Moving towards Universal Health Coverage: Public Sector Governance Challenges

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Health Challenges That All Nations Face:

--Sound program models: programs that are fiscally sustainable for society and both adequate and inclusive for the population being served.

--Sound management and delivery systems: systems that are efficient and accessible – and with public accountability and legitimacy.

" Policy options are always constrained by the legacies of existing policy, politics *and administration*….our choices today are burdened by our past…" --Ann Orloff

UHC Issue #1

The cube (Alanka Singh): (1) *population*: who is to be covered? (2) *services*: which services are covered? (3) *financial protection*: what do people have to pay?

Establishing scope of benefits and risk. Who pays and for what and how? Hospital care or primary care only, or a broader benefits package? If using an insurance model, is it the public sector that assumes risk or is it private insurers acting as purchasers and bearing the risk? Many, many tough questions!

UHC Issue #2

- **Sorting out central-state *fiscal and finance* arrangements and then establishing appropriate central-state health finance coordination structures (with active stakeholder participation).**
- **Effective conditional transfers should promote fiscal equalization, discourage substitution (MOE), establish state accountabilities and maintain a degree of state autonomy/flexibility.**
- **In addition, conditional transfers can - *and probably should* - provide separate funding and supports for comprehensive governance activities – staffing, technology, oversight functions, etc.**

Initial Governance Functions: Not Easy!

- **Enrolling providers and setting conditions of participation (examples: Medicare and civil rights in 1965; and Medicare and "assignment" incentives).**
- **Instituting state/central roles in beneficiary enrollment functions (RSBY India).**
- **Establishing initial standards for management information systems.**
- **Developing effective contracts and/or agreements with intermediaries (insurers, TPA's, as well as both public and private providers).**
- **Cost controls through rate setting, rate adjustments for severity, continual review.**

The Harder Challenges:

- **Performance management system: collection and ongoing analysis of quality data, and linking quality to financial incentives (examples: Costa Rica and 2% bonuses on infection rates; Massachusetts and "pay for quality" – reporting, training and results, Bangalore hospital)**
- **Dissemination of quality information to the public**
- ***SET PERFORMANCE GOALS. "Only the things measured receive attention – but remember that the reports might get faked!"***
- **Assessment of services information to assure equitable accessibility, including urban/rural**
- **Monitoring provider and insurer ethical behavior**

The Three Toughest Challenges?

- **How to reduce the incentives for unnecessary overutilization of services, which is even harder when financing mechanisms are split between primary care and secondary/tertiary care**
- **INVOLVE STAKEHOLDERS, but avoid "capture" by providers and key interests. How to establish *truly* rigorous governance systems, and not just a system of "management by exception."**
- **How to ensure that curative care is not incentivized and that primary care and public health systems receive both continued support and performance monitoring.**

FIRST, A QUICK LOOK AT THE USA

USA's Health Insurance Evolution

- **Insurance virtually nonexistent in 1920's, and enactment of a universal public system was rejected time and time again.**
- **Growth of "pools" -- private health insurance and employer based insurance.**
- **Government policies encouraged growth in this system, but government regulation of health insurance in USA has always had mixed results.**
- **Employer based health system became dominant in USA by 1960's, but <u>many</u> people were left out of the employer based health insurance system.**

"Unfortunately you have what we call 'no insurance'."

USA Health Insurance: Evolution

Private employer-based insurance became the foundation of the US system, but many people were not part of the employer based system. **Public programs were all designed to fill the three big gaps in coverage.**

1. ***1965: Medicare for the elderly*** **- built on a universal social security model**
2. ***1965-2000: Medicaid/CHIP for lower income families and children*** **- built on a federal/state based financing model**
3. ***2011: Obamacare for most of the rest of the uninsured, including those denied private coverage*** **– built on both federal/state and the private insurance system.**

THE US IS FINALLY GETTING CLOSE TO UNIVERSAL COVERAGE, BUT STILL HAS A WAYS TO GO.

Universalism makes a major difference, but with costs!

	1960	2014
Elderly Poverty Rate	35%	9%
S/S as % of GDP	2%	5%
Over age-65 Uninsured	45%	2%
Under age-65 Uninsured	30%	15%
Health costs %GDP	5%	17%

Under age-65 uninsured rate is projected to fall to about 7% over next 3-4 years

US Focuses on Costs and Quality:

Federal-State Health Finance Agencies – major investments made in oversight of public and private health insurance.

