Making Headway towards UHC

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UHC: What is it?
**UHC Representations**

- **Black hole?**
- **Appropriate, timely, high quality care and care pathways, affordable for all**

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- **Population: who is covered?**
- **Universal coverage of needed services and financial protection**
- **Costs: what do people have to pay out-of-pocket?**
- **Services: which services are covered, of what quality?**
- **Extend to non-covered**
- **Reduce user charges**
- **Include other services**
- **Resources**
- **Coverage**
- **Financial protection**
- **Package of care**
- **Quality**
- **Outcomes**
- **Enablers**
Why is it so tricky?

Requires a whole system approach

Demand and Supply

1. Removing price barriers creates more demand
2. Bolstering supply
3. Implicit decisions about rationing
Rationing – avoiding the black hole

Problem: Limited resources vs infinite wants and needs

Solution: Rationing Mechanisms

1. Pay on Use (pricing)
2. Burden of Payment
3. Waiting Lists and Queues
4. Lack of Information
5. Supply Management
   - Gatekeeping and Pathways
   - Geographic
   - HTA/CEA
   - Facility and Systems Efficiency
Moving to UHC and away from price rationing requires...

- No trade off with other negative rationing mechanisms
- Definite trade-off with positive rationing mechanism (Not optional)

In other words, if positive rationing mechanisms cannot be expanded... progress toward UHC will be entirely dependent on expanding the resource envelope
Demand - Financial Protection

Measure of affordability and burden
- Out of pocket payments
- Private Health Insurance

Impoverishing and Catastrophic Payments

Results (from 2010 data):
- 11.5% of households experienced unaffordable OOPs.
- Increases to 15.4% when PHI payments are also considered.
- Lowest consumption quintile disproportionately affected
### Expanding Financial Protection: Scenarios

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Cost €</th>
<th>Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Free Care</td>
<td>2,939,287,780</td>
<td>All</td>
</tr>
<tr>
<td>2. Financial Protection</td>
<td>668,134,116</td>
<td>All</td>
</tr>
<tr>
<td>3. Financial Protection: 4 biggest areas of unaffordable private health expenditure</td>
<td>487,953,492</td>
<td>OTC, OP, Dental, Insurance</td>
</tr>
<tr>
<td>4. Free Care: 3 areas where % of unaffordable spend highest</td>
<td>388,885,744</td>
<td>Dental, Nursing Home, Home Help</td>
</tr>
<tr>
<td>5. Financial Protection for Poorest/Medical Cards (Maximin)</td>
<td>183,658,228</td>
<td>All</td>
</tr>
</tbody>
</table>

+ Costs of meeting “unmet need” and “response to lower price”
Possible Financing Pathways

Expansion of publicly funded basket with lower out of pocket payments (Denmark, UK)

(Lower or establish) reimbursement thresholds (Ireland)

Expansion of private insurance cover for out of pocket payments (France, Slovenia)

Vouchers (Middle Income)
Recent Features

- Temp staff and revolving door
- Loss greater and recovery slower in non-acute settings
- Some protection of front-line staff and scarce skills

Implications

- Appropriate Care Pathways will require
  - more intentional workforce planning
  - Better use of scarce resources
Alleviating Waiting Lists

- 3 waiting lists
- Systemic capacity problem
  - Pathways
- Incentive problem
  - Dual practice
  - Litigation
  - Get me out of here
- Accountability problem
Unhelpful Further Obstacles

Tricky system features
Dual practice + waiting lists
Private beds in public hospitals
Lifetime community rating
EDs as access points
• How sticky?
The difficulties of space travel

Translation

The dangers of Dutch courage

Culture...nom nom

Path Dependency – Hostages to History?
BIG BANG vs incrementalism?
Conclusions

Supply must match demand
  – Capacity to match financing change

Don’t replace one negative rationing mechanism with another

Financial Protection not the same as free care

Human Resources and care pathways

Blast UFOs – collective stakeholder willpower

Bang bang
It’s time...

Thank You