THE GLOBAL MANAGEMENT TREND

CONVERGING TRENDS IN NATIONAL HEALTH SERVICE AND SOCIAL HEALTH INSURANCE SYSTEMS

Guillem Lopez-Casasnovas
Professor in Economics at Univ. Pompeu Fabra

Brief summary

Despite the difficulties in comparing problems and solutions in the reforms of the health care systems in Europe, I will emphasize in this short article that there are signs of convergence given the way that our systems respond to similar challenges. I will focus on common trends by observing recent developments in two healthcare type of systems: National Health Services (NHS) and Social Health Insurance Systems (SHIS). They both appear to favour models of (i) greater decentralization of responsibilities in managing insurance coverage, (ii) population based mechanisms to finance providers and (iii) more extensive consumer choice.

The paper is organised as follows: We first focus on the different nature and departure point of both NHS and SHI systems, we develop a theoretical inspired rationale sequence for health care reforms, we then look at the actual reforms and from the analysis of the implemented policies we conclude that similar problems lead to similar answers and that this is the main vector for the observed convergence, at present, between NHS and SHIS type of models.

INTRODUCTION.

As is well known, National Health Service and Social Health Insurance models each began in the past century with different initial historical foundations. However, in the way they develop and manage current problems today (such as the issue of sustainability and their aim to better serve citizens' welfare), they seem to apply similar solutions. This leads to convergence. The transfer of responsibilities and financial risk to health care providers in general, together with greater clinical autonomy and patient choice, are some of the converging policies.

In addition, both type of systems try to increase private finance in health care expenditure. The need to diversify revenue sources other than collective taxation (either general taxes or specific payroll contributions) arises from the difficulty of balancing the rise in health expenditure with the increasing burden of taxation on the economy. Pressure on containing the tax burden in a global, competitive economy go hand in hand with the argument that today it is less justifiable than ever to use solidarity finance to provide some services; at least in a universal non discriminatory way for any type of care that technology makes available at present. Indeed, in developed countries, public resources impact the flat part of the relation between health expenditure and health. It makes sense in this context to discuss alternative financing for those components of care that prove to be less cost effective, or whose efficacy is quite in doubt. New forms of 'utilitarian' health care in a modern, ageing and wealthy society are supplied. This seems to call for more out of pocket payments (such as charging fees, co-payments and complementary premiums) and hence less redistributive taxation. In other words, to continuously finance those new forms of health care by coactive taxes and to provide services on a universal basis, as most NHS systems have traditionally done, without needs and means testing, may prove to be actually unfair. This is due to the fact that to raise revenues by increasing taxes in order to finance new health care spending may not be income progressive anymore. Taxes today tend to be more regressive than in the past. Our modern fiscal systems are 'dual' in the sense that they tax labour more than capital income. Taxes on capital gains try to favour savings above consumption. It is seen easier to increase indirect rather than direct taxes. All this builds in regressive taxation policies. In this context, more selective (redistributive), rather than universal, public expenditure is more than ever needed. Public finance should be focused on the more cost effective components of health care technologically available. This creates the need to discuss in most European health care systems what role private resources should have in financing some components of the new 'cure and care' vector for health. SHIS seems to have some advantages in achieving this, since private sources of finance have always played a role; but NHS does not avoid this discussion either.

Another common response we observe in the way health care systems reform their financial mechanisms has to do with the idea that the providers' autonomy should go in

tandem with the financial transfer of responsibilities and strengthening of the role of primary care as a gate-keeper to the access by patients to health care services. NHS has some advantage in achieving this since restricted access has always existed, but migration from fee for service payments and from unrestricted consumer choice are also being proposed today in SHIS. In this new context, risk adjusted capitation formulas are proposed for those public entitlements covered by the basic public package (desirably, on the cost effective side of the balance). However, they may be complemented with private finance, either for excluded services, or non substantial aspects of care among those included, given the fact that not everything of the best quality can be provided free for all. NHS type systems show more difficulty in moving in this direction although they have entered the debate.

Let us now deal with some of these points in more detail.

THE'WAGNER ENGEL PRESTON'SEQUENCE

Total health care expenditure is well known to increase with GDP. This is a common empirical feature found in cross-sectional studies. In the nineteen century A. Wagner put forward this hypothesis on a time-dynamic framework for most public expenditure (the so called 'Wagner's Law of increasing state activity' in a developing country). Income levels and rates of increase of the gross domestic product explain health expenditure, but the composition in its public and private components may respond to different patterns according, precisely, to the country specific stage of development. This was a general observation of another nineteenth century economist E. Engel when he observed different patterns of consumption according to income level. By applying Engel's observation to our field of analysis, this might explain some expected features. On one side, Less Developed Countries (LDCs) probably need a larger public share of total health spending. Public expenditure in health care at early stages of development is highly productive (it exhibits large marginal productivity for each dollar spent) given the externalities that public health has on the whole economy. This is not always observed to be the case (rather the opposite unfortunately seems to prevail), but there are plenty of reasons to support public finance of total health care expenditure in LDCs for a large section of the public. However, on a time series basis, with higher income, we should easily observe that total

health expenditure rises (perhaps even with an income elasticity greater than 'one', as in Wagner's Law), but in these greater development levels, the impact of additional spending is very low in terms of some basic health outcomes. This was 'the flat part of the curve' Preston's observation in the seventies. Increasing health care expenditure does not in fact have a significant impact on life expectancy or on most of the conventional health indicators, other perhaps than those related to quality aspects–associated to individual utility and personal welfare and above mentioned. These other aspects of care, separate from the testable diagnostic and therapeutic values for 'cure', cannot be certainly ignored since they are a significant component of an individual's welfare, but their justification in terms of public finance is doubtful. This may be particularly the case in DCs with dual fiscal systems where, as commented, the trend to less redistributive taxation needs to be more than fully offset by a highly redistributive health care expenditure. In other words, given that in most developed countries we observe decreasing marginal benefits from additional health expenditure on life and death outputs, public revenues for its finance seems to be less justifiable. What if we add to the former scenario those outcomes related to quality of life? It may still be good value for the consumers, but the assessment for this cannot be always captured by traditional cost-effectiveness analysis. Individual utility and preferences are much more difficult to quantify on an objective way. It is then when the argument for general universal public finance probably vanishes and the need to open new complementary finance comes out.

THE EQUITY AND EFFICIENCY MIX OF *NHS* AND *SHIS* SYSTEMS

Cost effective analysis is needed in order to address health care resources to maximize total health outcomes, given the constraint of a limited financial budget . However, there are reasons for public intervention other than the *maximand*. Equity is also a goal for health systems, whether they are of the NHS or SHI type. The main argument for this refers here to the issue of *adverse selection*, that the absence of public intervention may leave some groups without access to health care. The solution to this problem calls for a compulsory insurance pool. However, this public intervention argument does not require coactive finance, but rather public compulsory regulation for those services to be covered. In the case that public finance is present, deductibles and private complementary insurance (for non duplicated coverage) are also required to improve welfare. This is due

to the fact that in order to achieve 'pareto superiority' (someone gains with the intervention, no one losses) a *menu of contracts* (ie. diversity of care coverage) should be in place. As has been stated, by extending public coverage and enforcing a basic pool (with a non opt-out system), SHIS and NHS may perform equally well for this purpose. In this sense, the equity concern is not in itself a differential feature between both type of systems.

A final line of argument for public intervention, also related to equity, refers to the aim to serve, through health care provision, a more general welfare redistribution purpose. This is usually pursued by equity of access to health care and fairness in treatment independently of the individuals' ability to pay. It appears to call for universal access. However, when following this path, being highly effective in redistribution requires more than just 'universal access': we need better to focus on target groups, on needs assessment and means testing to get the maximum impact given the amount of resources available. It forces the system be 'selective' more than 'universal', and flexible over time (changing resources in response to the status quo) by focusing on new health challenges wherever the burden of illness is, quite often in a broad social and economic perspective that spills over traditional health care. Hence it requires an explicit priority-setting strategy. For this purpose, universal health coverage should be limited perhaps to those less predictable events (for which individual insurance fails) and/or for those with exceptional financially catastrophic consequences. In this field SHISs have some initial advantages since the concept of eligibility and conditional access is more established in the insurance culture. Once again NHSs are moving in this direction too. In some respects, the English National Institute for Clinical Excellence (NICE) is an example of a more explicit approach to rational priority setting in the sense here argued.

By putting these two pieces together (regulation to guarantee basic access and to avoid risk selection, and public finance mostly orientated to the most effective health care) we may now draw several degrees or mixed vectors of public intervention in practice*:* from public regulation of private markets, to the operation of a social health insurance fund (basically with cash transfers to repay the cost of the services insured, with resources managed from several insurance carriers) and national health services with in-kind public

supplied services with free access at the point of delivery. All of these alternatives obviously have different implications for the health policy design in practice, on access (eligibility), extent of coverage (public/ complementary) and finance (solidarity). Nevertheless in this respect, as we shall see, we do not observe important differences between NHS and SHIS in this respect. NHS intend to restrict health care whereas SHIS try to extend eligibility of coverage. On the financial side, at the end of the day, pay roll taxes are taxes anyway, and increased coverage may be achieved by enlarging the initial employment-based insurance with public subsidies (for the unemployed and the poor) and not only by the entitlements of the citizens' right to health care. The search for a better equilibrium is at present the main reason for most of the observed health reforms.

