

The background of the page is a photograph of a modern building's facade, featuring a grid of dark window frames and light-colored panels. The image is split horizontally by a solid red band.

Global perspectives on methods of healthcare funding

About ACCA

ACCA (the Association of Chartered Certified Accountants) is the global body for professional accountants. We aim to offer business-relevant, first-choice qualifications to people of application, ability and ambition around the world who seek a rewarding career in accountancy, finance and management.

Founded in 1904, ACCA has consistently held unique core values: opportunity, diversity, innovation, integrity and accountability. We believe that accountants bring value to economies in all stages of development. We aim to develop capacity in the profession and encourage the adoption of consistent global standards. Our values are aligned to the needs of employers in all sectors and we ensure that, through our qualifications, we prepare accountants for business. We work to open up the profession to people of all backgrounds and remove artificial barriers to entry, ensuring that our qualifications and their delivery meet the diverse needs of trainee professionals and their employers.

We support our 162,000 members and 428,000 students in 173 countries, helping them to develop successful careers in accounting and business, with the skills needed by employers. We work through a network of over 89 offices and centres and more than 8,500 Approved Employers worldwide, who provide high standards of employee learning and development.

This paper brings together the views of senior ACCA members around the world on how different healthcare systems are funded.

The discussions provide an insight into the advantages and disadvantages of each system as well as identifying opportunities for shared learning.

FOR FURTHER INFORMATION

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Contents

Foreword.....	5	New Zealand	Gordon Ngai, FCCA	27
Bulgaria		Northern Ireland	Lesley Mitchell, FCCA	29
Mario Iliev	6	Pakistan	Ayaz Ahmed, FCCA.....	31
Canada		Scotland	Claire Wilkinson, FCCA	35
Henry Kalule Lukenge, FCCA	8	Singapore	Sito Hup Ying, FCCA	37
Canada		Slovakia	Martin Hrežo, FCCA	39
Jayshri (Jay) Makwana, FCCA	10	United Arab Emirates	Jawad Jamil, FCCA	42
China		Zimbabwe	Maurice Dube	45
Duke Chen, FCCA	14			
England				
Michael Schofield, FCCA.....	16			
Ethiopia				
Hruy Ababayehu, ACCA	18			
Ghana				
Alex Odoi Nartey, FCCA	20			
India				
Ravindran Balakrishnan, FCCA.....	23			
Mauritius				
Ramkumarsing Emrith, FCCA	25			

ACKNOWLEDGEMENTS

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Foreword

As an ACCA council member and an experienced finance professional working in the UK health sector it is my pleasure to write the foreword for this publication which brings together the views of senior ACCA members on how different healthcare systems are funded globally.

ACCA is already recognised as an international thought leader in healthcare finance and works with the European Commission and other organisations around the world to publish works that promote the economic benefits of providing better quality health care. This piece of work, produced in conjunction with senior ACCA members employed in health systems around the world, aims to build on that reputation by discussing some of the key payment systems in use and the advantages and disadvantages of each.

I would like to thank each of the contributors. They more than ably demonstrate the role ACCA members play in supporting delivery of high quality, cost effective healthcare across the world.

Globally, the health service is facing funding pressures from the:

- shortage of doctors and nurses
- increasing demand and expectation from patients
- technological advances that push up costs
- an ageing population
- increase in chronic diseases.

This report demonstrates that there is no easy solution to meeting these challenges. It does, however, provide a valuable starting point for discussion.

Accountants have an important part to play in ensuring the efficient use of health care resources and ACCA, working with its members, will continue to contribute to the debate.



Mark Millar FCCA
ACCA Council member and chairman of the
ACCA Health Network Panel 2003–6

Bulgaria

Mario Iliev



Organisation

AstraZeneca, Bulgaria

Position

Chief financial officer

Specialist interest in the workplace

Finance and sales excellence.

RELEVANT NATIONAL GUIDANCE

<http://www.mh.government.bg/>

<http://www.en.nhif.bg/web/guest/legal-framework>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN BULGARIA?

Bulgaria employs the following payment systems:

- capitation
- fee for service
- co-payment
- payment for outcomes.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN BULGARIA.

In the Republic of Bulgaria, public health insurance is mandatory. The insurance scheme is administered by the National Health Insurance Fund (NHIF) or one of its 28 regional offices: Regional Health Insurance Fund (RHIF). Founded in March 1999, the NHIF is an independent public institution that operates independently of the healthcare system.

The amount each person is required to contribute depends on such factors as employment status and income level. If the total contributions were insufficient then the scheme would be underfunded and this would reduce access to care and introduce financial risks to hospitals and pharmacies.