Health Insurance "Exchanges" -- private sector health insurers compete; comprehensive benefit packages; individual subsidies; tax penalties if no coverage.

Shared Savings Program - permits groups of health providers who take responsibility for the full care of patients to share in savings if efficient care provided.

Independent Payment Advisory Board– develops and submit proposals to Congress to slow cost growth and improve the quality of care. Recommendations automatically implemented unless Congress overturns.

Summary of USA's Health Challenges:

- **Obamacare implementation will continue to take center stage, as the US takes steps to move *ever closer* to universal coverage.**
- **The US has established strong central/state financing mechanisms, but the US still faces access, cost and quality issues. It continues to face major public sector *governance* challenges in overseeing the public-private insurance system.**

NOW, A QUICK LOOK AT INDIA

India Health: Evolution

- **India's public spending on health is very low: 1.2% of GDP -- and nearly three quarters of spending is out-of-pocket**
- **Many primary care and public health programs established, but are weakening over time as more people move to private care**
- **Both private health delivery systems and insurance models are institutionalized in India.**
- **Targeted central/state social assistance hospitalization insurance programs have recently been instituted (RSBY), and lots of state-based schemes and pilots are under development**

Rashtriya Swasthya Bima Yojana (RSBY)

- **Central/state funded program (75%/25%) provides hospitalization coverage up to Rs30,000 annually for poor families at nominal cost (Rs30).**
- **Very modest and fragmented central/state governance systems instituted –tiny state "nodal" agencies oversee functions.**
- **Insurers bid on risk-based contracts; hospitals reimbursed on cost basis by procedure (not fee for service).**
- **Beneficiaries can choose any "enrolled" hospital for services (demand-driven model) if the hospital is willing. Cashless transactions made through secure Smart-Cards.**
- **States are "topping up" RSBY in various ways; further expansions in the years ahead seem very likely.**
- **India's insurance schemes so far (1) are increasing enrollments but have low utilization rates; (2) have some impact on reducing the financial burdens of some families; (3) create incentives to expand services (some of this is good, and some bad!). Costs could explode in the future. No solid regulatory regime yet.**

India Planning Commission: 12th Five Year Plan

- **Expand public sector support for health from 1% to 2.5% of GDP**
- **Strengthen public health network**
- **Strengthen government sponsored health insurance to enable access to a continuum of comprehensive primary, secondary and tertiary care**
- **Move in the *direction* of universal health coverage for all, starting with expansion of insurance to all BPL families**

***HEALTH GOVERNANCE IN INDIA*:**

- **India has established its fiscal transfer system for secondary care insurance, but still needs a greatly expanded central *and* state public regulatory and governance system to ensure the effective delivery of care in both private *and* public facilities.**
- **Mechanisms need to be put in place to assure quality and to control costs and the overutilization of expensive services. Simply having standardized reimbursement rates for services and empanelment standards to certify hospitals is *not at all* sufficient.**
- **Mechanisms are needed to ensure that the growth in government insurance models doesn‘t lead to a continued erosion in support for India’s public facilities. Kerala is exploring ways to proceed.**

QUESTIONS FOR NEPAL BASED ON THE US AND THE INDIA HEALTH EXPERIENCES:

- Universalism has great benefits, but also real costs. It takes substantial spending to take real strides towards universal coverage. What's next for Nepal, and at what cost?
- You have to start from where you are. Find ways to build from existing institutional arrangements. In both the USA and India, it's increasingly the use of government funding and oversight of public and private health insurance to expand coverage. How should Nepal build on its public-private system?
- Finding the correct balance on the health roles of the central government and state/provincial governments takes continued work. Central government conditional financial support is essential, not only for health services but also for administration. How should Nepal proceed?

QUESTIONS FOR NEPAL BASED ON THE US AND THE INDIA HEALTH EXPERIENCES:

- **Developing a strong and well financed public governance and regulatory system is essential to ensuring health quality at reasonable cost, no matter what system Nepal institutes in its move toward UHC. *But it must be understood that it is MUCH harder to effectively manage a mixed public/private delivery/insurance setting.***
- **Focus on establishing a strong performance management system, but don't wait to start one until the perfect system is designed. It is best to start NOW, build a performance team and build the system incrementally.**
- **Don't lose sight of primary care! It is essential to strengthen public health and primary care, particularly if actions are taken to expand curative care and insurance for hospital care. Easier said than done…**