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# Comparison of case studies

## 2.1
## Demographics and health resources

Context and institutions are key factors in determining the choice of payment systems. A range of middle and high-income settings were selected for the study (Figure 3). Seven are OECD member states. Thailand and Malaysia are both upper middle-income countries. In three of these countries, more than one quarter of the population is 60 years or older (Japan, Germany, and France). In three other settings (Maryland, Thailand, and Malaysia), the population is relatively young.

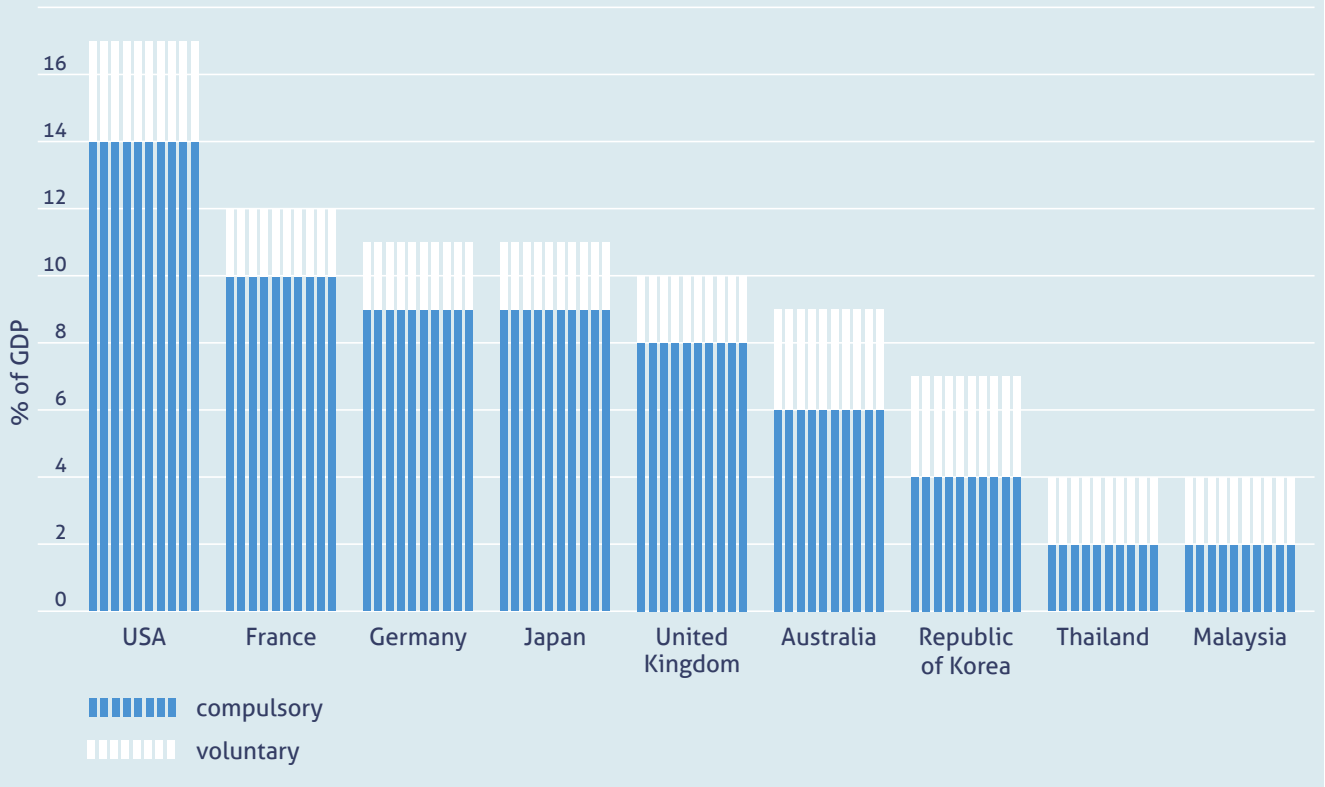
Figure 3
Characteristics of case study settings

| | | | | Inputs per 1000 population | | |
|---|---|---|---|---|---|---|
| Setting | Population 2015 | % of population >=60 years | GDP per capita, US$ 2016 | Physicians | Nurses and midwives | Hospital beds |
| Australia | 23,799,556 | 21 | 54,069 | 3.5 | 12.4 | 3.8 |
| England | 55,670,000 | 23 | 31,200 | 2.8 | 8.4 | 2.6 |
| France | 64,457,201 | 26 | 36,826 | 3.2 | 10.6 | 6.5 |
| Germany | 81,707,789 | 28 | 42,456 | 4.2 | 13.8 | 8.3 |
| Japan | 127,974,958 | 33 | 38,640 | 2.4 | 11.2 | 13.4 |
| Malaysia | 30,723,155 | 10 | 9,508 | 1.5 | 4.1 | 1.9 |
| Republic of Korea | 50,593,662 | 20 | 27,785 | 2.3 | 6.9 | 11.5 |
| Thailand | 68,657,600 | 17 | 5,911 | 0.5 | 2.3 | 2.1 |
| Maryland, USA | 6,042,718 | 15 | 55,404 | 2.6 | NA | 2.5 |

Sources: UN, 2017, 2019; United States Census Bureau, 2019; World Bank, 2019.

Wealth is correlated with the level of inputs to the health sector. Decisions about the allocation of resources is subject to aggregate constraints, whereby the first step is determined by the total resources available (Getzen, 2006). The total amount of resources for health varies widely across these settings. Current health expenditure as a share of GDP ranges from 17% in the USA to less than 4% in Malaysia and Thailand (Figure 4). The source of most spending in all settings is compulsory (i.e., set aside by the government for certain health programs or initiatives), except for Malaysia, where public compulsory and private voluntary expenditures are reported as equal shares.

Figure 4
Current health expenditures as a share of Gross Domestic Product (GDP), 2016 or most recent year




Source: WHO, 2019b. Note: Compulsory or mandatory refers to the mode of participation, whereby coverage of the population is automatic or universal, and participation is mandatory by law including social health insurce or compulsory private health insurance. Voluntary refers to coverage obtained at the discretion of individuals or firms, including voluntary private health insurance. Spending on capital items is not included.

## 2.2 Health care coverage

The nine settings included in the study each represent variations in the main source of health care coverage. Australia, Malaysia, England, and Thailand's Universal Coverage Scheme have systems of health coverage based on residence or citizenship. The other settings have employment-based contributory health coverage and vary by the number of payers. In the Republic of Korea, there is a single payer system, whereas in France and Japan, multiple payers exist with automatic (compulsory) affiliation. In Germany and the USA, multiple payers exist with choice of affiliation (Figure 5).

Figure 5
Main source of health care coverage for case study settings

| Main source of basic health care coverage | | Country |
|---|---|---|
| Citizen entitlement | | Australia, Malaysia, Thailand (UCS, CSMBS), England |
| Employment-based converage | Single payer | Republic of Korea, Thailand (SHI) |
| | Multiple payers with automatic affiliation | France, Japan |
| | Multiple payers with choice | Germany, USA |

Sources: Paris, Devaux and Wei, 2010; Jongudomsuk et al., 2015. Note: UCS: Universal Coverage Scheme; CSMBS: Civil Servant Medical Benefits Scheme; SHI: Social Health Insurance.

Among the settings studied here, voluntary health insurance (VHI) plays different roles (Figure 6). VHI can generate additional financial resources for the health care system. It should be noted that private funding is not equal to private provision, and private insurance can pay for covered services. At the same time, it can contribute to cost escalation, given that many cost-control measures used in the public sector – such as price regulation and global budgets – are not typically employed in the private sector.

In France, Germany, Republic of Korea and Japan, private insurers focus on covering the gap between public reimbursements and actual fees, as well as providing access to additional services (complementary insurance). In Germany, a share of the population opts out of the public social insurance program and obtains care from private insurers. In Japan, VHI developed as a supplement to life insurance and offers additional income in the case of illness (The Commonwealth Fund, 2019). In Australia, Malaysia, and Thailand, VHI also provides coverage for additional services. In the United Kingdom, people can purchase VHI to reimburse care in a private facility, which may offer quicker access for elective services (supplementary insurance).

Figure 6
Spending on private voluntary health insurance, population and services covered, categorized by insurance role

| Setting | % of total health spending | % of population covered | Services covered |
|---|---|---|---|
| A. Complementary: covers user fees | | | |
| France | 13 | 95 | Covers copayments for services included in the social insurance basket based on regulated prices; varying coverage of extra billing and extra services. Deductibles cannot be covered. |
| Germany | 9 | 27 | Outpatient care, per diem cash benefits for hospitalization. |
| Republic of Korea | 7 | >70 | Copayment for public insurance and payment for uninsured services. |
| B. Complementary: covers additional services | | | |
| Germany | 8.9 | 27 | Dental and eye care, more extensive ranges of services not covered by social health insurance; in addition to full coverage for self-employed. |
| United Kingdom | 3.4 | 5 | Dental care, complementary and alternative medicines, more rapid and convenient access to care, especially for elective hospital procedures. |
| Japan | 2 | 88.5 | Copayments; lump-sum payments when insured persons are hospitalized or diagnosed with cancer or another specified chronic disease, or through payment of daily amounts during hospitalization over a defined period. |
| USA | 50 | 14.6 | Persons eligible for public benefits, i.e., Medicare can purchase VHI for additional coverage including long-term care; spending figures also include primary care for people covered through employers. |
| C. Supplementary: amenities, choice, faster access | | | |
| United Kingdom | 3.4 | 9 | Faster access, choice of private provider and of specialist acting in a private capacity, better amenities. |
| Australia | 9 | 47 (hospital) 56 (general treatment) | Choice of providers (particularly in hospitals), faster access for nonemergency services, and rebates for selected services. |
| Malaysia | 10 | NA | Private hospital access, faster access. |
| Thailand | 7 | 24 | Exclusion of prior conditions and older persons; private hospital and faster access although more expensive. |

Sources: Sagan and Thomas, 2016; Commonwealth Fund, 2019; case studies (see annexes).

The extent of government regulation of private health insurance varies. Factors contributing to stronger regulation include the presence of private insurers, insurance policies about access, and level of premiums. Experience suggests that price setting for the private sector alone can create incentives for providers to shift care to other providers that are not subject to regulation. This can inhibit greater coverage, efficiency, and health outcomes (Kumar et al., 2014). Experience from France shows that the private insurance market can be effectively regulated with financial incentives (i.e., fiscal rebates) to reduce patient selection and price escalation.

## 2.3
## Health system characteristics

Price setting and systems of purchasing are dependent on key features of health systems that vary considerably across settings. For example, the OECD countries in this study have robust regulatory systems. This affects the degree of competition among purchasers and providers and choice of payment and price negotiation methods. The strength of professional associations affects systems of education and self-regulation. Strong professional associations enable formal systems of representation for price negotiations. In addition, market concentration is an important determinant of negotiating power, as seen in the USA, which can affect prices.

Figure 7
Mechanisms to nudge values towards Universal Health Coverage

| Mechanism | Instrument | Rationale |
|---|---|---|
| Command and Control | Health Law | Prohibition on unlicensed care |
| Command and Control | Minimum Facility Requirements | Indicator of Accreditation |
| Command and Control | Clinical guidelines and standards | Standard of care usually not complete |
| Command and Control | Issuance of license | Can be based on geographical location and needs |
| Command and Control | Accreditation | Done by professional body and tie to health insurance payment eligibility |
| Financial Incentives (including price control) | Funding to private general practitioners, hospitals, labs, pharmacies, etc. | Will need mechanism to monitor if service is of good quality |
| Self Regulation | Professional subcommittee function | Professional associations provide training, empowerment, etc. |

Source: Cowley, 2019.

Figure 7 illustrates key instruments used across the WHO Western Pacific Region, and places price regulation within the broader context of attaining the goal of UHC. The capacity of the health purchaser is a key determinant of the choice of payment methods, given that complex systems require higher capacity to collect and analyse information, and ensure standards of quality care. In some low- and middle-income settings, health laws may be weak or poorly enforced, which can result in technically substandard care. Formal systems of accreditation, which are assumed for high-income countries, may not exist or operate as focused accreditation for specific services or categories of facilities. The foundation for payment systems, particularly for bundled payments, is clinical care pathways that may not be implemented in all settings. The absence of these mechanisms limits choices; however, these supporting policies and instruments can be developed over time.

Weak information systems are particularly challenging in many countries. Mills (2011) analysed the impact of weak information systems on financing in four low- and middle-income countries (Ghana, Zimbabwe, India, and Sri Lanka). She reported poorly developed cost accounting systems in hospitals, limited data to cost public services, and lack of information about private facilities and activities. These factors represent capacities that affect the speed of implementation of payment mechanisms.