The health insurance programme does not cover the cost of many innovative therapies and medicines that are known to be of benefit to patients; medical devices and dietary foods, for example, are not covered by the scheme.

There are frequent changes to regulations, and this leaves little time to evaluate and reflect on initiatives related to health care provision; such changes also have a negative impact on the contractual process.

Reimbursement rates vary. Therapeutic areas that are classified as priorities –including oncology, respiratory diseases and diabetes – are reimbursed at 100% by the NHIF. Rates for other disease groups vary; cardiovascular services, for example, are reimbursed at 25%.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN BULGARIA?

Advantages

The price of reimbursed medicines must be set at the lowest of 12 reference countries. This guarantees that Bulgaria has some of the lowest drug prices in the European Union (EU).

Pharmaceutical prices are revised every six months.

The positive drug list (the list of drugs that may be prescribed through the health insurance scheme) is opened half yearly.

Disadvantages

Out-of-pocket payments, at 64%, are the highest in the EU. As a result, patients often delay seeking care until the later stages of disease, at which point treatment costs are frequently much greater than would otherwise be the case.

In comparison with other EU countries, Bulgaria is slow to introduce new products and technologies.

Insufficient administrative capacity allows no time for health technology assessment (HTA), healthcare economics or for the introduction of quality measures.

The healthcare infrastructure is not set up to track resource consumption or to measure outcomes at a patient level.

The funding allocated to health care in Bulgaria is half that of Western Europe – only 4% of GDP.

There is 20% VAT on medicines and this rate is expected to remain in place for the foreseeable future.

The low pricing of pharmaceutical products introduces the risk of parallel exports. (Where a trading firm purchases quantities of drugs and then exports them to another country where they can be sold for higher prices.) This introduces the risk that thousands of patients will be without medication.

Canada

Henry Kalule Lukenge, FCCA



Organisation

Nexim Healthcare Consultants

Position

President and CEO

Specialist interest in the workplace

Entrepreneurship, business development, project funding, project planning, financial analysis, innovation and product planning, project evaluation and social enterprise.

RELEVANT NATIONAL GUIDANCE

http://www.policy.ca/policy-directory/Detailed/Health-Care-Reforms_-Just-How-Far-Can-We-Go_-1860.html

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CANADA?

Canada has a publicly funded healthcare system. The federal government raises funds through payroll deductions (a health care tax). These funds are then used to pay private institutions for providing care to all Canadians, irrespective of their income.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CANADA.

The Canadian healthcare system, both the services provided and how they are paid for, has evolved over time. The underlying philosophy, however, is that people should have access to services regardless of ability to pay. This was enshrined in law by the Canada Healthcare Act of 1984 and expanded by the Medicare Act signed by the Lester Pearson's Liberal government.

The provincial ministry of health issues a health card to each individual who enrolls in the programme and this entitles each person to a standard level of care. There is no need for a selection of different plans as virtually all essential basic care, including maternity and infertility treatments, is covered.

The extent of coverage does, however, vary slightly between provinces. Dental and vision care, for example, are not covered by all provinces, though they are often covered by employers through private insurance companies, and in some provinces private supplementary plans are available for those who prefer to stay in private rooms when in hospital.

Cosmetic surgery and some non-essential surgical procedures are not covered; these can be paid for by the patient or through private insurers.

Healthcare coverage is not affected by loss or change of job, care cannot be denied because of unpaid premiums (in British Columbia) and there are no lifetime limits or exclusions for pre-existing conditions.

Canadians strongly support the public health system; they are not in favour of the for-profit private health system. A 2009 poll by Nanos Research, for example, found that 86% of Canadians surveyed supported or strongly supported 'public solutions to make our public health care stronger'. Another survey, undertaken by the Strategic Counsel in 2008, found that 91% of Canadians preferred their healthcare system to a US-style system.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN CANADA?

The Canadian healthcare system places the emphasis on end users and service provision. The focus is very much on reducing or minimising administrative costs. The government relies on employers to collect healthcare premiums and then to pass these to the federal government to fund health care for enrolled members. Claims for services provided by general practitioners and hospitals are paid without the need for intermediary organisations.

Another noteworthy feature is that because primary care providers have no direct profit motive, they are inclined to go above and beyond the call of duty to ensure that their patients get well. They encourage attendance for check-ups, for example, the use of alternative therapies and innovative treatments.

As with healthcare systems in other countries, Canada faces the threat posed by an ageing population and low birth rates, though immigration policies have helped to address this.

The disadvantages of the Canadian healthcare system mainly relate to long waiting times and difficulties in evaluating the performance level of hospitals and other service providers. The government assesses hospital and primary care provider performance through surveys but there is no effective way of quantifying value for money.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM CANADA?

