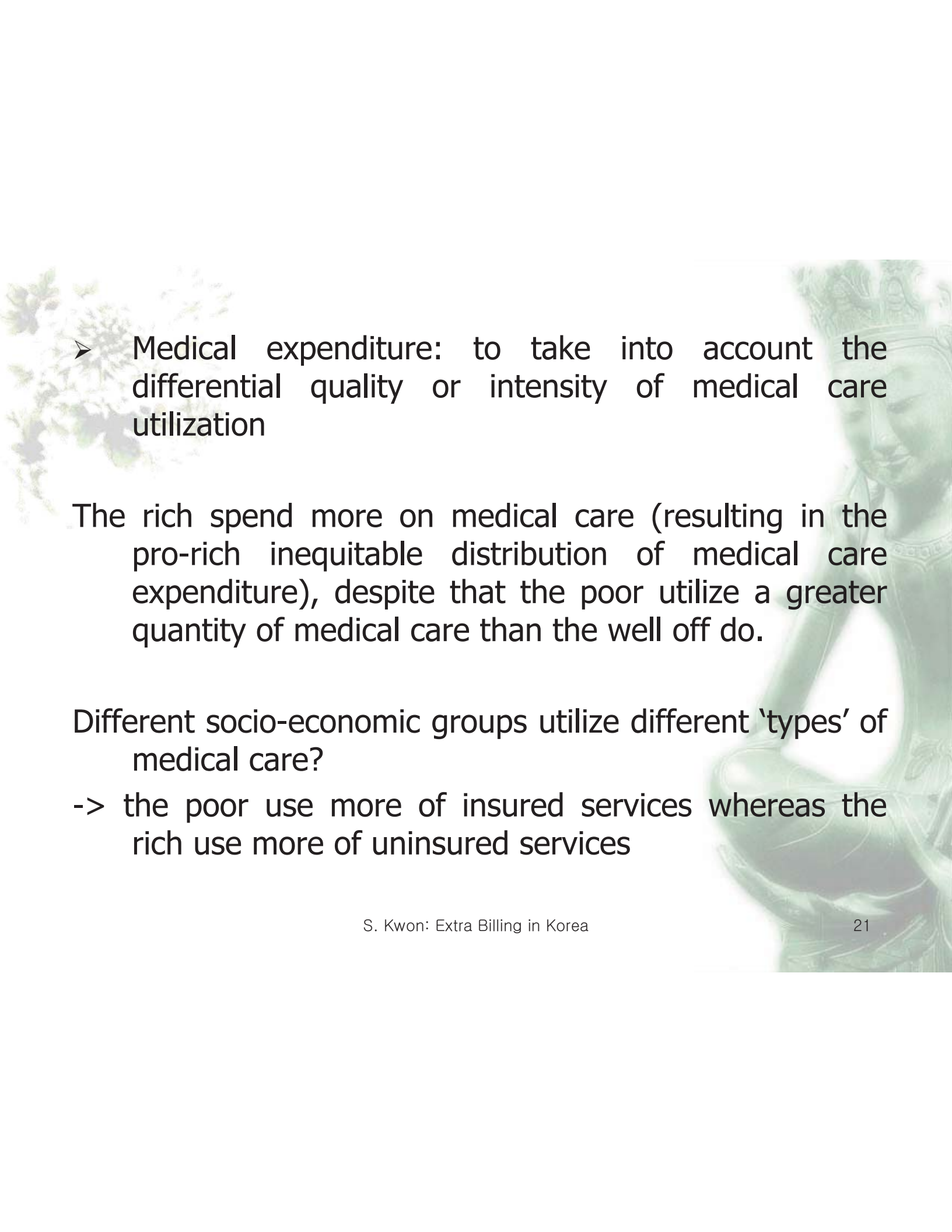
- Medical care expenditure does not lead to a substantial impoverishment of household in spite of high out-of-pocket payment
- Despite the high 'percentage' of out-of-pocket payment, its absolute amount may not be a big financial burden on patients thanks to fee regulation (of insured services)
- Social protection for the poor: poor people (3-4% of population) do not pay contribution. Half of them do not pay copayment for insured services, and the other half pay discounted copayment

2. Equity in Medical Care Utilization

Utilization of outpatient care, number of outpatient visits, is equitable (favorable for the poor even after taking into account medical care needs/health status)

Utilization of inpatient care, number of inpatient days, is equitable for the poor.

- Pro-poor (equitable) distribution of medical care utilization after controlling for medical care needs is a bit unexpected because of the high out-of-pocket payment at the point of service

- 
- Medical expenditure: to take into account the differential quality or intensity of medical care utilization

The rich spend more on medical care (resulting in the pro-rich inequitable distribution of medical care expenditure), despite that the poor utilize a greater quantity of medical care than the well off do.

Different socio-economic groups utilize different 'types' of medical care?

- > the poor use more of insured services whereas the rich use more of uninsured services

V. Concluding Remarks

- Extra billing for uncovered services has contributed to the expansion of private market for medical care in Korea -> irrational utilization or overprovision and serious financial burden on patients

- Political feasibility to limit the extra billing?
 - When many services remain uncovered, ban on extra billing would limit the access to necessary care.
 - Public debate on how NHI can increase contribution and extend its benefit coverage
 - Restructuring of benefit package?: reduce cost sharing for minor cases and increase cost sharing for catastrophic cases

THANK YOU !!!



Prof. Soonman Kwon

kwons@snu.ac.kr (Seoul National Univ.)

<http://plaza.snu.ac.kr/~kwons> (Homepage)



**International Seminar on Reforming Health
Social Security**

27 - 29 June 2005, Tokyo

**Financing Long-term Care:
Lessons from 19 OECD
Countries**

Manfred Huber, Health Division
OECD, Directorate for Employment, Labour and
Social Affairs



Overview of presentation

- Introduction
- A snapshot of current spending and care provision
- How to make funding for long-term care sustainable?
- Conclusions
- Where to find more information



OECD Long-term Care Study (2002-2004)

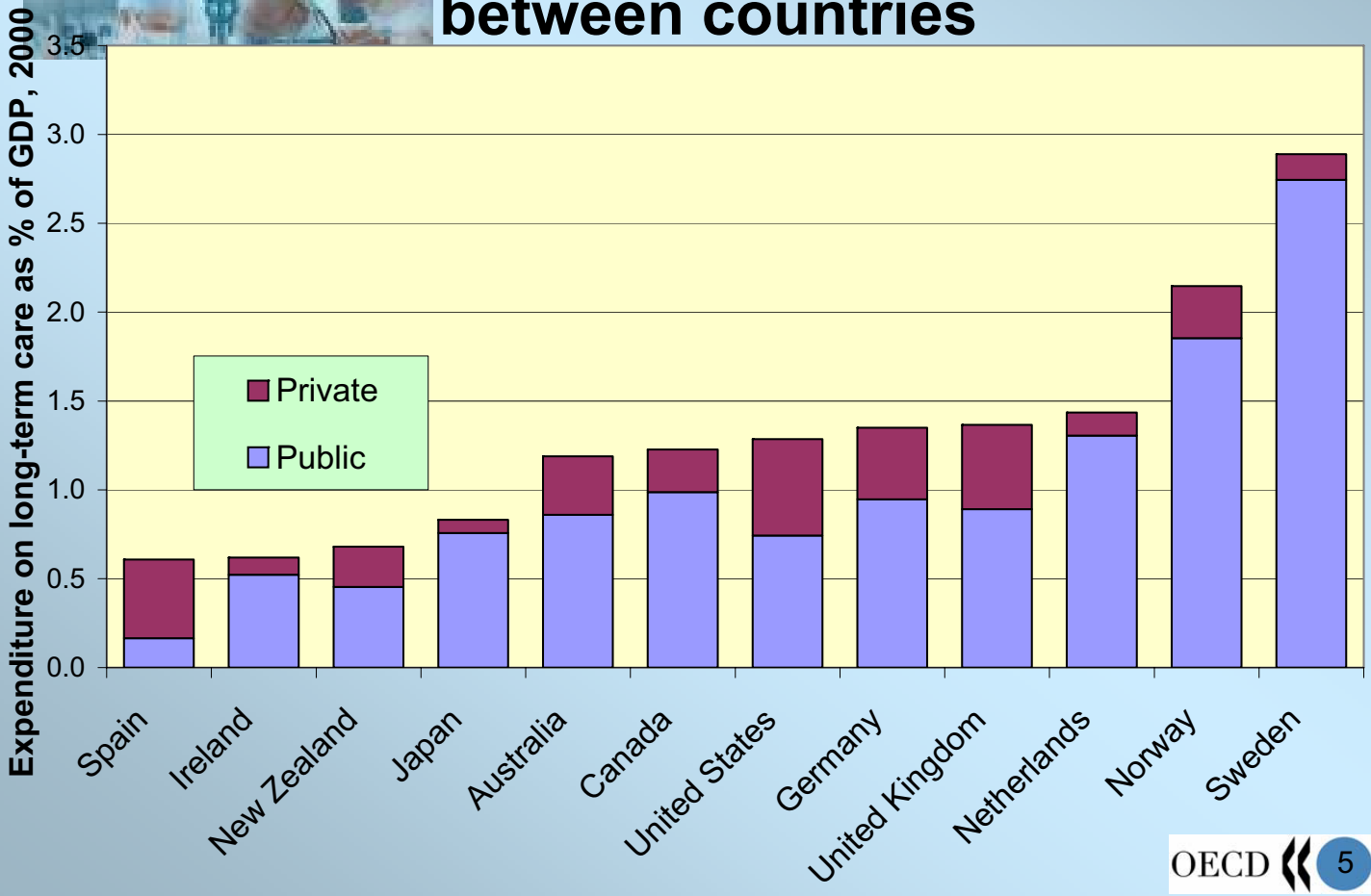
- Nineteen countries: Australia, Austria, Canada, Germany, Hungary, Ireland, Japan, Korea, Luxemburg, Mexico, Netherlands, New Zealand, Norway, Poland, Spain, Sweden, Switzerland, United Kingdom, United States
- Focus: review of recent reform experience, continuum of care and innovative ways of supporting care at home (consumer choice, care allowances etc.), quality of care, cross-sectional data on expenditure and beneficiaries



