

## Health Policy Design

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### Introduction

Following the adoption of the Sustainable Development Goals (SDGs) by the United Nations in 2015, members of the World Health Organization committed to achieving universal health coverage (UHC), whereby all citizens enjoy access to health care without suffering financial hardship. In the ensuing years, international and national efforts have been dedicated to establishing or expanding health care facilities and financing related programs.

However, many scholars and commentators have subsequently realized that expanded facilities and financing alone are insufficient to achieve UHC. This realization has led them to highlight the importance of the “governance” of health care, emphasizing transparency, participation, and accountability in policy design and implementation. While this broadening of the discussion marks an improvement, the discussions are largely abstract and overlook the specific systemic barriers to achieving UHC and the appropriate policy tools to address them. The purpose of this brief is therefore to highlight the gaps and suggest measures to bridge them.

Following a policy design approach, this policy brief outlines the policy problems innate to health policy that must be addressed if the goals of UHC are to be achieved on a sustainable basis.

### Health Policy Design: Systemic Challenges

Health policy aims to eliminate or mitigate the causes of access

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barriers to health care. Health policy design selects and deploys policy tools to remove or alleviate the conditions that prevent the achievement of UHC.

From a health systems perspective, there are five critical problems that policy makers must address in order to achieve UHC: *governance*, *provision*, *financing*, *payment*, and *regulation*. Addressing each of these problems requires a corresponding set of appropriate policy tools.

### *Governance*

*Governance* is an overarching function comprising the provision of direction to the sector and coordination of the disparate public and private activities that affect the population's health. The need for strong governance of health care arises from the conflicting interests of the key stakeholders – users (patients), providers, and third-party payers (insurers) – that need to be aggregated and reconciled. The various stakeholders' interests are inherently conflictual, even zero-sum, except when they are able to pass on the costs to the government or insurer. There is therefore a need for an external party, such as the government, to ensure that parties do not internalize the profits and externalize costs.

Restraining the self-serving behavior of the key stakeholders – especially providers – is an essential health policy function that the government is uniquely placed to perform. While private players – providers, third-party payers, users, professional associations, and unions – may play an important role in designing and executing health policies, only the government has the authority to construct and enforce compromises, by force if necessary.

But the function of the government does not end with restraining the self-serving behavior of stakeholders. The government must also formulate a vision, develop strategies, and bring the key stakeholders together. These governance challenges are met through active stewardship and vertical and horizontal coordination.

Strong *stewardship* in health care is essential yet difficult, because stewards face diverse and contradictory demands, which necessitate not only mechanisms for heeding local community and individual preferences, but also central direction and enforcement of accountability. Local participation in decision-making improves the quality of choices, but it weakens coordination, undermines economies of scale, and fosters interregional inequities. To overcome these obstacles, central governments need to constantly balance central direction and local autonomy.

*Coordination* has two dimensions: horizontal and vertical. The former centers on coordination of the objectives and activities of the large number of agencies involved in designing, financing, and

delivering health care services. There is a similar need for vertical coordination due to the different levels of government and organizations involved in delivering health care. It is ultimately the government's responsibility to ensure that all critical policy functions are appropriately allocated to the right level of government. Such arrangements are best described as “centralized decentralization,” wherein a strong central authority is combined with opportunities for local innovation. The nature of the relationships between central and local authorities and the extent and form of the direction that national governments provide to their local counterpart is contextual and depends on the conditions in which the choices are made.

### *Provision*

In health care, the organization of the production and delivery of services has a major impact on the sector's performance and outcomes. The form of ownership – public or private – is particularly important because of its effects on the use of tools such as payment arrangements and regulations.

Government ownership provides policymakers with mechanisms to intervene directly through internal decisions and instructions instead of through negotiation with external parties and regulations, as is the case with private ownership. However, the management of public hospitals and clinics is difficult due to inherent limitations of traditional bureaucratic structures and processes in service delivery organizations. Job security for staff and the lack of hard budget constraints compound the problems and challenge governments to adopt management processes that improve performance while maintaining a public service orientation.

Private provision overcomes many of the difficulties of public provision. But its overwhelming drive for profit causes a swathe of problems due to information asymmetry and monopolistic behavior. Consumers and third-party payers do not fully understand what they are paying for, which allows providers to oversupply and overcharge.

Provision of health care must be ideally organized such that public and private providers serve the public rather than their own interests. For private providers, this principle means curbing opportunities for profit maximization at the expense of users. For public providers, in contrast, it usually involves motivating personnel to remain responsive to patients' needs and pay more attention to management issues.

Vertical integration of various levels of health services – primary, tertiary, and specialist – is a further aspect of health care provision that requires policymakers' attention. Primary care provides cost-effective services for the vast majority of care, but in practice, this level of services is insufficiently used for a variety of reasons. A key responsibility for policymakers is to integrate the

services such that users receive care at the level most appropriate for their need. Achieving such integration requires complex system controls and incentives to shape providers' behavior.

### *Financing*

Designing a financing system for health care that is effective and equitable as well as financially sustainable is essential, but complicated by the various market failures that characterize the sector.

Out-of-pocket (OOP) payments for health care (either paid directly or through medical savings accounts) are inefficient and inequitable, in addition to ineffective for those unable to pay. Yet, OOP payments represent a large share of total health care expenditures in many countries, reflecting deliberate government strategy to curb demand or to fill gaps in public financing. Unlike most private goods and services, which may be left to the private decisions of buyers and sellers, the large and unpredictable costs of medical treatment make OOP payment undesirable as a financing tool and necessitate payment through risk pools. Risk pooling in health care can take various forms, including government budget and public or private insurance. However, risk pools produce deep moral hazard problems that require prudent management and offsetting measures to curb oversupply and overcharging.

Governments are a large (often the largest) source of health care financing in many countries. Government financing may serve to subsidize the population's health insurance premiums or to subsidize producers' costs to allow them to provide services at reduced or no cost to users. These two options – targeting insurance premiums on the demand side or providers on the supply side – variably affect the sector's performance and outcomes. Subsidies for insurance premiums improve insurance coverage and thereby health care access but have the inadvertent effect of promoting moral hazard among both users and providers. Subsidies for producers, conversely, give the government a lever to directly alter the recipients' behavior through the imposition of performance requirements as a condition for the subsidy. This is especially the case with private providers, who are otherwise difficult to control due to their information advantages and political power.

Compulsory and contributory social insurance represents a useful tool for pooling resources to pay for health care, but runs into severe moral hazard problems, leading to oversupply and overconsumption. Social insurance can also serve as a powerful tool for altering the behavior of providers and users, but only if the government actively uses its bulk purchasing function, which is not always the case. Social insurance is sometimes fragmented by population segments or occupational groups, which undermines their ability to negotiate with providers for better prices or quality. Insurers' ability to pass on the costs in the form of higher premiums also undermines their motivation for controlling costs or improving quality.

Private insurance is a major source of health care financing in many countries – Switzerland and the United States, for example – but it is inequitable and inefficient. Private insurance is either unavailable or too expensive for low-income households or population segments with high demand, such as the elderly, who must resort to publicly financed programs. As such, private insurance can play only a supporting and not central role in health care financing.

### *Payment*

How providers are paid has a major impact on how they behave and therefore requires careful consideration. An effective payment system is one that incentivizes providers to provide necessary services in a cost-conscious manner.

At the broadest level, there are two types of payment methods: retrospective and prospective. Under retrospective arrangements, such as fee for service (FFS), providers are paid after a service has been delivered, usually based on the type and volume of services. While FFS is effective at making providers attend to users' needs, it also allows the former opportunities to increase the volume and price of services they provide. Furthermore, providers may take advantage of information asymmetries to prescribe and sell treatments and drugs that offer the largest profits. FFS is particularly problematic in the context of insurance financing, because it is convenient for insurers to passively approve claims rather than to use their payment authority to reduce costs or improve quality.

In contrast, providers are paid in advance under prospective arrangements such as global budget, case-based payment, and capitation payment. Global or line-item budgets have traditionally been the main payment mechanism in the public sector, while private providers are traditionally paid on an FFS basis. By setting payment rates in advance, prospective payments are more effective at containing costs, but are prone to encouraging providers to skimp on the quality and quantity of services.

A combination of prospective and retrospective *payment* tools is necessary to ensure that the mechanisms for paying providers do not create perverse incentives for providers or users. For FFS payments, this means dampening the motivation to over service patients, while the opposite is the case for prospective payment mechanisms. In public health systems, in which providers are typically paid on a prospective basis, the challenge is to ensure that users receive the services they need in a timely manner. In contrast, the main challenge in private systems is to curb providers' profit-seeking instincts without undermining the user focus.

## ***Regulation***

Finally, to function effectively, health systems need to ensure the safety, quality, and affordability of medications, treatments, and services delivered to patients. Health systems with significant private provision and financing require governments to set the terms of market exchange with the goal of protecting patients. Defining the minimum *standards* of conduct for providers and insurers requires governments to establish a regulatory framework to promote appropriate competition while protecting the physical and financial interests of users.

Regulations are a powerful tool available to governments to shape the health care sector according to public goals and priorities. Regulation is especially important in systems dominated by private provision where the government lacks organizational and financial tools to shape the providers' behavior. Conversely, systems with a large share of public ownership and high budget spending can do without extensive regulations because they can achieve the same objectives as owners and payers. However, designing and enforcing regulations requires immense policy capacity on the part of the government.

## **Concluding Observations**

This policy brief has highlighted the system-level challenges in health care and the policy tools required to address them.

Governments do not have a free hand in choosing policy tools, as they must live with the lasting effects of past policies. Choices made at the onset of the development of the modern health care system constrain the choices available to policymakers. Contemporary governments that started with a centralized health system built on public provision and financing (the “Beveridge” health care system found in the UK and its former colonies), for example, have exhibited a distinct advantage in achieving UHC at affordable costs. In such systems, the government owns and operates health facilities, funds them from public accounts, and pays the providers prospectively through fixed budget allocations. Furthermore, such systems have a low need for regulatory oversight and information, because all key health system functions are internal to the government. As a result, they already have in place most of the critical design elements for effective delivery of UHC. In contrast, “Bismarckian” systems featuring private provision and social insurance financing have faced the problem of runaway costs because of the need for policy measures to constrain and incentivize private providers and third-party payers.

The Achilles heel of government-dominated Beveridge systems is poor management of public facilities due to a lack of appropriate controls or incentives needed to guide managerial and medical

staff to serve users in an appropriate and cost effective manner. Poor management of public facilities undermines public trust, which leads to the facilities' decay and abandonment. The erosion of the public health system, in turn, promotes the proliferation of private providers which, unless regulated effectively, fosters the growth of private financing and FFS payments, which are major impediments to universal access to health care. Publicly organized health systems that have avoided this fate are those with governments that have taken active measures to support their public hospitals and clinics with both resources and necessary management reforms.

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