There are many great elements of the Canadian healthcare system but the following are particularly noteworthy.

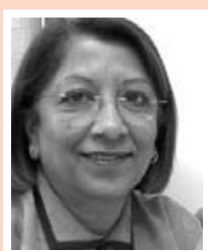
Eligibility: free health care is available only to Canadian permanent residents or resident aliens; it is not available to anyone who turns up at a medical establishment.

Low litigation culture: Canadians, unlike Europeans and people in the US, tend not to sue for medical malpractice. While working in Europe and the US I saw growing numbers of doctors and hospitals sued for what were often trivial matters. The legal charges and pay-outs related to these claims inflate hospital and primary care running costs, increasing the cost of providing care. If the litigation culture could be minimised in Europe and the US then doctors could focus on service provision. I have seen fewer cases of clinical litigation in Canada than anywhere else I have worked or lived.

Minimisation of non-medical costs: this enables the maximisation of each dollar spent on health care.

Canada

Jayshri (Jay) Makwana, FCCA



Organisation

Vancouver Coastal Health (VCH), British Columbia

Position

Director, strategy and evaluation, Regional Mental Health and Addiction Program

Specialist interests in the workplace

Strategic planning and the evaluation of systemic transformational efforts. This includes innovation and performance management of an integrated approach to care that is patient-centred, equitable, accessible, appropriate, cost effective and sustainable.

RELEVANT NATIONAL GUIDANCE

<http://www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoc02vol6-e.htm>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CANADA?

Canada employs the following payment systems:

- capitation (funding based on population needs)
- fee for service (physician funding and activity-based funding)
- co-payment (global budgets)
- payment for quality
- payment for outcomes
- bundled funding (funding per episode of care).

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CANADA

The Canada Health Act is federal legislation that puts in place conditions by which individual provinces and territories in Canada receive funding for healthcare services. There are five main principles in the Act: public administration, comprehensiveness, universality, portability and accessibility.

Population-based funding refers to historical methods and rules for allocating funds from central government to regions in order to fund the healthcare services for the residents of the regions. This method uses physician, hospital and post-acute care data plus demographic, socio-economic, and other health-related characteristics to project a geographic region's healthcare expenditure over a fixed period of time.

Under global budgets, a fixed amount of funding is distributed to a health care provider, who is then responsible for healthcare services for the region's residents for a fixed period of time. The health care providers include most Canadian hospitals, long-term care facilities, publicly funded rehabilitation facilities, and mental and public health programmes. Few developed countries use only global budgets for funding health care services. The Canadian funding model is based on historical spending, inflation, negotiations and politics in many provinces, rather than on the type and volume of services provided.

Physicians in Canada are primarily paid through a fee-for-service (FFS) system. FFS is a retrospective payment system

that is intended to cover all costs borne by a physician plus a margin for each service provided. FFS provides incentives for physicians to increase the volume of services provided to patients. FFS can also apply to un-bundled service activities such as magnetic resonance imaging (MRI) as part of a patient care plan.

Activity-based funding (ABF) is becoming the norm for funding acute care and is based on the type and amount of care provided using diagnosis-related groups (DRGs): services for clinically similar patients are aggregated into a group. While ABF is most common for acute hospital services (where patients' episodes are relatively easy to observe) it has also been adapted for funding non-acute care services, such as long-term care, mental health, continuing care, inpatient rehabilitation and ambulatory care as well as some community and home care programmes.

ABF for complex continuing care is fundamentally different from ABF for acute care. Whereas, in acute care, hospitals are remunerated for each hospitalisation, this is not the case in complex continuing care. In complex continuing care, providers are remunerated for each day of stay (a 'per diem' system); however, the amount of funding for each patient is based on the clinical and functional characteristics of the patient. The daily funding amount is intended to compensate providers fairly for the provision of care while creating incentives to do so efficiently. New models are under development to give incentives for diverting patients from hospitalisation, with community and home support where appropriate.

Pay for performance is a form of activity-based funding with additional accountabilities for improving quality, patient safety, timely access and appropriateness along the continuum of care.

Payments for bundles of care are for a set of services or treatments provided to a patient for an episode of care that takes place across providers and settings; this breaks down 'silos' and supports more coordinated and collaborative care. For bundled payments to create effective incentives, accurate, timely and linkable data needs to be collected across all healthcare settings, including hospitals, post-acute care settings and providers, physicians and emergency departments, as well as primary care programmes.

Motivated to improve quality while striving to ensure a sustainable healthcare system by constrained costs, Canadian

provinces have begun experimenting with healthcare funding reforms. In 2010, British Columbia implemented several funding changes under the umbrella of patient-focused funding (PFF) in the largest hospitals.

