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Why pricing is important

1.1 How does pricing fit within the commitments for Universal Health Coverage?

In 2015, United Nations member states reiterated their commitment to universal health coverage (UHC) so that all people have access to quality health care without exposure to financial hardship (WHO, 2019a). Implementing UHC reflects three dimensions of coverage: who is covered, what services are covered, and how much will be paid. In this report, we focus on the price of health services but omit the prices of pharmaceuticals and health insurance. Pharmaceutical prices are covered in detail elsewhere (OECD, 2018; WHO, 2015a).

Pricing health services is a key component in purchasing the benefits package (the covered services) within the overall financing system (Evetovits, 2019). Pricing and payment methods are important instruments in purchasing that provide incentives for health care providers to deliver quality care. A second instrument is contracting, in which the conditions for the payment of services are defined, and prices can be used as signals to providers. A third is performance monitoring. Where health care providers are rewarded based on the outcomes they achieve, these payments also must be priced correctly to provide the right incentives.

If the price set is too high or too low, it can easily overshadow the incentives in payment mechanisms. Prices should reflect actual costs and take into consideration broader health system goals and health outcomes. If not, unintended negative consequences could arise. In example, if prices are set too low for capitation payments, this could result in low quality care, provider selection of healthier patients, or referral of complex cases that require a higher intensity of services to another service provider. Where the FFS payment is low, providers may try to compensate by increasing volume and providing additional (unnecessary) services. If prices are not fair, service quality, efficiency, and sustainability also suffer. In some settings, low prices that do not sufficiently reward health care providers are blamed for informal fees to patients, in which the financial burden falls on individuals and society.

In the case of balance billing, health care providers are permitted to bill patients at prices higher than the regulated rates, and the difference is paid by the patient. Under balance billing, services could be underprovided where patients are unable to pay – even though the services are part of the benefits package and valued by communities and societies. In this case, the government's commitment to deliver on UHC would shift some of the financial burden to individuals.

1.2
Why intervene in pricing?

To attain their commitments to UHC, governments are obligated to take reasonable regulatory and other measures, within available resources, to achieve the progressive realization of the right to health care. This is particularly important in health care markets, which are characterized by such failures as information asymmetry, lack of information on prices and quality that preclude consumer choice, adverse selection, and moral hazard (Arrow, 1963).

For most commodities, pricing is determined based on supply and demand. Unlike other commodities, payers and consumers of health care usually know far less than the "seller" (i.e., the health care provider), who advises about which treatments or medicines are the best options – while concurrently having a financial interest in the ultimate decision on what option to use. For many commodities, consumers assess the price and value of goods; in health, insurance insulates consumers from the full price. Given that accurate comparable information about prices and technical quality are frequently unavailable, the value of health services is difficult to assess. At the same time, demand for acute care and hospital services provided in times of health need is less responsive to price. Information asymmetry is also present in health insurance markets, since insurers do not know what health conditions consumers have – thus leading health insurance companies (where unregulated) to implement policies to reduce their risks of accepting high risk patients.

Important externalities exist in health, implying that investments have broad benefits for communities and the public. Successfully treating someone with tuberculosis, for example, benefits not only the patient but also the community in which s/he lives. In this instance, price setting (among other tools) can be used to ensure adequate funding for public health goods, such as uncompensated hospital care that benefit communities; thus, prices should reflect the value of services to individuals and society. This is particularly important given that hospitals are, in many cases, obligated to serve all patients with medical need regardless of ability to pay.

As such, health markets differ from conventional markets in several key ways (Clarke, 2016). Consumer purchasing power is either centralized in a single purchasing agency or allocated to users in the form of vouchers rather than cash. This change in consumer purchasing power makes consumers less sensitive to price signals. Non-profit organizations compete for public contracts, sometimes in competition with for-profit organizations. Consumers are represented in the market by agents instead of operating by themselves. In addition, the price signals that connect purchasers and providers operate in a rather different way, as prices are not formed directly by the interplay of demand and supply, but rather are administered, collectively negotiated or individually negotiated.

Controlling the growth of health care spending while maintaining or increasing access is a major policy priority of most governments. Generally, health care spending increases at rates higher than general inflation. This is a function of both volumes of care and prices. In the USA, high prices alone are estimated to account for half or more of the growth in health care spending (Martin et al., 2014). Wide price variation can be seen both across countries and within the same country across regions and facilities (Cooper et al., 2018). Increases in both prices and volumes can be attributed to the adoption of new technologies, increases in income, insurance design and demographics. The demand for health and social services are expected to increase with population ageing (European Commission, 2018). In this context, price setting serves as an instrument to reduce or increase volumes of certain services or treatment modalities to control costs (Anderson et al., 2003; Anderson, Hussey and Petrosen, 2019).