THE EFFICIENCY AND REDISTRIBUTIONS GOALS IN *NHS* AND *SHIS* REFORMS

The specific, operational way both NHS and SHI systems combine the 'efficiency' and 'redistribution' goals can be detected in the semantics they employ: *'national' 'health' 'service' (NHS)* and *'social' 'health insurance', 'system' (SHIS)*. These components are reflected in:

1-the scope of choice that public regulation allows the agents in each system: either from a cash transfer strategy to rescue payments or by the in-kind benefit provision at the point of service; 2-the degree of public involvement in health management: in both the balance, and depth of the public provision/public-private production split differs; 3-the extent of health care coverage on limited opting-out grounds: for a basic (tax financed) package, a complementary (tax-favoured, under regulated community premia) and/or additional (private out-of-pocket) services; and finally, 4- in the way they allocate management responsibilities between the health care agents: If low accountability and retrospective finance prevails, this is going to be bad for efficiency but lacking incentives to inequitable risk selection (good for equity); if high accountability and prospective finance this means in principle greater incentives for efficiency, prevention, and so on, but carries potential inequities from cream-skimming demand (bad for equity).

The combination of the aforementioned factors compound alternative frameworks for health care provision. This is made according to the way in which the relevant functions for health are allocated to the existing agents. These functions are health planning and

the distribution of health care equipment/ the finance of the system (combining general taxes, earmarked contributions, premia, etc)/ insurance coverage (services selected for coverage)/risk management (optimal pooling)/purchasing services (licensing producers, contracts and payment mechanisms)/ and production of care from market factor inputs. Among the agents, we observe how at different stages regulation, finance and management, initially in hands of a single entity as the Social and Welfare Departments are decentralised to Health Care Services Autonomous Units (for managerial reasons in NHS type of models) or to insurance funds (public-private in SHIs); to regional/geographical Areas or Health Action Authorities and to Health Care units, either on a single isolated basis (paid by activity) or forming networks of health care providers (financed then on a population basis). The content of the functions for each of these agents shape a different mix of 'politics' and 'managerial capabilities'. In the early stages, politicians tried to be involved in all the functions, from health planning to production of services, but over time political departments themselves confined their influence to regulation and macro finance issues, moving out of the production/ purchase of the services. Some additional differences may come out of the acceptance by the models of private and non profit agents in contracting out some services and even in allowing private insurance carriers to manage public coverage. Actual institutional differences may seem high in the way that all this reflects in NHS and SHIS structures, but the content of the functions in both models are evolving rather similarly.

ASSESSING HEALTH CARE REFORMS: WHAT IS BEST?

The arguments for assessing the superiority of each model, given the specific allocation of functions among agents, are very controversial since they respond to different political or ideological perspectives. They may be judged, for instance, in terms of the incentives they align in pursuing health from the production of services, of the degree of financial risk that they transfer to the providers and on the scope of consumers' choice put in place. No significant differences arise in NHS and SHIS from the concerns to reduce 'excessive' health care consumption (the risk of a moral hazard is a common feature of both 'public' and 'social' insurance), by introducing co-payments (a service excluded from the basic package means one hundred per cent co-payment), deductibles, or by forcing quid-pro-quo responsibilities for a more rational utilization of care services.

Some other aspects on the operational arena that may be considered in judging which system is better in achieving the mix of equity and efficiency goals each model has, refers to the way providers are paid, for example, on a fee-for-service open ended basis for any number of activities performed, on a closed global budget basis or under capitation (more or less risk-adjusted), or by salary (with more or less job protection. Some other features of the systems have to do with the nature of their workforce, either as civil servants or as independent professionals under contracts, with central regulation of technology assessment (which is expected to be good for macro allocative efficiency purposes) or with decentralized regulation (much better in principle for micro economic efficiency in utilization). Finally, some differences can be observed on the way total resources are allocated, either by 'money follows the patient's choice' or by the 'patients follow the money'. However, as commented next, the introduction of greater institutional autonomy (Trusts, Consortia, Limited Liability Corporations) in NHSs and changes in financial arrangements in SHIS (for aligning incentives from health care input producers to final health outcomes) lead the vectors for systems convergence.

COMMON TRENDS AND COMMON ANSWERS FOR CONVERGENCE

Despite the fact that NHS and SHIS have different departure points, distinct stylistic features and some tendency to path dependence in the way they operate, common management trends exist at present to answer new global challenges.

The following are our views in order to postulate 'convergence' from similar answers to similar problems. Most of the commonalities among health systems come from the organizational, financial and management field. They are (i) an increasing recognition of greater autonomy on the providers' side. Mutual funds, trustees, cooperatives, consortia, limited liability companies, public corporations, and so on, are created in order to reinforce the production and provision split; (ii) that by looking at both systems for 'the perfect agent for the principal', the primary health care physician achieves a more prominent role as the gate-keeper of the system or the 'health broker' for access to health care; (iii) changes in the way health providers are financed are put in place (pay per performance type) in searching for the most cost –effective, evidence based, medical practices; and

finally, (iv) a more explicit service prioritization, for instance, with the implementation of positive and negative lists of drugs, either reference pricing or market competition for generics and, in general, the search for a fourth hurdle in drug approval. NHS and SHIS show little differences on this.

Does this mean that a *'global management trend'* is arising from all of these trends*? Is it evidence based?* Is *managed care* the convergence factor? Can we detect a common trend towards the *integration of health care* and/or towards the creation of (*virtual) holdings of health care providers?* Yes. We believe that this is indeed the case. Effective health planning and efficient managed care require in all these cases a shift in the financial risk from payers to providers, more explicit financial (professional) incentives to clinicians for efficient care delivery and the creation of competition among providers in cost, scope and quality of services, embedded with a higher role for consumers choice.

Does this mean that a perfect system exists for health care? Yes, we believe that this is the case, although still today it is much easier to define than to implement. Nevertheless, basic features are: 1-the integration (even virtually, there is no need for it to be done hierarchically!) of providers for better coordinated management of services; 2- clear purpose, in the fact that the main target for the finance of our health systems is to improve population health outcomes, and for this, health care services and health care providers are simply inputs in the process; 3- the need to align incentives among all the health care agents in the added value chain for health, in order to avoid the effect that *whenever it is worst for the system* (lower patient health or more illness episodes), it is *better for the providers* (larger amounts of finance for providers' tasks and supply of inputs); 4- the search for a better balance between user charges and tax payers revenues in order to make the system sustainable.

This leads to contracts between financers and insurers which combine prospective capitation rates -good for efficiency (promoting prevention…)- and risky for equity (incentives to select patients…), and retrospective financing (the opposite effects). This means purchasing health care coverage, rather than health services, under population risk-adjusted mechanisms and optimal risk-pooling, likely with reinsurance.

With regard to the contracts between insurers and health care providers, it would imply maintaining an activity budget based contract, case-mix adjusted, blending here prospective with actual costs and with the macro envelopment of global budgets (re-scaling finance and activity in computing payment units). Finally, with regard to the users' financial flows, money should tend to follow the patient's choice, accepting individual decisions on coinsurance for complementary services, and co-payments at the providers' level where this is the case. Equity adjustments through fiscal expenditure may be in place too.

A desirable feature of the convergence trends of NHS and SHIS is to achieve greater accountability at all levels: politicians facing tax payers by explicit prioritization; insurers facing politicians in proving comprehensiveness and no risk selection; providers facing insurers by supplying cost-effective health care without waste; and in general, users facing providers, insurers and politicians, gaining social legitimacy by proving that the whole system is good value for money (the goals of the system are achieved at lower social costs)

Some other specific suggestions may be raised in the pursue of optimality. For instance, in the *hospital setting*, health systems should search for differential production lines, to be identified as close as possible to the health services plan; maintaining specific clinical rationale within each of these product lines, moving out of fee for services payments, to pay per performance. It should be tried to offer interchangeability among the lines of hospital activity at initial equal finance (favouring the dynamics of better profitability in each product line instead of just increasing gross revenues on the whole), by promoting ambulatory surgery, home visits and social care for some chronic conditions.

For these reforms to be successful it may, in addition, be necessary to emphasize the value of health and the health care cost aspects that shape social investments. Gradual reforms may be needed, but always trying to be selectively 'radical', showing commitment to change; as the old aphorism says: 'you will never be able to take advantage of the winds if you don't know where you are going'.

SUMMARY

In brief, this is a short summary of the main messages of the convergence strategies observed in NHS and SHIS and commented in this paper. We need to maintain a health and human development policy perspective when dealing with health services (following the *Wagner Engel Preston* argument, for example); be clear on what is substantially normative in terms of public intervention in health care and what is empirical-ideologically driven (the limits of the reform are in the *opting-out* alternative); not to be afraid to be more selective on redistributive grounds, if we are serious about redistribution, since by trying to be universal the finance of the system may collapse. Finally, in terms of efficiency, systems should fight to improve coordination of health care services for better health outcomes, awarding providers' with autonomy and appropriate degrees of financial risk. Reformers need for this to be flexible and to blend prospective and retrospective systems for a second best optimum.