Historically, kidney and cardiac services in British Columbia have used funding methods based on procedural costing; this means that funds are allocated according to expected costs of service provision for all aspects of clinical care. Variations of ABF models are being phased in for funding long-term care in some provinces.

The emergency department pay-for-performance (ED P4P) programme in British Columbia hospitals is designed to create financial incentives for hospitals to improve access to emergency care by reducing waiting times in emergency departments. Hospital funding is based on the number of patients meeting established waiting time targets.

ABF has been implemented in many provinces under the Federal Wait Time Strategy, whereby provinces use targeted funds to purchase additional surgical care from hospitals to reduce waiting times, thus providing an opportunity for hospitals to generate additional funds linked to the volume of surgical procedures performed.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN CANADA?

The population-based method can reduce inequities in the funding of healthcare services by allocating funds to regions on the basis of the characteristics of the people living there rather than the amount they received in previous periods. Furthermore, population-based funding is also seen as strengthening regional autonomy, and flexibility, in providing healthcare services.

On the other hand, population-based funding methods are limited by their ability to capture accurate and objective measures of the underlying population's need for medical care. Many of the models are based on historical use data, which may not reflect appropriate use of medical care when assessing outcomes. Another limitation of population-based funding methods is that they may not accurately reflect legitimate geographic variations in health care need.

Global budgets provide an effective method of controlling expenditure through the use of a cap. The primary strength

of global budgeting is that it provides budgetary predictability and, in some cases, transparency.

To meet budget targets, some providers may, however, restrict access to services. This results in waiting lists, a frustration with which many Canadians are familiar. Moreover, global budgets provide little incentive for improving efficiency, investing in quality improvement or for integrating services with providers across the continuum. It is not uncommon to find healthcare institutions restricting or rationing funds early in the year to ensure that sufficient resources are available later in the year. Together, these factors can reinforce historical inequities in funding or inefficient models of care. It can be argued that global budgets provide financial disincentives for providers to maximise the cost efficiency and cost effectiveness of their services.

A major drawback of global budgets for hospitals is the lack of incentives to integrate their services with those of post-acute care providers. As a result, one in eight beds is routinely occupied by a patient waiting for discharge from hospital. The lack of integration between hospital and community providers has negative implications for quality: it results in higher system-wide costs, leads to suboptimal clinical outcomes, introduces risks to patients' safety and reduces access to hospital services for those waiting.

This modality of funding introduces a financial risk to healthcare institutions if changes occur in volumes, case-mix or complexities of care.

The most common objectives for adopting activity-based funding (ABF) are to make funding more transparent and to create incentives for increasing productivity and efficiency. ABF is associated with increased access to hospital care and reduced waiting times for acute care services. Policymakers see several benefits of introducing ABF methods into continuing care settings: it is a means of providing opportunities to align funding with patient characteristics, of reducing unwarranted variation in costs and of monitoring quality of care.

This positive outcome is partly undermined by the commensurate increase in expenditures due to increase in volumes. In contrast to global budgets, the depth of information needed to support ABF is relatively high.

Bundled funding is an emerging form of healthcare funding

that is patient centred, and seeks to create financial incentives for providers to formalise linkages between care providers so as to improve care transitions and care coordination, and to reduce inappropriate cost shifting. Potential benefits of bundled payments include the opportunity to develop comprehensive and longer-term measures of quality and outcomes, explicit incentives to reduce readmissions due to fragmented care, and holding providers responsible for the consequences of disjointed care.

As bundled payments are a fairly new mechanism for funding health care, they face methodological challenges, including the means of consolidating and measuring inputs and outcomes across care continuums, which is necessary before payment tariffs can be set.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM CANADA?

Issues and challenges currently being shared across Canada include providing for an ageing population, managing internal cost pressures, finding how to meet the health care needs of a diverse population, and the lack of standardised information technology, as well as the size of the country.

There is a realisation that in order to provide modern, effective and efficient health care, the 'silos' endemic in the current system need to be removed and care needs to be aligned to patients' physical and emotional needs. Only a pan-Canadian healthcare system can take full advantage of shared knowledge development, best practices and purchasing power across healthcare sectors.

This means that current system deficits could be addressed by reconfiguring the system and implementing evidence-informed practices to achieve effective health and economic outcomes. Provincially developed guidelines and standards of care are being implemented across all the regions.

Some provinces in Canada are already experimenting with a mix of funding models based on global packages and performance/activity-based funding models to constrain costs, support innovation and improve quality and patient outcomes.

