Designing a World-Class Health Care Financing System

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Health Care Systems Potentials

Health Ideals, Ethics/Ethos, and Politics Shape the Potential of a Health Care System
“Health can be seen as a means, a foundation for achievement, as a first achievement itself, and a necessary premise for further achievement. The sick individual suffers isolation, loss of wholeness, loss of certainty, loss of freedom to act, loss of the familiar world; the future is in doubt and all attention is concentrated on the present. When ill, we no longer trust our bodies and ... we no longer trust life.”

Roberto Mordacci and Richard Sobel
Health Ideal

“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

An expansive definition of health from:
WHO Preamble to its Constitution, 1946

How admirable!
To see lightning and not think
Life is fleeting (Basho)
Non-Medical Considerations

- Societal ethic
- Medical decision making ethic
- Family ethos
- Political – economic ideology
- Political decision making

One size does not fit all
Health Care Systems

The Means by Which Societies Provide Support for Citizens to Maintain Their Good Health
Health Care Systems Objectives

**Effectiveness - Quality**
Improving population health

**Social Acceptability - Responsiveness**
Responding to peoples’ expectations
(“needs” and “wants”)

**Cost**
Fair financing of health care and,
Providing financial protection against costs of ill-health
Health Care Systems Goals

United States
Universal access to high-quality, comprehensive, cost-effective health care

United Kingdom
Comprehensive, high-quality medical care to all citizens on a basis of meeting professionally judged medical needs and without financial barriers to access

World Health Organization – “New Universalism”
Delivery to all of high-quality essential care, defined by criteria of: effectiveness, cost, and social acceptability
Health Care Systems Goals

United States – Idealized
Universal access to high-quality, comprehensive, cost-effective health care

United States – Reality
All the care we “want” and “need” --- when we want it!*

* Daniel Callahan, The Hastings Center
Health Care Systems Overview

Functions the system performs

- Stewardship
- Creating resources
- Financing

Objectives of the system

- Responsiveness
- Fair financial contribution

Creating resources → Delivering services → HEALTH

World Health Care Systems Performance

The World Community’s State of Health, and, Its Health Care Systems’ Structures and Performances
Health Spending

- United States is the world champion spender --- 13.7% of GDP in 1997
- EU spending averaged 8.2% of GDP in 1997
- U.K. spent 6.8% --- well below EU average
- Industrialized nations (OECD) spent 6% -10% of GDP in 1997
- Nigeria and Niger are the most seriously deficient nations

Source: WHO 1997 estimates
Health Outcomes

- Japan is the world’s healthiest population: 74.5 years
- Siera Leone (25.9) and Niger (29.1) are the least healthy
- EU average is 71.4 years
- U.K. ranks #14, 71.7 years
- U.S. ranks #24, 70.0 years

Note: DALE < 80 years are years of poor health and premature death

Public Spending Versus Health

DALE > 70.0: range of 44.1% - 91.4% public spending
Spending Versus Health

$1,000 US funds 70.0+ years of DALE

Per Capital Health Expenditure (US$), 1997

DALE in years
Facts and Demonstrations

• Spending a basic amount on health care and public health ($1,000 US) is needed to avoid unacceptable health outcomes
• Spending beyond a basic amount does not necessarily continue to improve health outcomes
• Government stewardship and public programs are essential to an effective health care system
• All effective health care systems are, by political choice, mixed public – private systems
Comparison of Effective Health Care Systems

Whose Health Care System Is “Best” and Why
## Health Care System Performance

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<th>Health Performance</th>
<th>Overall Performance</th>
<th>Overall Attainment</th>
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Ranking Health Care Systems

WHO Health System Performance

Overall Performance

Health Performance

Overall Attainment

Health

Health Dist

Responsiveness

Resp Dist

Cost

Fairness

Rank

U.S. Strength

U.S. Weakness

U.K. Strength

U.K. Weakness

U.S.A.

U.K.

E.U.
Health Care Systems Characteristics

**United Kingdom**

**Strengths**
- World-class health outcomes
- Equitable distribution of health outcomes
- Financial fairness
- Low cost

**Weaknesses**
- Inadequate responsiveness

**United States**

**Strengths**
- World-class health outcomes
- High Responsiveness

**Weaknesses**
- Uneven distribution of health outcomes
- Financial unfairness
- World champion spender
Responsiveness: “Wants” vs. “Needs”

*Respect for persons*
- Respect for dignity
- Confidentiality
- Autonomy

*Client orientation*
- Prompt attention
- Quality of amenities
- Access to social support networks
- Choice of provider
• Industrialized nations with world-class health outcomes, (DALE >70.0 years), which includes U.K. and U.S., all spend “enough” on health care to fulfill their population health care “needs” (essential services)
• Additional amounts spent on health care improve responsiveness (“wants”) more than health outcomes
• Public programs are increasingly having difficulties providing all health care “wants”
• Private health insurance programs are attractive “safety valves” for providing many “wants” that exceed health care “needs”
Public or Private Health Care Programs?

Public or Private Programs --- Which Approach Might Work Best, and, When and How Their Different Characteristics Might Be Used to Determine “Right” Mix
Private Insurance Market Failure

“Economists generally prescribe competition as a solution for markets that do not work well….Insurance markets differ from most other markets because in insurance markets competition can destroy the market rather than make it work better.”

Michael Rothschild
Joseph Stiglitz
Market Failure

- Adverse selection – asymmetric information
- Incomplete insurance
- Moral hazard

Source: Kenneth Arrow
Private Insurance Market Failure
Private - Voluntary Markets: Choice

Frequency

Severity

Universe

All Insurers

Insurer A
Market Dynamics
Private – Voluntary System

- **Choice** causes uncertainty about the level of risk borne by all insurers
- **Choice** causes uncertainty about the level of risk borne by each insurer
- Insurance causes consumers to increase demand for covered goods and services (moral hazard)
- Competition among insurers, asymmetric information, moral hazard and buyers’ pursuit of individual equity shapes marketplace behavior
- **Market failure**: incomplete insurance, adverse selection and moral hazard naturally arise to lesser or greater extent
- Insurers compete to satisfy buyers’ “needs” and “wants”
Public Program Market Failure
Public – Mandatory Markets: No Choice

Universe

Severity

Frequency
Market Dynamics
Public - Mandatory System

• A lack of *choice* eliminates uncertainty about the level of risk borne by public risk bearer
• Insurance causes consumers to increase their demand for covered goods and services (moral hazard)
• Buyers’ pursuit of individual equity is largely eliminated from marketplace behavior
• **Market failure:** incomplete insurance and moral hazard arise, but generally to lesser extent than in private-voluntary markets. Adverse selection problem is solved.
• Political, bureaucratic and provider-oriented issues often supplant focus on population “needs” and “wants”
### Comparative Performance

#### Private – Voluntary System

**Strengths**
- Choice (responsiveness)
  - Expansive “wants” benefits
- Available to most customers willing to pay an equitable cost for coverage
- Private control of decisions over provision of health care

**Weakness**
- Universal coverage impossible
- Fragmentation of risk pool
  - “Cherry – picking”
  - High sales and administrative costs
- Risk-rated premiums
- Challenge to limit costs

#### Public – Mandatory System

**Strengths**
- Universal coverage
- Direct cost control through government budgets
- No market fragmentation
- Tax – salary based financing (financial fairness)
- Low overhead costs

**Weaknesses**
- Bureaucracy (unresponsiveness)
- Not likely to provide all health care “wants” demanded by public
- Strong public involvement in provision of medical care services (may be considered a strength)
Facts and Demonstrations

- Private – voluntary markets are not capable of providing for universal coverage, or, tax based financing
- Insurers and customers in private systems will naturally exhibit a range of unattractive market behaviors
- Public systems are needed as the core of world-class health care systems, subject to adequate government stewardship and effective incentives for providers and patients
- Private systems, subject to adequate government supervision, may be most appropriate means to fund voluntary extended health care benefits, particularly those benefits that satisfy “wants” rather than “needs”
Making “Best” Even Better

WHO’s
New Universalism

What a Strange Thing!
To Be Alive
Beneath Cherry Blossoms (Issa)
New Universalism

- Enlightened government stewardship
- Effective public health programs
- Universal core health care program covering most health care “needs” (social solidarity)
- Private sector non-core insurance allowing coverage of additional health care “wants” (autonomy and liberty)
- Seamless, non-duplicative interface between universal core and private non-core programs
- Adequate health care personnel, capital and resources
- Effective process for medical research and introduction of appropriate new knowledge and technology
- Adaptive system allowing for continuous improvement in effectiveness and efficiency
Issues Implementing New Universalism

- Recognize and satisfy population “needs” and “wants”
- Identify, design and implement effective public health interventions
- Create incentives for efficiency and improve effectiveness of public health care resources
- Define public program “core” health care “needs”
  - Psychological services
  - Preventive care
  - End of life treatments
  - Technology dissemination
- Design, implement and manage a rational, seamless interface between public “core” and private “non-core” programs
- Design, implement and manage public oversight of private “non-core” health insurance programs
- Rationalize public vs. private resource and medical decision making