Lessons from the OECD Long-term care study

A snapshot of current care provision

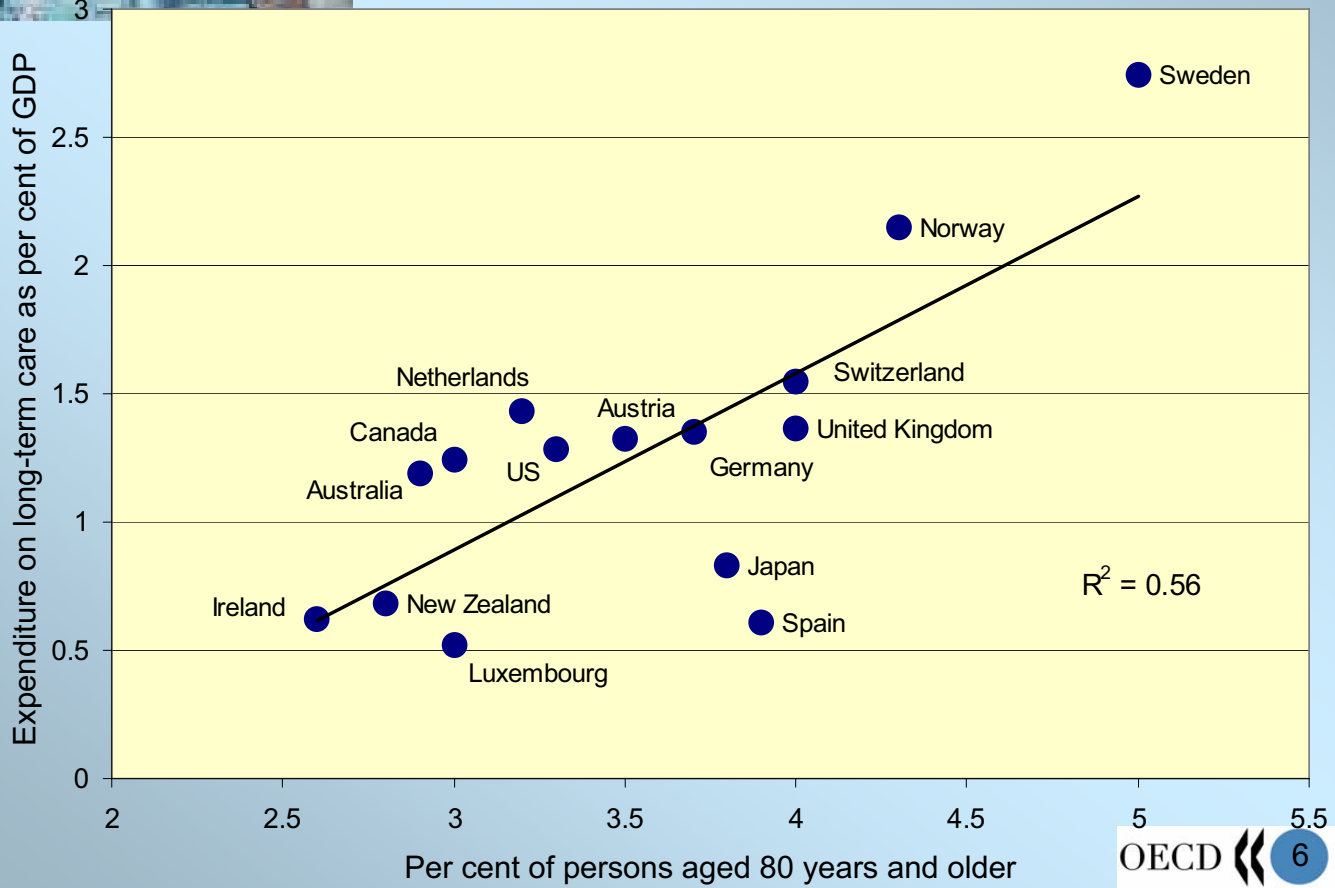
Large differences in public and private spending for long-term care between countries



Source: Long-term care for older people, OECD, forthcoming

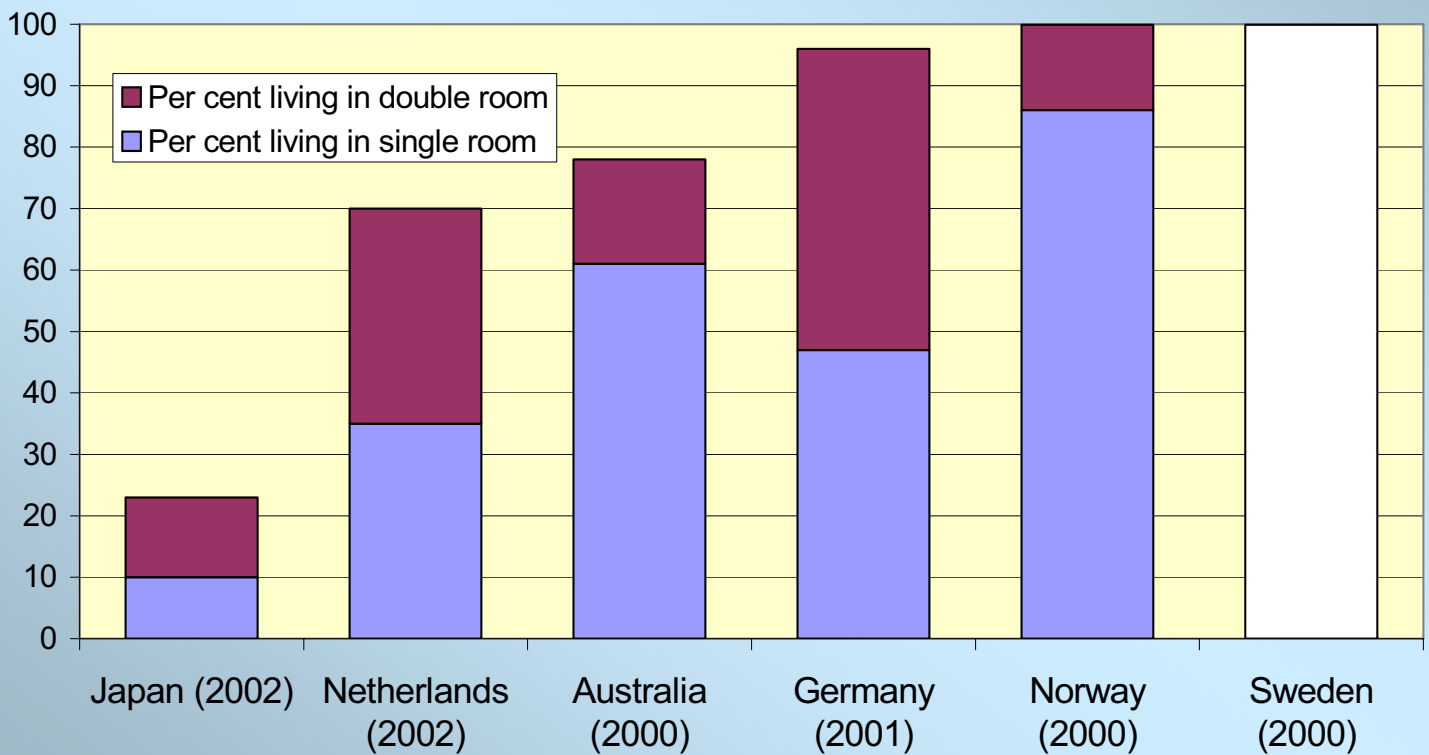


Correlation between LTC spending and ageing is weak: other factors play an important role



Source: Long-term care for older people, OECD, forthcoming

Quality of care has a price? Privacy in nursing homes: per cent living in single or double rooms