In British Columbia there is a push towards funding models with a balanced, value-for-money approach to resourcing appropriate services that support seamless navigation for

patients and families along the continuum of care. While in the past most of the resources were allocated to acute settings, current changes are enabling the re-alignment of resources to primary, community and home care. This is leading to a move away from providing care in the more expensive acute setting to community or home care, with no adverse impact on quality. The acute, home-based treatment programme for mental health and addiction patients has received a highly positive response in 'experience of care' surveys. Changes in policies have been successful in improving health promotion and disease prevention, in early intervention and in the integration of primary and community care programmes.

One of the key factors that will lead to fundamental change in the healthcare sector is the appreciation and acceptance that true patient/family-centred care requires the patient and family voice to be at the centre of any transformational discussions on culture and working practices of health care providers and administrators. Patients and family advisers now participate at senior-level debates on moving the current provider-centred healthcare system towards a more patient-centred care model.

Canada's healthcare system is the subject of much political controversy and debate in the country. Canadian policymakers are becoming more committed to the sustainability of health and healthcare systems to support achievement of the societal goal of health and wellness of Canadians.

The challenges mentioned are complex in nature and felt internationally. Perhaps the collaboration and sharing of knowledge and experiences can go beyond the pan-Canadian forum in efforts to make a real change in our approach to better health and the care of our health internationally.

FURTHER READING:

Daniel Muzyka, Glen Hodgson and Gabriela Prada (2012), *The Inconvenient Truths about Canadian Health Care*.

Jason M. Sutherland, Nadya Repin and R. Trafford Crump (2012), *Reviewing the Potential Roles of Financial Incentives for Funding Healthcare in Canada*.

Jason M. Sutherland (2011), *Hospital Payment Mechanisms: An Overview and Options in Canada* (Ottawa, Canada).

Marcy Cohen, Margaret McGregor, Iglia Ivanova, Chris Kinkaid (2012), *Beyond the Hospital Walls: Activity Based Funding Versus Integrated Health Care Reform* <<http://www.policyalternatives.ca/abf>>.

Canadian Institute for Health Information (2010) *A Primer on Activity-Based Funding*.

China

Duke Chen, FCCA



Organisation

Kingdee Healthcare Software Co. Ltd

Position

Executive director

Specialist interest in the workplace

How to improve profit.

RELEVANT NATIONAL GUIDANCE

The National Health and Family Planning Commission proposals to further promote the payment system reform, http://www.mohrss.gov.cn/yiliaobxs/YILIAOBXSzhengcewenjian/201105/t20110531_83732.htm

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CHINA?

China employs the following payment systems:

- capitation
- fee for service
- co-payment.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN CHINA.

Initially, the People's Republic of China used a fee-for-service payment system as this was believed to be the quickest way to settle the health care costs of 400 million people. The government set standard prices for all services and these were then used to reimburse hospitals.

The weaknesses in this payment system became apparent with the growth of the market economy and the increasing demand for health care: doctors were ordering tests and prescribing drugs that were considered to be non-essential. Health care costs were rising; patients were finding it more and more expensive to visit hospital and government subsidies to providers had to increase rapidly.

In June 2011, the Ministry of Human Resource and Social Security issued a proposal for reforming health care payment by using a system called Total Amount Prepay.

On 31 October 2011 Beijing and 39 other cities were identified as pilot sites for the new capitation-based payment system. The healthcare reforms, announced by the National Health and Family Planning Commission, proposed the adoption of a 'total amount' prepay system, with a fee for disease treatment, a fee for diagnosis-related groups (DRGs) and capitation, to replace fee-for-service items by 2015.

For users, the preferred reimbursement methods are fees for disease treatment and fees for DRGs; healthcare funders, however, favour total amount prepay and capitation.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN CHINA?

Total amount prepay

The total fee to be paid to each hospital is estimated in advance and then prepaid. This transfers the financial risk of overspending to the hospital.

Advantages

Total costs can be controlled. Administratively, this is relatively simple.

Disadvantages

It is difficult to calculate the total amount to pay hospitals. If the estimate is too low, hospitals will bear the risk and the quality and effectiveness of care will reduce. If the estimate is too high, the excess funding will encourage over-diagnosis and treatment, such as the increased prescribing of drugs and the ordering of unnecessary tests.

Capitation

A fixed fee is paid for each citizen in the health insurance scheme. Any spending above this limit is a financial risk carried by the hospital.

Advantages

Improves the healthcare services for some citizens. Forces competition between hospitals.

Disadvantages

Hospitals may attempt to reduce overall costs by treating only those patients with minor diseases; patients with more serious conditions will not be treated.

Fee for disease treatment

A standard fee is set for the treatment of each disease. The calculation of the fee is based on best practice, evidence-based medicine, clinical experience and statistical data collected over many years.