Many OECD countries have established price schedules enabling them to purchase services from the private sector.

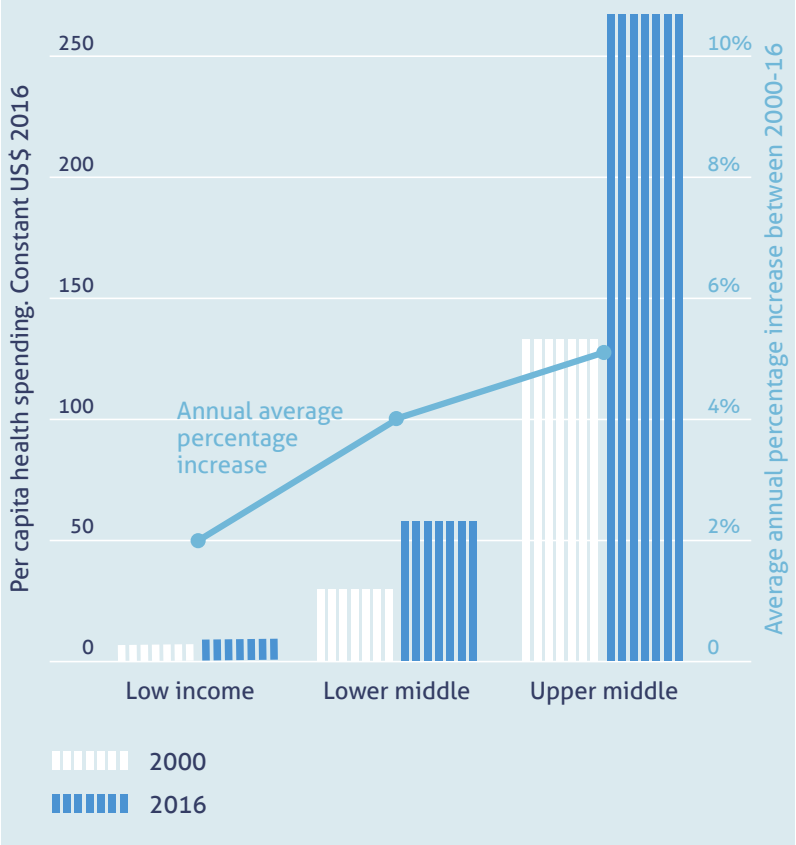
The progressive realization of UHC implies that all countries strive to extend or ensure coverage while facing technological progress, ageing populations, and increasing expectations for good quality health care. Rising health care spending has pressured policy-makers to maximize all available health resources towards meeting these expectations. Governments frequently draw on the private sector to promote sustainability, optimal use of resources, and increased choice of care. In doing so, policy-makers face the challenge of harnessing resources and efficiency gains while addressing the market failures and equity concerns associated with the private financing of health care. Many OECD countries have established price schedules enabling them to draw on private sector facilities to expand access to care. This is used to purchase services from the private sector, provide benchmarks for private insurers, and negotiate with private insurers and facilities. These experiences may be informative for low- and middle-income settings.

1.3 Relevance to low- and middle-income settings

Low- and middle-income countries represent a diverse group of nations. The 34 poorest countries in the world differ greatly from high-income countries. Low-income countries focus on extending access to basic services and, in some cases, rely on external funding for health (WHO, 2018). Experimentation in financing health services is also being done as a part of donor contributions. Health systems challenges in middle-income countries are similar to those in high-income settings. Middle-income countries with a gross national income between US$1006 and $12,235 per capita represent more than 70% of the world's population and a large share of the disease burden (World Bank, 2019). Increases in public spending on health[2] are

2 For ease of reading, we refer in this paper to spending by government and compulsory health insurance as "public" spending on health.

Figure 1
Per capita public spending on health, 2000-16, constant US$ 2016, low- and middle-income countries



Source: WHO, 2018.

occurring across all countries (WHO, 2018), whereby spending on health rises with per capita income. However, the share of public spending on health doubled between 2000 and 2016 in middle-income countries (Figure 1).

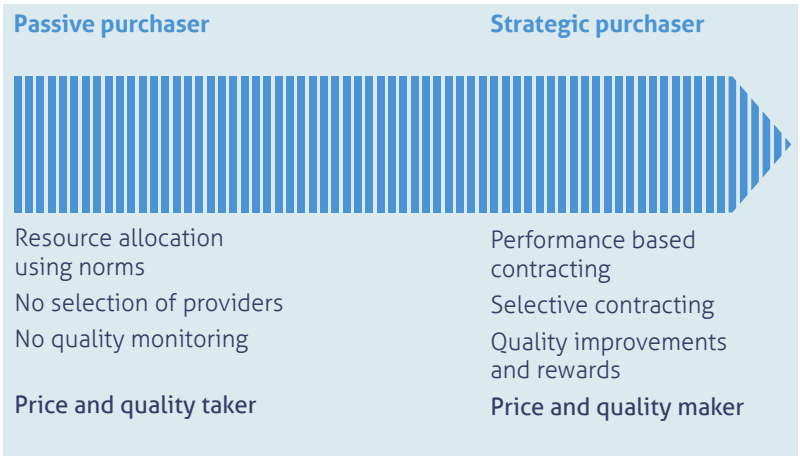
Within the increase in public spending on health, countries are striving to establish well-functioning health systems towards attaining UHC. In doing so, they are paying more attention to value for public spending on health, and the decisions about how to channel funding and organize services to respond to people's needs. This is particularly true for inpatient services and curative outpatient care, which accounts for 70% of total public spending on health on average globally (WHO, 2018). As health systems mature, policies take on greater importance in ensuring financial protection. Policy decisions about the services covered, payments to providers, and the conditions for these payments become the determining factors in driving patient costs –and far overwhelm any individual care-seeking behaviours (Getzen, 2006).

In response to these opportunities, many countries are introducing new ways to finance, organize, and deliver health care. Understanding the methods for price setting takes on a higher level of importance where systems are rapidly changing to account for increasing levels of resources and changing

patient needs. To more strongly align payment with the costs that health care providers incur in delivery different types of services, countries are modifying the basis for payment for health care providers from line-item budgets to alternatives such as FFS, per diem, and diagnosis related groups (DRGs), and determining how to price these services. Substantial numbers of low- and middle-income countries have already established DRG-based payment systems to pay for acute inpatient care (Mathauer and Wittenbecher, 2013). Such a move enables countries to take an active strategic approach in defining what services are purchased and paid for, and how to link payments with quality and performance. Further this move allows purchasers to shift from being a "price and quality taker" to a "price and quality maker" (Figure 2).

In some low- and middle-income settings, a large share of health care utilization is in the private health care sector, which can range from unregulated pharmacies to specialized tertiary care hospitals. A key question is how to make use of all health resources – from both private and public sources – to attain health-related goals. In middle-income settings, high prices in the private sector can undermine UHC objectives by draining resources from the public sector where most of the population accesses services (Barber et al., 2018). Where prices and premiums are unaffordable for most people, the private sector does not contribute to improving population health commensurate with its share of resources. Accordingly, governments are obligated to address high prices because of their implications for equal access to health services.

Figure 2
Moving from passive to strategic purchasing



Source: Evetovits, 2019.

Some aspects of health systems in low- and middle-income countries should be considered when implementing changes in financing systems. There are higher rates of poverty; middle-income countries are home to 73% of the world's poor (World Bank, 2019), which underscores the importance of protection from catastrophic health spending and promoting equitable access to services. These settings tend to have less robust regulatory environments for controlling quality in health care facilities (public and private) and medical products, and less advanced professional associations (Clarke, 2016). In settings with weaker professional associations, changes in the base for payment to capitation has resulted in an under-provision of services (Mills et al., 2000). Some level of hospital autonomy is needed to ensure that hospitals have decision-making authority to respond to incentives for efficiency. Moreover, purchasing arrangements assume a level of managerial capacity, including financial management, systems of information about health, utilization, and expenditures, and the ability to enforce contracts. Experience from high-income countries shows that DRG-based payments are complex and require careful monitoring of care quality as well as volumes. Systems are needed to monitor and adjust prices to align with system-wide objectives. These institutional factors affect the speed in which changes in purchasing can be implemented. However, the process of change is both incremental and dynamic – and many countries implement changes in financing while also building critical capacities in health systems during implementation (Mathauer and Wittenbecher, 2013).

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