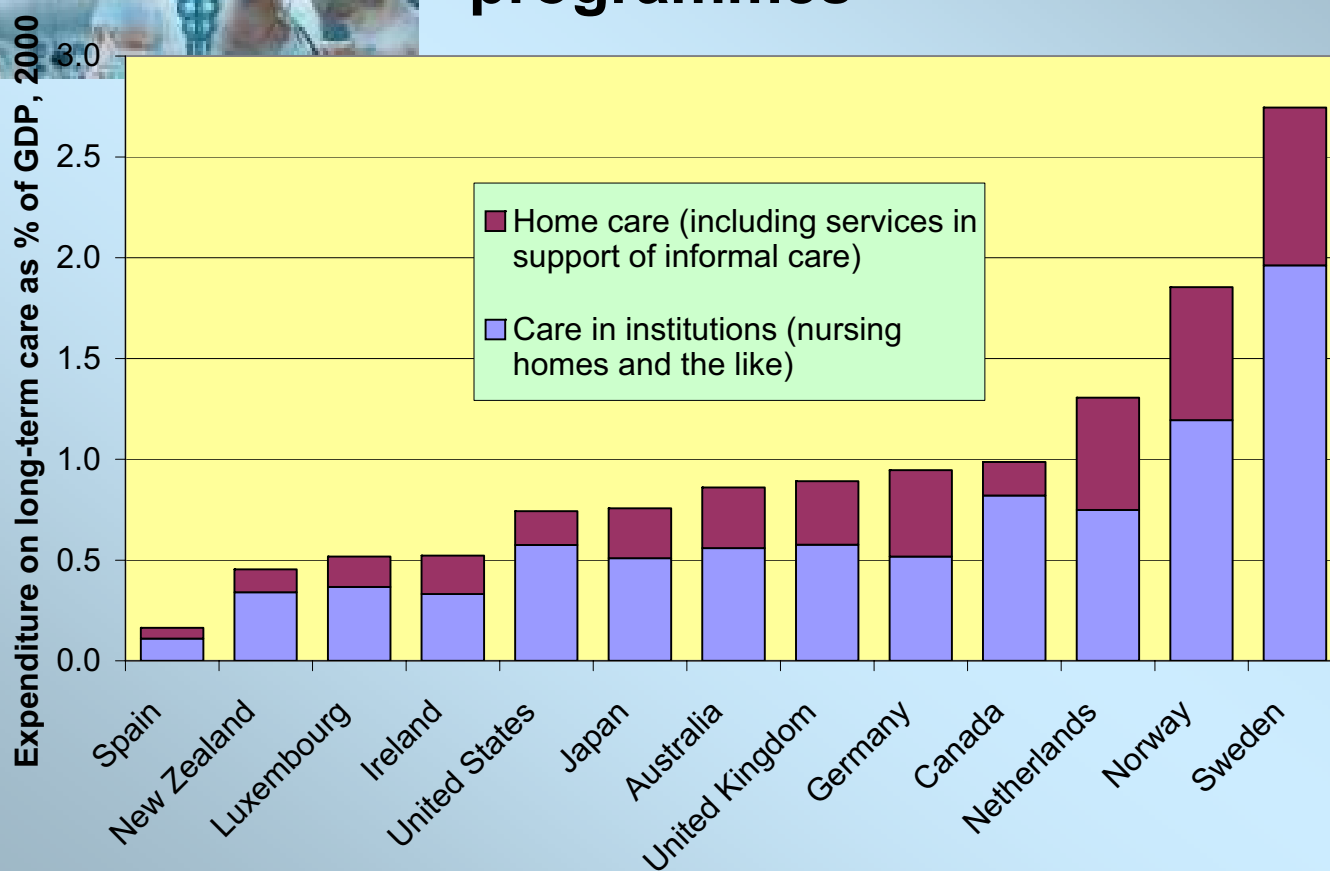
Lessons on likely future spending trends

- Need for improving the quality of long-term care services likely to be important driver of future cost
- Concerns about staff shortages raise questions about sustainability of current remuneration levels
- Several countries start from very low levels of public provision of services; considerable cost for “catching up”
- Family care will remain an important source of support raising a number of questions: Is there a larger number of older couples living together in the future? Medical progress with dementia care could change the picture substantially?



No place like home?

Home care important part of services under public programmes



Source: Long-term care for older people, OECD, forthcoming



Universal public schemes for funding long-term care are spreading

- Number of countries with universal public schemes to cover long-term care (Austria, Germany, Japan, Luxembourg, Netherlands) is growing
- ..providing coverage to the whole population
- ..and reducing the need for social assistance and means-testing.
- Universal schemes are driving forces of growth of private provider markets in these countries.
- Some other countries provide universal coverage through public services (e.g., Norway, Sweden)



Reforms of long-term care financing in countries with tax-funded services

- Reforms in Australia, New Zealand, Sweden, United Kingdom all aim at targeting more expensive services on those with most severe disabilities...
- ..and adjusting the level of personal contribution to achieve a “fairer” balance of public and private – but in Australia the personal share has gone up and in NZ and UK it has gone down..
- ..Australia, NZ, UK all accept means-testing to set the personal share – Sweden prefers to maintain universal scheme but with much tighter targeting



How to make funding for long-term care sustainable?



Conclusions: strategies to make long-term care financing more sustainable

- Putting the right mix of services in place today is essential..
- ..to ensure that high-quality services will be affordable in the future and contribution of informal care maintained at high levels
- Cost-pressures will continue and OECD countries will have to set more aside for long-term care services in the future



For further reading

- Long-Term Care for Older People, OECD, 2005 (forthcoming).
- HUBER, M. (2005, forthcoming), *Estimating expenditure on long-term care*, OECD Health Technical Papers (draft available at: <http://www.oecd.org/dataoecd/45/13/33833563.pdf>).
- HUBER, M. (2005, forthcoming), *Long-term care: services, eligibility and recipients*, OECD Health Working Papers, Paris.
- LUNDSGAARD, J. (2005), *Consumer direction and choice in long-term care for older persons. How can it help improve care outcomes, employment and fiscal sustainability?* OECD Health Working Papers, No.20, Paris.
- MOISE, P., M. SCHWARZINGER and M.-Y. UM, (2004), *Dementia Care in 9 OECD Countries: A comparative analysis*, OECD Health Working Papers No.13, OECD, Paris.



For further information

- For more information on the OECD's work on long-term care policy for older people, and ongoing work on long-term care data, please contact:
- Manfred Huber, e-mail: manfred.huber@oecd.org ;
- tel.: + 33 1 45 24 76 33.
- www.oecd.org/health/

Long-term care in Germany

**Public Symposium on Reforming Health Social Security
Tokyo, June 27-29, 2005**

Prof. Dr. Heinz Rothgang
University of Bremen

Contents

- I. Background: Long-term care insurance in Germany
- II. Provision of care
- III. Fiscal developments
- IV. Issues for reform and reform proposals
- V. Lessons from Germany?

I. Background: Long-term care insurance in Germany (1/4)

- Long-Term Care Insurance (LTCI) Act 1994 introduced:
 - a public LTCI for almost 90% of the population and
 - a mandatory private LTCI for the rest of the population.
- Financing in public LTCI:
 - Pay-as-you go system
 - Financing is solely based on contributions and interest from liquidity
 - Income-related contributions up to an income ceiling, paid by
 - employers and employees (50% each), exception: Saxony
 - pensioners (reduced from pension)
 - employment insurance for the unemployed
 - Contribution rate is legally fixed at 1.7% of contributory income
 - Contributory income relates solely to earnings and earning-related payments as pensions, unemployment benefits etc.

I. Background: Long-term care insurance in Germany (2/4)

- Administration by public LTCI funds
- Negotiations between LTCI funds and professional services to determine prices for formal care (home and nursing home)
- No age restriction to eligibility
- Amount of benefit is legally fixed and identical to all funds (as contribution rates) => no competition between funds
- Capped benefits, nominally fixed, without adjustment till today
 - means-tested social assistance as last resort, utilized by about 1/3 of all dependent persons in nursing home care
 - 10% of overall LTCI expenditure finance by social assistance
 - about one quarter of overall expenditure financed out-of-pocket

I. Background: Long-term care insurance in Germany (3/4)

- Three levels of dependency are distinguished
- Assessment by the medical service of LTCI funds.

Definition of levels of dependency

| | Level I | Level II | Level III |
|-------------------------------------|---|--|--|
| Need of care with basic ADLs | At least once a day with at least two bADL | At least thrice a day at different times of the day | Help must be available around the clock |
| Need of care with instrumental ADLs | More than once a week | More than once a week | More than once a week |
| Required time for help in total | At least 1.5 hours a day, with a least .75 hours for bADL | At least 3 hours a day with at least 2 hours for bADLs | At least 5 hours a day with at least 4 hours for bADLs |

Source: § 15 SGB XI.

I. Background: Long-term care insurance in Germany (4/4)

- Three types of capped benefits:
 - The use of cash benefits is to the beneficiary's discretion
 - In kind benefits can only be used for professional services
 - In nursing homes LTCI benefits are for care costs only, costs of accommodation and food are for inhabitants, investment should be financed by provinces

=> High co-payments in nursing home care (> 50%); implicit co-payment in home care because of loss of cash benefits

Amount of LTCI Benefits (major types of benefits)

| In Euro / month | Home care | | Day and night care | Nursing home care |
|-----------------|---------------|------------------|--------------------|-------------------|
| Grade | Cash benefits | In-kind benefits | In-kind benefits | In kind benefits |
| I | 205 | 384 | 384 | 1,023 |
| II | 410 | 921 | 921 | 1,279 |
| III | 665 | 1,432 | 1,432 | 1,432 |
| Special cases | | 1,918 | | 1,688 |