Advantages

Encourages innovation and process improvement. Encourages quantity and quality outputs.

Disadvantages

Clinical-path software support is required. It is difficult and time consuming to set a standard fee for each disease. Work needs to be undertaken on funding non-standard cases – longer stays in hospital, for example.

Fee for DRGs

A DRG is assigned to each patient on the basis of principle diagnosis or condition and providers are paid a fixed fee based on the DRG classification.

Advantages

Encourages innovation and process improvement. Encourages quantity and quality outputs. Supports healthcare reform.

Disadvantages

Needs mature IT support. Requires significant work to identify a standard set of DRGs.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM CHINA?

Other countries can learn from the following practices in China.

Multi-layer healthcare institutes span the whole country, from villages to towns, to cities, to counties, to provinces and then to national medical centres. The institutes are all separate but they work in collaboration.

Everyone can go direct to a hospital to see a doctor; no appointment is required.

The government guarantees basic medical and healthcare services.

The hospital information systems which were developed by China's software companies, offer many innovative features that align with Chinese characteristics. Examples include a guide and queue system and pre-set barcode-based laboratory intelligence systems.

England

Michael Schofield, FCCA

**Organisation**

Brighton and Hove CCG and High Weald Lewes Havens CCG

Position

Chief financial officer

Specialist interest in the workplace

NHS commissioning organisations and financial strategies.

RELEVANT NATIONAL GUIDANCE

<http://www.gov.uk/government/collections/payment-by-results-2013-14>

<http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-9>

<http://www.ntda.nhs.uk/blog/2012/12/21/nhs-tda-publishes-planning-technical-guidance-for-201314/>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ENGLAND?

Between 2003 and 2005 the Department of Health began the tariff-setting process that led to 'Payment by Results' (PbR). Initially this covered just 15 elective healthcare resource groups (HRGs) on a cost and volume basis, but the extent of coverage has since dramatically increased so that PbR now covers the vast majority of acute hospital services.

The currency is HRGs with the main element of an HRG episode being an inpatient stay; outpatient attendances and attendances at clinics and A&E departments are also episodes of care.

PbR is not used for either mental health or community services. This is because the information and data flows for these services are not as mature as those in the acute sector and because the measure of activity is more nebulous.

PbR operates on a fee-for-service basis but increasingly there are both quality and outcome elements to the fees paid to provider organisations.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ENGLAND

The PbR system was designed (as is the commissioner/provider split) to ensure the wise spending of the additional funding that the government has invested in the NHS to bring total healthcare spending up to European averages. PbR ensured that the money followed the patient and although titled 'Payment by Results' it is essentially related to volume of activity; there is little measurement of actual results, i.e. quality or outcomes.

PbR worked very well during the period of funding growth but it has proved less satisfactory in today's environment of flat-line funding and year-on-year increases in demand. 'Demand management schemes' are a key element of commissioners' plans but there is little incentive for providers to reduce capacity, which is needed to achieve the savings from these schemes. If the capacity is retained it will be used and, under PbR, commissioners will be required to pay for the activity.

The government has introduced a quality premium – Commissioning for Quality and Innovation (CQUIN) – to be paid on top of the PbR tariff. This has to be earned and is intended to encourage providers to improve quality. PbR also incorporates ‘best practice tariffs’ that are designed to raise quality and improve outcomes of patients.

Many recognise that PbR is no longer ‘fit for purpose’ and that, to ensure the sustainability of the NHS, it needs a radical overhaul; PbR is overly complicated and does not incorporate the correct incentives for the current environment. The NHS is at present implementing the latest round of healthcare reforms, however, so this is not a good time to disturb the funding flow.

Thankfully, for the users, the funding issues are invisible; care is provided free at the point of access.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN ENGLAND?

Advantages

The main advantage of the current system is that it does (in the main) ensure that funding follows the patients and, therefore, that money is spent in the right place. This supports patient choice and rewards organisations that are successful in either retaining patients or attracting additional referrals.

Disadvantages

One of its disadvantages is that PbR was designed for a different time, to meet a particular set of circumstances; it no longer provides incentives for what is required. It was not designed to meet the requirements of today, which focus on encouraging the most efficient use of resource.

The other main disadvantage is that the funding regime works to skew commissioners’ spending to acute services, because mental health and community services are not included in the tariff system. PbR does not encourage early intervention to avoid a higher future cost but most NHS commissioners now want to invest in these sorts of initiative.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM ENGLAND?

Most countries are trying to ensure effective spending on health care. The models used tend to stem from the culture of the country and England is justly proud that health care is provided free at the point of access; the NHS is owned by the population, which is both a blessing and a curse.

Unlike Scotland and Wales, England does not have an integrated health service. A number of countries across the world are considering services integration and I think this is an area where there is potential for joint learning across the globe.

Ethiopia

Hrui Ababayehu, ACCA



Organisation

TMS plus

Position

Audit manager

Specialist interest in the workplace

Public accounting practice.

RELEVANT NATIONAL GUIDANCE

<http://www.fmhaca.gov.et>

<http://www.moh.gov.et>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ETHIOPIA?

Ethiopia employs the following payment systems:

- fee for service
- payment for quality.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ETHIOPIA.

The Ethiopian government follows the Health Sector Development Program (HSDP), which was initiated in 1998. The 20-year HSDP, which runs in a series of five-year investment programmes, is now in its fourth cycle.

Ethiopia has adopted a four-tiered healthcare system for service provision. This consists of:

- primary healthcare units (a health centre with five satellite health posts) with a catchment population of 25,000
- district hospitals with a catchment population of 250,000
- zonal hospitals with a catchment population of 1,000,000
- specialised hospitals with a catchment population of 5,000,000.

Public sector health care provision focuses on activities related to the prevention of communicable diseases while the private sector focuses on providing services targeted at non-communicable diseases.

The payment system is based on fee for service with the price determined by the cost of the services.

In my opinion the healthcare funding system is very poor. Those earning a middle income cannot afford the medical costs for treating emerging non-communicable diseases such as coronary heart disease or cancer. The government is planning to launch a health insurance system; this may address this issue to some extent.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN ETHIOPIA?

Advantages

The advantage of the fee for service payment system is that the patient knows in advance what procedure is planned and what type of test will be done. This increases patients' awareness and understanding of their health issues and makes it easier for them to decide whether they want the treatment.

Disadvantages

The disadvantage is that patients may discontinue their treatment or check-ups owing to lack of cash or time.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM ETHIOPIA?

The establishment of health centres and health posts helps ensure equitable access to care and supports the management of the majority of diseases.

Training health professionals to provide services in the home supports the more effective and efficient promotion of preventative activities.

For poorer African countries, it is difficult and too costly to provide high-quality, standardised healthcare services for the whole population, hence the Ethiopian experience may provide a lesson for them.

Ghana

Alex Odoi Nartey, FCCA



Organisation

National Health Insurance Authority

Position

Deputy chief executive for finance and investments

Specialist interest in the workplace

Building public financial management systems from scratch and capacity building in the public healthcare sector.

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN GHANA?

The National Health Insurance Authority (NHIA) in Ghana uses a mix of payment systems for the reimbursement of health services to its providers:

- capitation for primary health care and out-patient services
- fees for services for reimbursement of medicines
- diagnostic related groupings (DRGs) for secondary and tertiary healthcare services. DRGs are a statistical system for classifying patient stays into groups for the purposes of payment. Factors used to determine the DRG payment amount include the diagnosis as well as the hospital resources necessary to treat the condition.

Ghana's health insurance system covers about 95% of diseases in the country. Co-payment is not allowed under the NHIA-run health insurance scheme.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN GHANA.

The history of health care provision dates back to Ghana's independence, when the state offered free medical care to all citizens in Ghana. In the 1980s, owing to funding issues, the free healthcare system was replaced by a payment system that became known as 'cash and carry'. In the 1990s financial risk protection became of interest and, in response, some parts of the country began piloting private mutual health insurance schemes. By 2000, health in Ghana had become such a political issue that in 2003 the government in power passed a law for the introduction of the tax-funded National Health Insurance Scheme (NHIS).

In its early days, the NHIS operated through autonomous district schemes. Reimbursement was largely based on 'fees for services'. By 2005, claims were increasing to such an extent that the annual budget was in jeopardy and the sustainability of the entire health insurance system was in question.

Other systems of paying for services were introduced to:

- contain and control cost escalation by sharing financial risk between schemes, providers and subscribers
- introduce managed competition for providers and choice for patients, as a way of increasing the responsiveness of the healthcare system
- improve efficiency through more rational use of resources
- correct some imbalances, such as supplier-induced demand whereby patients might be encouraged to have unnecessary treatments, tests or check-ups to enable the provider to claim additional payment
- simplify claims processing
- address difficulties in forecasting and budgeting.

Currently capitation, which was initially piloted in the Ashanti region of Ghana, is being rolled out for the payment of primary health care providers. Medicines are reimbursed on a fee-for-service basis

Ghana-DRG is used to reimburse secondary health care and tertiary health care providers. Under Ghana-DRG, services are bundled to pay for the case in its totality. A hernia repair, for example is paid for as a case, not according to the number of days taken to treat and operate on the hernia.

Reforms of the payment system

Health insurance in Ghana is in its infancy, considering the length of time it generally takes to develop such a system.

From its introduction in 2003 to the current day, the payment system has been operated manually. Reforms are now in progress, with claims administration introduced as a centralised management component of the insurance system in four zonal offices around the country.

To improve efficiency and effectiveness, the NHIS is introducing an electronic claims system (e-claims). The modernisation of the payment system is encouraging providers to move onto electronic platforms for health information management so that they can submit online claims to the zonal processing centres (CPCs). The electronic transfer of funds is also being considered; this will support the prompt payment of suppliers.

A biometric authentication system, which instantly confirms an individual's membership of the scheme, has been piloted in certain districts and hospitals in the country and is now being rolled out to other parts of the country.

Basis of calculation for reimbursement Ghana-diagnosis related grouping (G-DRG)

The tariff structure has been developed to recognise the different levels of care provided by primary, secondary and tertiary providers and takes account of case mix, severity of disease, direct, indirect and overhead costs at each of these levels.

Direct care costs (made up of three components) include:

- consumables used in the wards and in theatre, and during recovery
- investigative costs including reagents, stains, X-ray film and specimen containers
- anaesthetic drugs, face masks, syringes, etc.

Indirect and overhead costs include food, housekeeping, administration, and utilities, etc.

Capitation

All providers in the payment system are paid, usually in advance, a pre-determined fixed rate to provide a defined set of services for each individual enrolled with that provider for a set period of time. The per capita amount is paid for every active member enrolled with a preferred private provider (PPP), whether or not they access service.

The capitation pilot began in 2012. It was based on:

- total claims for outpatient services and drugs in 2010
- net claims derived from total claims reduced by clinical audit deductions
- a cost-of-capitation basket derived from net claims less outpatient specialty services
- a cost-of-member rate derived from the cost-of-capitation basket divided by the total number of members
- adjustment of the capitation amount per member by an interim tariff adjustment rate.

Fee for service for medicines

A standard price is paid per item. To arrive at the standard price:

- a nationwide medicine price survey is carried out by the NHIA research team, in private and public wholesale/retail pharmacies and manufacturing companies
- the data is captured and analysed
- the World Health Organization (WHO) Health Action International methodology is used in ascertaining median prices,
- stakeholder meetings are held to discuss survey prices.

A provisional list of prices is agreed upon. This is then reviewed by a technical committee comprising representatives of all stakeholders, who then propose the final list of medicines and prices.

The financial impact of the proposed prices on claims reimbursement is calculated.

The list and the impact are presented to stakeholders for approval.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN GHANA?

An advantage of the capitation payment system is that it has minimised the problem of delayed payments to service providers. It also makes it easier for the NHIA to budget. The disadvantage is that providers tend to underprovide; they do not provide all the services and care that their clients require.

An advantage of using DRGs is that it ensures uniformity in claims; it does not allow patients with the same condition/principal diagnosis to be given different charges because of slightly different procedures or treatments. This is important as each of the insurance schemes was allowed to negotiate, independently with their providers, itemised fee rates to pay for services, consumables and medicines. This resulted in what appeared to be random, rather than clearly justified, price variations in the system for the same procedures and consumables and a tendency towards rapidly rising costs.

The advantage of fee-for-service medicines is that the NHIA will pay providers the agreed standard cost for all listed medicines. The disadvantage, however, is that some clients claim that medicines are often prescribed that are outside the health insurance system so they have to pay out of their own pockets.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM GHANA?

The health insurance system in Ghana is a unique, 'country-brewed' system. Officials from developing countries, who visit Ghana to learn about the health insurance system, are surprised by the level of attainment within its short 10 years of existence. Strong political commitment is required for the introduction and operation of such a system.

For any country introducing such a scheme, the following lessons can be learned from Ghana.

There should be a phased approach to the introduction of health insurance. Ghana's healthcare system is composed of public providers, quasi-government providers, Christian and faith-based (CHAG) providers, and private providers. Ghana took an ambitious approach to the introduction of health insurance, with all providers brought on board from the outset.

A more cautious, phased roll-out would have been better. This would also have given the NHIA more time to prepare so it was able to embrace the system better.

Ghana's benefit package under the health insurance system is overly generous; covering about 95% of diseases. This has repercussions on the sustainability of the healthcare system.

The necessary information and communications technology (ICT) platforms should have been in place before or soon after the insurance system started so that checks could be made on over-use and abuse of the system. Improper use is a risk that can occur in any part of the developing world.

Whatever payment mechanism is chosen, it must incorporate some co-payments. This helps to guard against abuse of the system. