

Economic benefits from well-designed reforms to achieve Universal Health Coverage (UHC)

1. Overview

Health care reforms that aim to achieve Universal Health Coverage are being implemented in more than 100 countries globally. Governments are concerned about the costs of implementing UHC, which are difficult to quantify and depend on the way in which health care reforms are implemented. At the same time, costs need to be evaluated in light of the gains to the economy over the long term. The critical issue is how such reforms are implemented, and the ways in which these pathways promote health coverage and financial protection.

This paper aims to provide a few examples of how well-implemented reforms to achieve UHC can have wide-ranging impacts including greater financial security among households, reduced growth in health care costs, and stronger labor markets.

2. Micro-level reforms to increase efficiency and qualityⁱ

Examples of micro-level reforms that have been implemented as a part of the UHC agenda include strengthened organization of health care, provider payment mechanisms, and active purchasing. Well-implemented, such reforms can slow the growth of health care costs by reducing unnecessary care that does not contribute to better health outcomes – thus increasing quality at lower costs.

Gatekeeping is one example of strengthening the organization of care, whereby a primary care provider manages patient care and coordinates referrals to specialists and other levels of the system. Such a system helps to control costs by screening out unnecessary services, i.e., where people access costly emergency departments for primary care. Many countries require registration with and/or referral by primary providers. In some settings, patients have financial incentives to register, whereby registered patients have lower copayments.

Provider payment reforms are critical to improving the volume, quality and efficiency of health services. The way health care providers or hospital are paid provide incentives. Fee-for-service systems, for example, can increase volume and quality, but can provide incentives for health care providers to offer more services – some of which may be unnecessary.

Figure 1. Gatekeeping systems in OECD countriesⁱⁱ

	Referral by primary care provider required to access secondary care		
	Required	Incentives	None
Registration with primary care provider	Required	Denmark, Finland, Ireland, Italy, Netherlands, Portugal, Slovenia, Spain	Czech Republic
	Incentives	Australia, New Zealand, Norway, Poland	Belgium, France, Switzerland
	None	Canada, Chile, UK	Austria, Germany, Greece, Israel, Japan, Korea

Capitation promotes prevention but can also result in unnecessary referrals. Some countries combine capitation with fee-for service payments in order to reward physicians for achieving desired outcomes. Many countries use mixed methods to balance incentives: to attract patients to register and provide prevention to reduce the number of curative care consultations (capitation) and reducing unnecessary referrals (fee for service).

Figure 2. Advantages and disadvantages of two categories of provider payment: fee for service (FFS) and capitation

Provider payment mechanism	Advantages	Disadvantages
Fee For Service: pays provider according to number of services delivered	<ul style="list-style-type: none"> Accessibility Payment for delivering services 	<ul style="list-style-type: none"> Over-provision (unnecessary services provided) High administrative cost
Capitation (typically for GPs): paid fixed sum on basis of number of patients, typically adjusted by patient profile, e.g. age	<ul style="list-style-type: none"> No incentive for excess/unnecessary care More preventive care 	<ul style="list-style-type: none"> Under-provision of health care Shifting of complex cases to other health providers
MIXED method: Capitation + FFS: Used in Czech Republic, Denmark, Finland, Italy, Norway, New Zealand, Portugal, Slovakia, UK	Encourages GPs to attract patients for capitation, encourages prevention to reduce curative consultations, and reduces number of unnecessary referrals.	

Where health care providers are salaried, countries have introduced an activity-based bonus or capitation to increase motivation. At hospital level, case-based payment systems have improved efficiency.ⁱⁱⁱ In order to reduce unnecessary procedures, some countries have introduced “tapering” mechanisms, whereby the unit prices for reimbursements decline after reaching a fixed budget.^{iv} **Active purchasing** implies that fund holders are

“active” in terms of monitoring quality and prices to ensure value for money. This can include selective contracting of providers based on their performance. Active purchasing can be done through explicit contracts that set prices and quality.

3. Macro level reforms to control costs as a part of the UHC agenda can include price controls and consumer protection from catastrophic spending.

Price controls regulate health care inputs, and may include activities such as reference prices for pharmaceutical products and price setting for health services. In high- and middle-income countries, the public sector tends to have some form of price setting for specialist services, which is used to purchase services from the private sector and can provide benchmarks for private insurers.^v

Insurance reforms that cap annual out-of-pocket spending and prohibit insurance companies from selling low-quality policies with annual or lifetime limits on coverage also provides financial security. A critical aim of UHC is ensuring that people who get sick do not face catastrophic health spending (i.e., where medical costs exceed 25% of total household expenditure). Insurance reforms that protect consumers from high spending or caps on benefits can eliminate poverty resulting from catastrophic health care spending.

Delinking health insurance as an employment benefit.

Where people rely on their employers for insurance, they can be locked into a job - particularly for people or family members with pre-existing medical conditions. By establishing universal entitlements to health care, health insurance is no longer tied to employment - and thus promotes financial security as well as labor mobility as people are free to move to new jobs without fear of losing their health coverage.

4. Conclusions

By increasing efficiency and reducing waste, reforms can reduce the rate of growth in health care costs. Many countries implement reforms because they face health care prices that are increasing above the rate of inflation. Examples of reforms that can achieve greater efficiency and slow the growth in health care costs include changing the way health providers are paid. This can reduce excessive and unnecessary payments to medical

providers. These payment models can also provide incentives for high-quality care and health outcomes.

Slowing the growth in health care costs can have broad economic benefits to employers and the economy as a whole. Slowing the growth of health care costs can reduce the increases in health insurance premiums paid by employers or government – and the share paid by employees. In the short run, lower health insurance premiums can promote employment by reducing the cost to the employer of hiring additional workers. Reductions in the share of premiums paid by employers can be passed onto employees as higher wages. Lower premiums paid by both employers and employees can increase disposable income, which can be spent on other goods and services to promote economic growth.

By giving families more options for obtaining affordable health care not linked with their employers, reforms make it easier for people to take risk – change careers, start a business, take time out of the labor force to raise a family, or retire when they are ready. **Increasing job mobility can increase an individual’s wages and productivity, and encourage entrepreneurship – which support a healthy labor market.**^{vi}

Reforms that promote access to quality health care can prevent illness and premature death. Preventing illness enables people to live longer, healthier and more productive lives. Healthier people miss fewer days of work, are less likely to become disabled, and tend to spend more years in the workforce.

Governments are rightly concerned about the costs of UHC. However, costs should be evaluated based on gains – to health as well as the economy over the medium and long-term. Where reforms have been well-designed and well-implemented, economic benefits result – including increased household financial security, reduced growth in health care costs, greater productivity, and a stronger labor market.

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