II. Provision of care

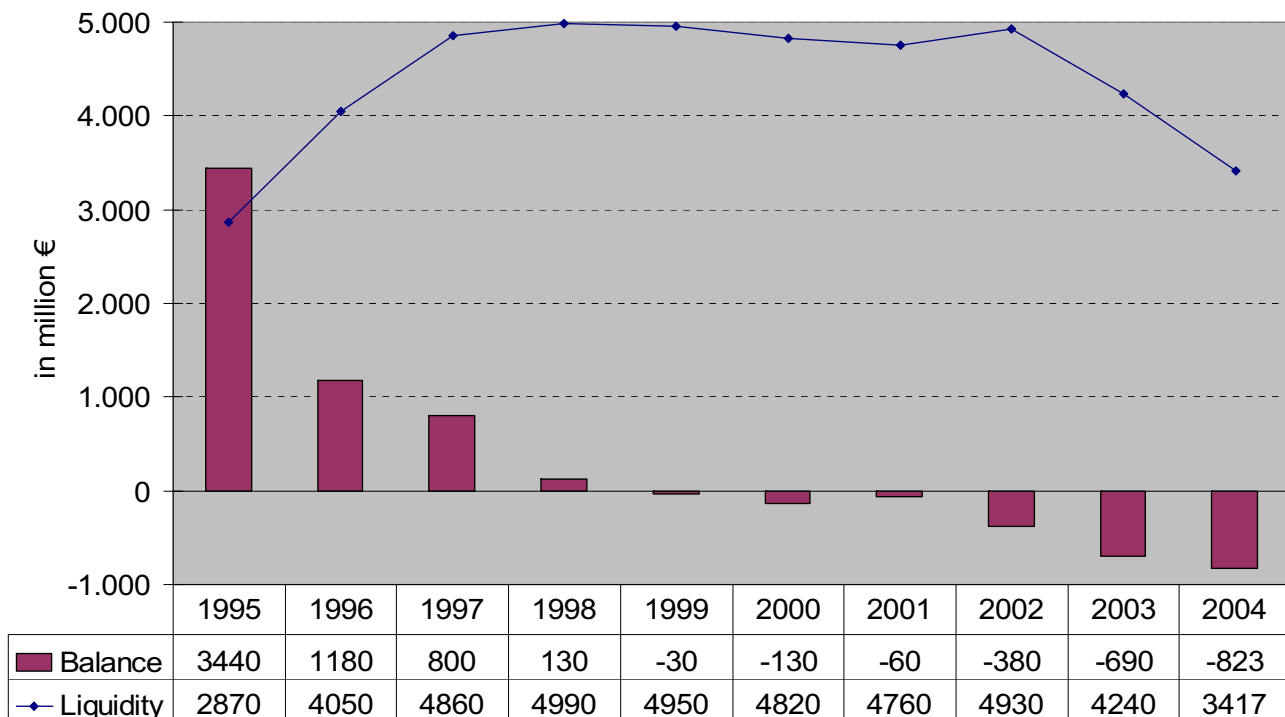
- Today
 - about one third of dependent elderly live in nursing homes
 - more than 70% in home care are cared for without formal care services being involved
- Over the last decade: moderate, but constant shift
 - from home care to nursing home care
 - from informal to formal care among those in home care

These trends are expected to continue.
- The share of dependent persons in low levels of dependency has increased. As there is no medical reason for such an development this indicates tougher assessments.
- The capacity of the formal care sector has increased and is still increasing in nursing home care.

III. Fiscal developments (1/5)

- Starting with high surpluses the system has produced increasing deficits over the last years.

Balance sheet of public LTCI



III. Fiscal developments (2/5)

- From 1997-2004 the number of beneficiaries has been growing by an average annual rate of 2.0%
- This led to an annual growth rate of expenditure of 2.2%, which must be considered as moderate.
- Contributions have been growing at an annual rate of 0.8%. This is below inflation and leads to decreasing contributions in real terms
- Thus, the system is out of balance despite of efficient cost control, because of an implosion of contributions.

III. Fiscal developments (3/5)

Growth Rates of Contributions and Expenditure



III. Fiscal developments (4/5)

- Reasons for moderate growth of expenditure in public LTCI
 - Tough assessment by Medical Service
 - Restricted definition of „dependency“
 - Capped benefits in LTCI
 - No adjustments to benefits
- „Price“ for moderate growth of expenditure in public LTCI
 - Discrimination of people with dementia
 - mixed financing (public and private)
 - still considerably role of social assistance
 - declining purchasing power of LTCI benefits, eventually leading to a delimitation of the system

III. Fiscal developments (5/5)

Reasons for unsatisfactory development of contributions

- Changes in social law
 - reduced contributions from the unemployed (since 2000)
 - reduced contributions from employees with small income (Mini-Jobs and Midi-Jobs)
 - sacrificed contributions for pensions („Eichel-Rente“)
- Reduction in the number of jobs subject to social insurance contributions
- cyclical and structural unemployment
- low (if any) rises in wages and pensions

IV. Issues for reform and reform proposals (1/2)

- Reform debate relate to benefit structure and financing
- With respect to benefits reform proposals relate to
 - additional benefits for persons suffering from dementia
 - an equalization of benefits for formal home care and nursing home care to reduce nursing home care particularly in level I

Both are likely to be implemented after the general election.

- The budgets can be balanced by
 - tightening of eligibility criteria and assessment
 - cuts in the benefits per case
 - additional revenue
- Since the former roads have been explored exhaustively already, future reforms concentrate on the latter.

IV. Issues for reform and reform proposals (2/2)

- The transformation of existing LTCl into either a tax-financed system or a funded private system is unlikely.
- The integration of LTCl and health insurance is also unlikely as it would not generate new revenue.
- Future reforms are likely to contain some of three elements
 - The introduction of an additional contribution for pensioners
 - the extension of the system to the good risks which are outside now
 - the introduction of a supplementary mandatory LTCl, which would fill the gap between social LTCl benefits which remain frozen and growing prices for services.
- Christian Democrats who are likely to form the incoming government seem to favour the latter in particular.

V. Lessons from Germany? (1/3)

- Successes of the German LTCI
 - Immediate benefits for all people with dependency
 - Strengthening of family care particularly through care allowances
 - Reduction of fiscal burden for social assistance, reduction in number of beneficiaries of social assistance
 - Growing capacity of formal care sector, improvements in quality of formal care
 - Cost control of LTCI spending

V. Lessons from Germany? (2/2)

- Structural problems of service provision
 - Quality of care is still not satisfactory,
 - slow development of alternative care facilities (assisted living etc.)
 - too little rehabilitation for dependent elderly
 - breaks in the chain of care between institutions (hospitals, nursing homes, rehabilitation), no traject management, no case management
- Problems resulting from underfunding
 - narrow concept of dependency
=> neglecting of needs of communication etc.
 - neglection of particular needs for people with dementia
 - understaffing of residential homes
 - declining purchasing power of LTCl benefits
- (Too) slow growth of revenue => (growing) deficits of LTCl

V. Lessons from Germany? (3/3)

Generalisations

- Cash allowances can help to stabilize family care and thus expenditure
- Cost control is possible through
 - capped benefits and missing adjustment of these caps
 - assessment of dependency by agency financed by LTCI funds
- Cost control of this kind has its price:
 - high co-payments and substantial role of social assistance
 - declining purchasing power of LTCI benefits
- Cost control is not sufficient unless steady growth of revenue can be guaranteed.



Increasing Investment in the UK-NHS

By
Alan Maynard
University of York, England



Outline

1. Background
2. The goals of the “modernisation” of the NHS
3. The achievements
4. Some problems
5. Overview



Background :funding

- The National Health Service (NHS) was established in 1948 to allocate access to care on the basis of need, defined usually as patient ability to benefit per unit of cost or in relation to the relative cost effectiveness of competing interventions
- Care is provided “free” at the point of consumption with user charges only for pharmaceuticals and some dentistry
- The NHS is funded out of taxation (5% from user charges)



Background:provision

- Primary care is provided largely in group practices of general practitioners(GPs) and nurses.Thirty five per cent of GPs are salaried and the rest are self-employed.
- Most acute care is provided in public sector hospitals, with until recently only marginal use of private hospitals for elective care. Doctors are paid by salary
- The private insurance industry covers 12% of the population with a limited benefit package.



“Modernising” the NHS

- The Government published the NHS Plan in July 2000. It highlighted 4 problems:
 1. A lack of national standards
 2. Old fashioned demarcations between staff and barriers between services.
 3. A lack of clear incentives and levers to improve performance
 4. Overcentralisation and disempowered patients



Investment with reform

- The Prime Minister pledged sustained increases in investment in the NHS of over 7% annually until 2008 on the condition that the NHS “acted smarter” and reformed.
- The Department of Health sets standards, with inspection by the Healthcare Commission, the National Institute of Clinical Excellence (NICE) evaluates new technologies and the Modernisation Agency acts as a catalyst for change



Target setting

- In primary care, maximum waiting times for access to care have been set
- In elective hospital care, waiting times are being driven down progressively
- In major service areas (e.g cancer, heart, and elderly), National Service Frameworks have identified quality improvement targets
- All targets have to be met progressively at particular times and are incentivised by performance grading and incentives



Wait and Access Targets

| Table 1 Wait and Access Targets | | Delivery Date |
|--|--|----------------------|
| Hospital services | | |
| Maximum wait for inpatient treatment: 6 months | | End 2005 |
| Maximum wait for inpatient and day case: 3 months | | 2008 |
| Maximum wait for outpatient appointment: 3 months/13 weeks | | End 2005 |
| Maximum time from GP appointment to treatment: 18 weeks | | 2008 |
| Emergency care | | |
| Maximum wait in A&E: 4 hours | | End 2004 |
| 75% of emergency ambulance calls to be responded to within 8 minutes | | 2001 |
| Primary care | | |
| Guaranteed access to primary care professional within 24 hours | | 2004 |
| Guaranteed access to primary care doctor within 48 hours | | 2004 |



Achievements

- Waiting times have been driven down for elective and some emergency procedures. Median and mean wait times have fallen more slowly as management effort has focused on “tail gunning” the longer waits
- Quality standards (e.g delivery time for thrombolytics) have improved but much remains to be done in areas such as the better development of specialised stroke services that are demonstrably cost effective



Incentives:some examples

1. Performance rating of hospitals: three star hospitals get financial rewards and kudos, with those getting 0 and 1 stars facing management change and supervision
2. Chief Executives reviewed in relation to performance targets and may lose their jobs if they fail
3. New GP contract offers generous additional fees for service for 10 performance targets e.g hypertension control



Lessons to be learnt 1

- NHS Plan is ambitious and has fuelled expectations of rapid change , rather than a slow, sustained and uneven improvement
- Even with high levels of NHS activity, there is insufficient capacity to deliver the targets
- This has led to the channelling of funding to the private sector to complement NHS capacity, particularly in elective and diagnostic sectors (15% of capacity in 2008)



Lessons to be learnt 2

- The inelasticity of supply particularly for physicians and even for experienced nurses who can be delegated physicians' roles, has led to labour shortages
- Changes in skill mix (e.g nurses taking on physicians' tasks) is not well evidenced based but policy changes are radical with nurses increasingly doing prescribing of drugs, endoscopy, minor surgery and anaesthetics



Lessons to be learnt 3

- Acquisition of rents by some labour groups and the construction industry I.e the NHS Plan has increased prices with little volume and quality effect in some areas
- Technology assessment and rationing by the National Institute for Clinical Excellence (NICE) has been weak with a low cut-off level (£30,000 per Quality Adjusted Life Year or QALY)



Lessons to be learnt 4

- What is the goal of the NHS? Is it to:
 1. Improve the delivery of health care?
 2. Improve the health of the population?
- The political focus was initially on the improved **delivery of health care**. This is now shifting to a focus on **whether investing in health care improves the health of the population**



Lessons to be learnt 5

- Time to measure improvements in health, not with mortality data alone but with **patient reported outcome measures (PROM)**
- The Government plans to evaluate the performance of specialist NHS and private elective surgical units with either Short Form 36 or EQ5D. A commercial firm is now marketing these instruments to the NHS
- Such measures can be used for consumer protection and to evaluate physician performance



Overview 1

- Large increase in NHS funding 2000-2008
- To date some success in reducing waiting times for elective and, less so, diagnostic interventions. Patients to be given choice of providers as capacity rises
- Large increases in private sector provision of NHS care and changes in skill mix (deconstruction of medical tasks and delegation to other skill groups)



Overview 2

- Midway through a large social experiment with very limited evaluation
- Problems of rents for provider groups (physicians and the pharmaceutical industry) relatively poorly managed
- Care processes improving and increased pressure to measure success in terms of patient related outcomes



Challenges for Japan 1

- If Japan increased investment in health care, what lessons can be learnt from the UK?
 1. Increased investment marketed vigorously to society for electoral reasons but this raised short and medium term expectations which exceeded the capacity of the system to change, particularly in the short run



Challenges 2

- Short term inelasticity of supply, for instance physicians, leads to non-evidenced based use of other skill groups. Caution is needed!
- Rationing through technology assessment is economically essential and politically difficult to manage efficiently especially when funding is rising for a short period
- Increasing recognition of the need to establish “value for money” leads to PROM, which is welcome but surprising for some!



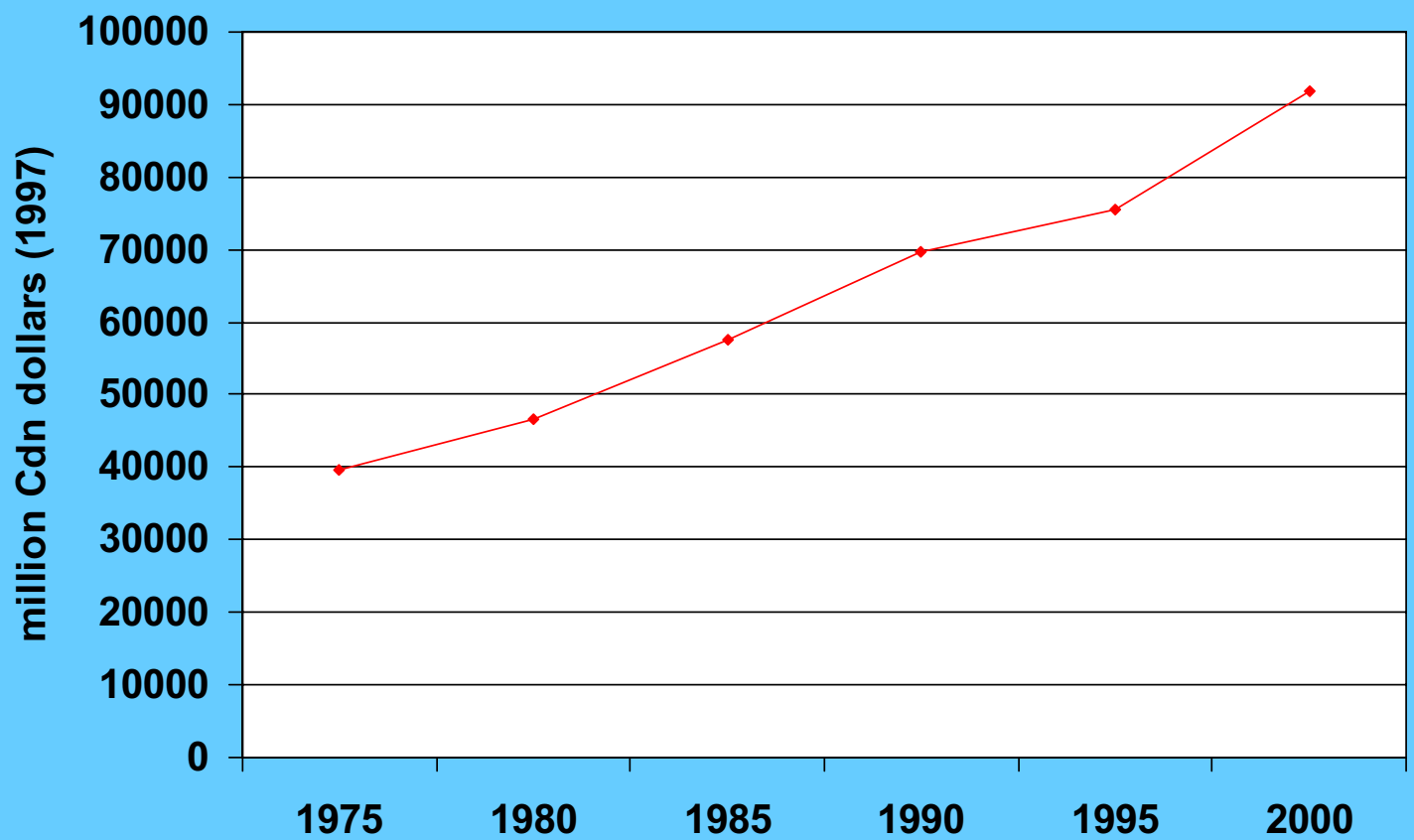
The Final Challenge

- Take care when increasing funding. The then President of the Royal College of Physicians criticised the Thatcher reforms as follows:
- “Instead of ready, take aim and fire, the Government chose the make ready, fire and then take aim”!
- This is a common tendency to be seen with all health care reform efforts internationally!

Federalism and Health Care Financing in Canada

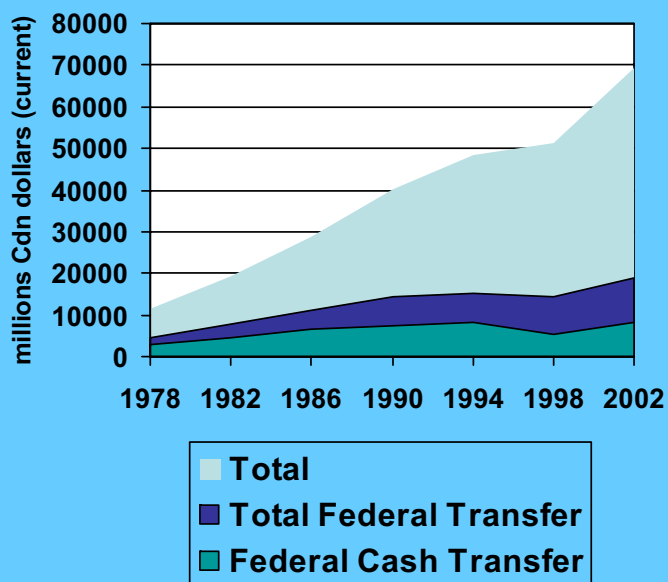
Joseph Wong, Ph.D.
Political Science
University of Toronto

Total Health Care Expenditure (1997 dollars)

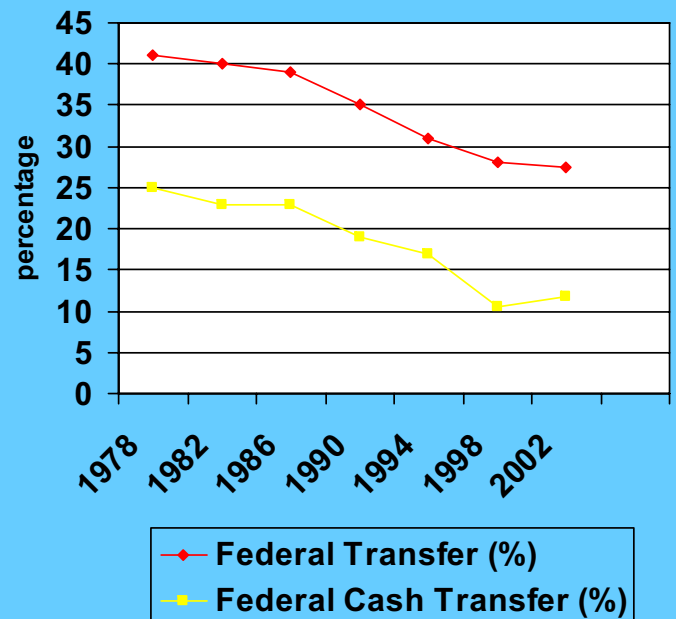


Federal Funding for Health

Federal Funding Share of Total Provincial-Territorial Health Spending, 1978-2002

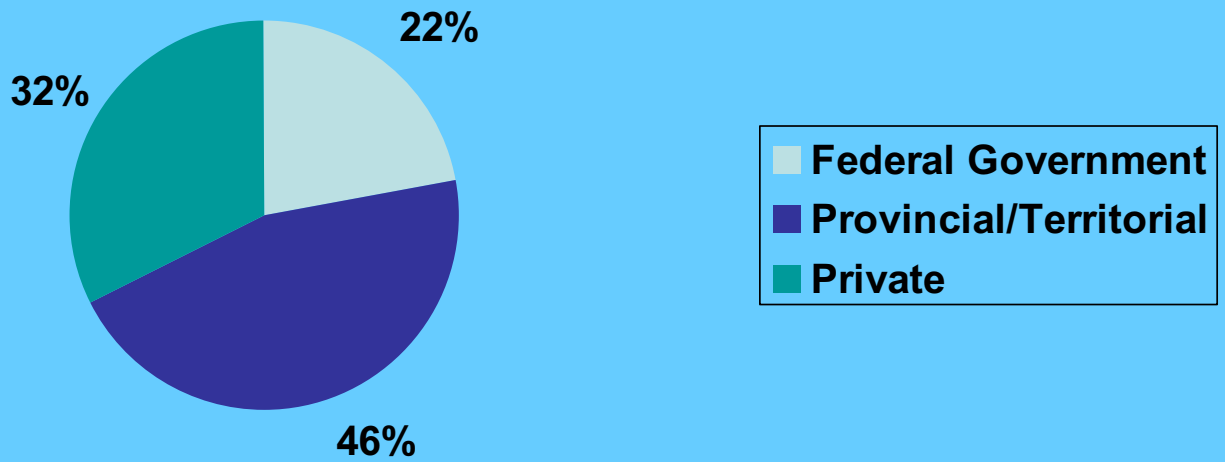


Federal Funding as % of P/T Health Spending, 1978-2002



The Global Picture

Health Financing, 2001-2002 (by source)



Federal Health (and Social) Cash Transfers to Provinces/Territories, 2000-2005

(millions Cdn dollars, current)

| | 2000-2001 | 2001-2002 | 2002-2003 | 2003-2004 | 2004-2005 |
|---------------------------|-----------|-----------|--------------|--------------|--------------|
| Federal Cash Transfer | 16000 | 18800 | <u>19100</u> | <u>22325</u> | <u>27005</u> |
| Rate of Growth | -- | 17.5% | <u>1.6%</u> | <u>16.9%</u> | <u>21%</u> |
| Public Health Expenditure | 68958 | 74590 | 79539 | 86034 | 91054 |
| Rate of Growth | -- | 8.2% | 6.6% | 8.2% | 5.8% |

Provincial Variation

| | population, 2004 | GDP per capita, 2003 |
|---------------|-------------------|-------------------------|
| Newfoundland | 517,000 | 35,266 |
| P.E.I. | <u>137,900</u> | <u>28,161</u> |
| Nova Scotia | 937,000 | 30,889 |
| New Bruns. | 751,400 | 29,896 |
| Quebec | 7,542,800 | 33,857 |
| Ontario | <u>12,392,700</u> | 40,344 |
| Manitoba | 1,170,300 | 32,695 |
| Saskatchewan | 995,400 | 36,765 |
| Alberta | 3,201,900 | <u>54,069</u> |
| B.C. | 4,196,400 | 35,043 |
| CANADA | 31,946,300 | 38,496 |

Federalism: Balancing Diversity and Uniformity

- de jure constitutional division of powers
 - de facto jurisdictional overlap

 - 1984 Canada Health Act
- centrality of federal spending power

Negotiating Crisis

Into the 1990s...

- fiscal crisis
- medicare crisis
- crisis of federalism

Into the 21st Century...

- 2002 Romanow Commission Report
- 2003 (Feb) Health Accord
- 2004 (Sept) Ten Year Plan

Explanation

1. fiscal surplus
2. political agenda setting
3. convergence of priorities

| 2003 Health Accord Proposed Spending | | | |
|---|---------------|-----------------------|-----------------|
| Investment | Amount | Fiscal Year(s) | Duration |
| Increase to CHST | \$9.5 billion | FY2003-2008 | 5 years |
| Romanow Gap | \$2.5 billion | FY2003-2004 | 1 year |
| Health Reform Fund | \$16 billion | FY2003-2008 | 5 years |
| Medical Equipment Fund | \$1.5 billion | FY2003-2004 | 1 year |
| Health Information Technology | \$600 million | FY2003-2004 | 1 year |
| Other Investments | \$1.6 billion | FY2003-2009 | 6 years |
| Other Investments (II) | \$1.3 billion | FY2003-2008 | 5 years |
| Aboriginal Health | \$1.3 billion | unspecified | -- |
| Research and Development | \$500 million | unspecified | -- |

| 2004 Ten Year Plan Proposed Spending | | | |
|---|-------------------|-----------------------|-----------------|
| Investment | Amount | Fiscal Year(s) | Duration |
| Canada Health Transfer Base | \$19 billion/year | FY 2005-2014 | 9 years |
| Additional Transfer | \$500 million | FY 2005-2006 | 1 year |
| Romanow Gap | \$3 billion | FY 2004-2006 | 2 years |
| Wait Times Reduction Fund (I) | \$4.5 billion | FY 2004-2010 | 6 years |
| Wait Times Reduction Fund (II) | \$1 billion | FY 2010-2014 | 4 years |
| Medical Equipment | \$500 million | FY 2004-2005 | 1 year |
| Aboriginal Health | \$700 million | unspecified | -- |

Appraisal

- new federal funds
- targeted funds
- accountability mechanisms
- policy space for bottom-up innovation

Making Federalism Work

- fiscal health
- goal oriented federalism
- collaborative federalism
- normative commitment to equity

| | population, 2004 | GDP per capita, 2003 | HCE per capita, 2002 | 65+ years (% of population), 2004 | HCE for 65+ years per capita |
|---------------|---------------------|-------------------------|---------------------------------|---|------------------------------------|
| Newfoundland | 517,000 | 35,266 | <u>2787</u> | 12.9 | <u>10331</u> |
| P.E.I. | <u>137,900</u> | <u>28,161</u> | 2518 | 13.9 | 7656 |
| Nova Scotia | 937,000 | 30,889 | 2205 | <u>14.1</u> | 7405 |
| New Bruns. | 751,400 | 29,896 | 2238 | 13.7 | 7427 |
| Quebec | 7,542,800 | 33,857 | <u>2135</u> | 13.5 | 7718 |
| Ontario | <u>12,392,700</u> | 40,344 | 2239 | 12.8 | 7328 |
| Manitoba | 1,170,300 | 32,695 | 2540 | 13.5 | 8207 |
| Saskatchewan | 995,400 | 36,765 | 2406 | 14.8 | <u>7220</u> |
| Alberta | 3,201,900 | <u>54,069</u> | 2482 | <u>10.4</u> | 8186 |
| B.C. | 4,196,400 | 35,043 | 2616 | 13.7 | 8299 |
| CANADA | 31,946,300 | 38,496 | 2321 | 13.0 | 7764 |

| Total Major Federal Transfers to Provinces, 2004-2005 (per capita) * | | |
|--|--|--|
| | Per Capita Transfer, 2004-2005 (in descending order) | Fiscal Capacity, 1999-2000 Index Average = 100 |
| P.E.I. | 2930 | 67 |
| New Brunswick | 2739 | 71 |
| Nova Scotia | 2455 | 74 |
| Newfoundland | 2449 | 61 |
| Manitoba | 2428 | 80 |
| Quebec | 1757 | 85 |
| British Columbia | 1383 | 99 |
| Saskatchewan | 1332 | 91 |
| Ontario | 1322 | 108 |
| Alberta | 1321 | 142 |

* CHT, CST, Health Reform Transfer, and Equalization

Challenges

1. fiscal health
2. maintaining political commitment
3. ensuring compliance
4. pathologies of benchmarking

Increasing Public Expenditures in Health Care

Discussion Topics

International Seminar on Reforming Health Social Security
June 28, 2005

Size of Spending Increases

- U.K.
- Canada
- How Reliable is the Governments' Commitment?

Three Basic Purposes for Increased Spending

- Investment for increased productivity (e.g., supposedly, information technology)
- “Investment” as labeling: simply a choice to buy more services
- Investment for deferred maintenance, to continue current level of services – or perhaps increase, but nowhere near as much as the spending might suggest.

Political Pressures for Increases

- Internal Pressures: What was new?
- External Comparisons: How did they matter?
- Which segments of government took the lead?

Who Decides How the Money Will be Spent?

- Politicians vs. Bureaucrats
- Policy-makers vs. Clinicians vs. Managers
- Levels of Government
- The role of “the public” or “the community”

How Will Spending Be Evaluated for Effectiveness or Value?

- Standards set in advance to guide decisions?
- Organizations given power to develop and/or apply standards? (e.g. NICE)
- Is language about cost-effectiveness, primary care, or other common goals of policy researchers seriously guiding decisions?

What Can Go Wrong?

- Rents
- Inability to expand services as quickly as can expand funding
- Targeting
- Others?

What Can Go Right?

- Response to public concerns
- Equity of Life Chances?
- Improved health status on average?

Are Canada and the U.K. Unusual?

- Level of prior spending constraint relative to politically obvious comparison countries
- Level of public dissatisfaction with previous system trends
- Public willingness to pay
- Extent to which system design allows policymakers to expand funding with some sense of what they might buy

Lessons for Japan and Other Countries

- Fill in This Box!

***HEALTH SYSTEM ISSUES, CHALLENGES,
AND OPTIONS: REFLECTIONS ON
CHINA- INDIA - KERALA***

K.MOHANDAS

DIRECTOR

**SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL
SCIENCES & TECHNOLOGY**

TRIVANDRUM

INDIA

CHAIRPERSON

ASSOCIATION OF COMMONWEALTH UNIVERSITIES

POST INDEPENDENT INDIA

FAILURE OF PUBLIC HEALTH CARE

A. RHETORIC NOT MATCHED BY ACTION

- FIVE YEAR PLANS EMPHASISED IMPORTANCE OF COMMUNITY CENTRED, QUALITY CARE AT AFFORDABLE COST FOR ALL - BUT FUNDS ALLOCATION PROGRESSIVELY DWINDLED FROM 3.3% TO ABOUT 1% CURRENTLY
- FAILURE TO MEET PLAN TARGETS WERE NOT PROPERLY ASSESSED & REMEDIED.

POST INDEPENDENT INDIA FAILURE OF PUBLIC HEALTH CARE

B. HEALTH CARE A STATE (PROVINCE)

SUBJECT → DIFFERENTIAL

IMPORTANCE & BUDGET ALLOCATION

IN THE ASBENCE OF STRONG NATIONAL POLICY

**C. NO EFFECTIVE GOVERNMENT REGULATION/
INTERVENTION OF PRIVATE SECTOR.**

HOSPITAL CARE

HEALTH CARE INDUSTRY

- DRUGS, DEVICES

**D. SKEWED, DISEASE CENTRIC
MEDICAL EDUCATION**

**E. FAILURE OF THE MEDIA TO EFFECTIVELY
HIGH LIGHT the ROLE & the RESPONSIBILITY OF
GOVERNMENT in HEALTH CARE**

THE WORSENING INEQUITY

- HEALTH CARE DELIVERY INSTITUTIONS
CONCENTRATED IN URBAN AREAS
- POORER HOUSE HOLDS MORE PRONE TO INEFFICIENT
HEALTH CARE
- HEALTH EXPENDITURE-
80% OUT OF POCKET
17% GOVERNMENT
- INSIGNIFICANT INSURANCE COVERAGE
- DOUBLE BURDEN OF DISEASE
COST OF CARE + LOSS OF LIVELY HOOD →
↑INDEBTNESS↑POVERTY
- EPIDEMIOLOGICAL TRANSITION
COMMUNICABLE & NON COMMUNICABLE
DISEASES COEXISTING
- DEMOGRAPHIC TRANSITION - ↑AGED
- FURTHER BURDEN ON HOUSE HOLD BUDGET OF THE
POOR
- NEW & REEMERGING DISEASES

WOES OF THE URBAN POOR

- 22% OF URBAN POPULATION LIVE IN SHANTY TOWNS
- POOR HOUSING & SANITARY CONDITIONS
- UNSAFE DRINKING WATER - AIR & NOISE POLLUTION
- CASTE & GENDER DISPARITIES
- LITTLE or NO SUPPORT SYSTEM AS MOST WORK IN THE UNORGANISED SECTOR
- HIGH COST OF CARE EVEN IN PUBLIC SECTOR

RURAL - URBAN DIVIDE

- BED-POPULATION RATIO SIGNIFICANTLY LOWER IN RURAL AREAS
- PUBLIC & PRIVATE HEALTH CARE DELIVERY INSTITUTIONS CONCENTRATED IN URBAN AREAS
- POOR QUALITY & UNCERTAIN AVAILABILITY OF HEALTH CARE
- FORCED TO SEEK CARE IN URBAN CENTRES
→ADDS TO OOP EXPANSES

MUSHROOMING OF PRIVATE PROVIDERS WITH QUESTIONABLE TRAINING /QUALIFICATIONS TO BRIDGE SUPPLY-DEMAND GAP

50 –70 % 'ILLEGAL PRACTITIONERS PROVIDING PRIMARY CARE

PRIVATE SECTOR

- HETEROGENEOUS
- FIVE STAR CORPORATE SECTOR HOSPITALS WITH STATE OF THE ART FACILITIES TO NURSING HOMES WITH A FEW BEDS, SUBSTANDARD PHYSICAL INFRASTRUCTURE, ABSENCE OF NURSES & TRAINED PERSONNEL AND POOR/ABSENT RECORD KEEPING
- HIGHLY QUALIFIED PRACTITIONERS TO POOR/UNQUALIFIED DOCTORS & 'CROSS OVER' PRACTITIONERS
- NEXUS BETWEEN GOVERNMENT DOCTORS - PRIVATE HOSPITALS - DIAGNOSTIC CENTRES

PRIVATE SECTOR THRIVES...

- DECLINING PUBLIC INVESTMENT IN HEALTH SECTOR
- WIDENING SUPPLY DEMAND GAP
- LONG WAITING LIST & INCONVENIENT TIMINGS OF PUBLIC HEALTH CARE CENTRES
- NON AVAILABILITY OF MEDICINES & TREATMENT FACILITIES
- RISING COST OF CARE IN PUBLIC SECTOR
- PERCEPTION OF DECLINING QUALITY OF CARE - DUE TO INEFFICIENCY & CORRUPTION IN PUBLIC INSTITUTIONS

Table:1 Public-Private Sector Utilisation for Outpatient Care: All-India
(Percentage distribution)

| | Rural | | Urban | |
|--|---------|---------|---------|---------|
| | 1986-87 | 1995-96 | 1986-87 | 1995-96 |
| Share of Public Sector | 25.6 | 19.0 | 27.2 | 19.0 |
| Share of Private Sector | 74.5 | 80.0 | 72.9 | 81.0 |
| Private hospitals | 15.2 | 12.0 | 16.2 | 16.0 |
| Private doctors (Private practitioners) | 53.0 | 55.0 | 51.8 | 55.0 |
| Others | 5.2 | 10.0 | 2.9 | 7.0 |
| Total | 100.1 | 99.0 | 100.0 | 100.0 |

Sources: Gita Sen et al 2002, NSSO 1992, Statements 13R and 13U, pp 67-68, Statement 2R and 2U, pp 53-54. NSSO1998, Table4.10, p22; Table4.16, p28.

Table: 2 Public-Private Sector Use for Inpatient Care: All-India

(Percentage distribution)

| | Rural | | Urban | |
|-------------------------|---------|---------|---------|---------|
| | 1986-87 | 1995-96 | 1986-87 | 1995-96 |
| Share of public sector | 59.7 | 45.2 | 60.3 | 43.1 |
| Share of private sector | 40.3 | 54.7 | 39.7 | 56.9 |
| Others | 1.7 | 0.8 | 1.2 | 0.6 |
| Total | 100.0 | 99.9 | 100.0 | 100.0 |

Sources: NSSO 1992, Statements 13R and 13U, pp 67-68, Statement 2R and 2U, pp 53-54. NSSO 1998, Table4 .10, p22; Table4.16, p28.

THE 1990s - FUTURE INCREASE IN INEQUITY

- PROPORTION OF HEALTH TO TOTAL GOVERNMENT EXPENDITURE FALLS FROM 7% to 5%
- INCREASE IN PER CAPITA ALLOCATION
- BUT RESOURCE DISTRIBUTION FAVOURS TERTIARY CARE AT THE EXPENSE OF PRIMARY & SECONDARY CARE
- INCREASED ALLOCATION MERELY TO OFFSET SALARY & SERVICE BENEFITS OF STAFF
- POOR DRIVEN TO SEEK PRIVATE CARE IN SPITE OF THEIR DESIRE OTHERWISE
- COST OF CARE SKYROCKETS & EQUITY SUFFERS EVEN FURTHER

Table3: Average Expenditure on Medical Care: All-India, A Comparative Picture during 80s Vs 90s (Rs per illness episode/hospitalization)

| | Rural | | | Urban | | | Urban-Rural Ratio* | |
|-------------------------------|---------|---------|----------------|---------|---------|----------------|--------------------|---------|
| | 1986-87 | 1995-96 | Percent change | 1986-87 | 1995-96 | Percent change | 1986-87 | 1995-96 |
| Outpatient care | | | | | | | | |
| Public sector | 73 | 129 | 77 | 74 | 166 | 124 | 1.01 | 1.29 |
| Private sector | 77 | 186 | 142 | 80 | 200 | 150 | 1.04 | 1.08 |
| Total | 76 | 176 | 132 | 79 | 194 | 146 | 1.04 | 1.10 |
| Private: Public Ratio@ | 1.05 | 1.44 | | 1.08 | 1.20 | | | |
| In-Patient Care | | | | | | | | |
| Public sector | 320 | 2080 | 549 | 385 | 2195 | 470 | 1.20 | 1.06 |
| Private sector | 733 | 4300 | 486 | 1206 | 5344 | 343 | 1.64 | 1.24 |
| Total | 597 | 3202 | 436 | 933 | 3921 | 320 | 1.56 | 1.22 |
| Private: Public Ratio@ | 2.29 | 2.07 | | 3.13 | 2.43 | | -- | -- |

Notes @Measures the private-public differential in average expenditure.

*Measures the urban-rural differential in average expenditure

Sources: NSSO 1992, Source Table 11.00, p S-516, Statement 6, p 59.

NSSO1998, Table4.19, p32; Table4.21, p33.

THE KERALA MODEL OF HEALTH & DEVELOPMENT

- **GOOD HEALTH AT LOW COST**
- **HEALTH INDICES COMPARABLE TO DEVELOPED COUNTRIES DESPITE LOW PER CAPITA INCOME**
- **GOOD PERFORMANCE & EASIER ACCESSIBILITY OF PUBLIC SECTOR**
- **RURAL HEALTH CARE DELIVERY EVEN BETTER THAN URBAN**
- **STEADY GROWTH OF PUBLIC OF PUBLIC DELIVERY CENTRES –TILL MID 1980s**

Table 4 Growth in Number of Govt. Beds in Kerala

| Year | 1961 | 1971 | 1986 | 1996 |
|-------------|-------|-------|-------|-------|
| No. of Beds | 13000 | 20000 | 36000 | 38000 |

Source: Kutty VR (2000)

SOME REASONS...

- **STRONG FOUNDATIONS LAID IN PRE INDEPENDENCE PERIOD**
- **HIGH HEALTH AWARENESS & EXPECTATION OF THE PEOPLE**
- **PROGRESSIVE SOCIAL MOVEMENTS**
- **HIGH LITERACY & WOMENS' EMPOWERMENT**
- **SUCCESSIVE GOVERNMENTS'**
- **EFFORTS FOR POVERTY REDUCTION & EQUITABLE DISTRIBUTION OF RESOURCES- UNTIL MID 1980S**

SOME MORE REASONS...

- **ANNUAL GROWTH RATE OF GOVERNMENT HEALTH EXPENDITURE (13.04%) HIGHER THAN TOTAL GOVERNMENT EXPENDITURE (12.45%) - UNTIL MID 1980s**
- **PUBLIC PARTICIPATION, PUBLIC RALLIES EVEN STRIKES - TO HIGHLIGHT SOCIETAL ISSUES**
- **HIGH MEDIA FOCUS ON HEALTH ISSUES**
- **CONSEQUENT POLITICAL INTEREST IN GOVERNMENT INVOLVEMENT**

THE 1990s

- **DECLINE IN PUBLIC RESOURCE ALLOCATION**
- **TOO MUCH SOCIALISM & POLITICAL ACTIVISM AT THE EXPANCE OF ECONOMIC DEVELOPMENT**
- **POOR GENERATION OF WALTH & RISING UNEMPLOYMENT**
- **ECONOMIC NEAR BANKRUPTCY OF THE STATE**
- **DECLING MEDIA FOCUSS - CONSEQUENT SHIFT OF POLITICAL ATTENTION FROM DEVELOPMENT ISSUES TO POLITICS OF POWER**
- **SKY ROCKETING OF COST OF CARE**

LEADING TO...

- **STAGNATION OF INFRASTRUCTURE EXPANSION & UPKEEP OF THE EXISTING ONES**
- **INCREASED ALLOCATION BARELY MEETING SALARIES etc**
- **DWINDLING FACILITIES & SERVICES IN PUBLIC SECTOR**
- **RISING USER FEES & INEFFICIENCY COSTS**
- **PRIVATE SECTOR MOVING IN TO FILL THE VOID**
- **'KERALA MODEL' – A THREATENED SPECIES**

OTHER FACTORS

- EPIDEMIOLOGICAL TRANSITION - RISING INCIDENCE OF NCDs
- DEMOGRAPHIC TRANSITION - AGING POPULATION WITH INDEQUATE SUPPORT SYSTEMS FOR THE AGED
- LOW MORTALITY WITH HIGH MORBIDITY
- INCREASING OOP EXPENDITURE WITH THE POOR SPENDING AS MUCH AS 40% OF INCOME for HEALTH CARE

OTHER FACTORS *(CONTD...)*

- CONTINUING BURDEN OF CDs & RE-EMEGING DISEASES - PARTICULARLY AMONG THE DISADVANTAGED
- PRESENCE OF THE AGED PROPORTIONALLY INCREASING HOUSE HOLD HEALTH EXPENSES

POLITICAL DECENTRALISATION

A RAY OF HOPE

- **ENVISAGED AS AN ENGINE OF CHANGE - PARTICULARLY IN THE RURAL AREAS**
- **LOCAL GOVERNMENT ADMINISTRATIVELY & FINANCIALLY EMPOWERED**
- **CAPABLE OF RESPONDING TO COMMUNITY NEEDS & ACCOUNTBLE TO IT WITHIN A BROAD NATIONAL FRAME WORK**

DECENTRALIZATION

THE NEW KERALA MODEL

- **PROJECTED AS AN ALTERNATIVE DEVELOPMENT MODEL TO THE GLOBALIZATION CHALLENGES FACED BY POOR COUNTRIES**
- **PARTICIPATORY DEVELOPMENTALISM TO COUNTER DEMOCRATIC PRESSURE POLITICS**
- **DECENTRALISATION PROCESS CONVERTED TO MASS MOVEMENT WITHIN A BROAD LEGISLATIVE FRAME WORK**

SOME HURDLES...

- **BEAUROCRATIC RESISTENCE TO LOSS OF CENTRAL CONTROL**
- **INEXPERIENCE OF LOCAL GOVERNMENTS IN PLANNING**
- **LACK OF TIMELY ALLOCATION OF FUNDS TO LSGs**
- **LACK OF CLARITY OF ROLES OF LSGs IN IMPLEMENTING STATE LEVEL & CENTRAL GOVERNMENT PROGRAMMES**
- **RESISTENCE OF HEALTH PERSONNEL - ESPECIALLY DOCTORS TO WORK WITH LSG LEADERS**

ENCOURAGING EARLY RESULTS IN HEALTH SECTOR

- **REFOCUSSING ON PREVENTIVE & PRIMARY CARE**
- **RESOURCE MOBILISATION LOCALLY**
- **BETTER ACCOUNTABILITY OF THE PUBLIC HEALTH SECTOR**
- **DOCTORS BEGINNING TO WORK WITH LOCAL GOVERNMENTS IN PANNING & IMPLEMENTING HEALTH PROMOTION PROGRAMMES**
- **LOCAL SENSE OF OWNERSHIP OF HEALTH CARE DELIVER SYSTEMS**
- **AMBULATORY ILL HEALTH CARE GAINING IMPORTANCE→**
- **LOWERING OF COST OF CARE**

**GOVERNMENT
DECENTRALISATION**

HEALTH CARE FINANCING

- **TAX BASED FINANCING**
- **COMMUNITY FINANCING**
- **SOCIAL INSURANCE**

**GOVERNMENT
DECENTRALISATION**

KERALA – ADVANTAGES *COMMUNITY FINANCING*

- **LITERATE POPULATION**
- **HIGHER LEVEL OF PUBLIC PARTICIPATION**
- **BETTER ACCEPTANCE OF
DECENTRALIZATION**
- **RELATIVELY EMPOWERED WOMEN**

**GOVERNMENT
DECENTRALISATION**

CONSTRAINTS

- **NOT COMPETENT TO TAKE DECISIONS WITH NATIONAL IMPACT**
- **CANNOT BE INDEPENDENT UNITS**
- **TERTIARY CARE DELIVERY - BEYOND THEM**

Practical Issues in Priority Setting in health care

Wendy Edgar
Ministry of Health
New Zealand

Health resources are finite –
we must do the best with
them

These remarks cover:

- The resource allocation process
- Priority setting on the delivery side

The resource allocation process - A List of core services ?

- ◆ To determine the health services to be publicly funded

Any listing cannot be separated from the clinical context – health need and ability to benefit

New Zealand Core Services Committee (NHC)

- Proposed a “qualified” list
- Based on practice guidelines and evidence of clinical benefit
- To clarify when services should be publicly funded and how quickly

NZ Guidelines Group

- Pilot NHC work from 1993 – 1995 continues
- Health professionals and patients / consumers
- To answer questions of effectiveness, efficiency, equity, and acceptability

Mildly raised blood pressure

- A disease that must be treated?
or
- A risk factor for heart attack or stroke

Taking a total risk approach informs treatment options – especially for people with lower risk

Prostate Cancer Screening

- PSA Test – has increased calls for population screening, even for men without symptoms
- False positives and false negatives require further examination
 - ◆ Needless worry for many
 - ◆ Risks e.g. from biopsies

NHC advice

Does not currently support population-based screening for prostate cancer or opportunistic screening using PSA or digital rectal examination for asymptomatic men in NZ

- Further examination for men with symptoms
- A man may have a PSA test, even if grounds are questionable, but he must pay for it
- The Guideline gives clear patient and doctor information on risks and benefits of screening

Status of Guidelines

- Advice – not protocols, no regulatory implications
- Apply in usual circumstances, and require clinical judgement
- Authoritative summary of clinical evidence, supported by peer review of practice

Priority Setting on Delivery Side – Focus on Primary Care

- Primary care is not free in NZ
- High co-payments are a barrier to access
- Result? – increased use of A&E, rise in avoidable hospital admissions

Since October 2003, the Government has substantially increased primary care funding

Deliberate decision to allocate most 'new' health money to primary care

- Significant economic improvement
- Focus on early access / treatment
- Increasing share of funding for primary care: 2003/04 – 11.79%, 2004/05 – 12.93%, 2005 - 2007 still rising
- Actual funding for other services has not reduced

Conclusion

- Future funding pressures are inevitable
- Allocating new money is easier than reallocating existing funding and reducing some services
- Agreed goals, information, representation and mediation all contribute to success of setting priorities

No easy solutions – good will is a key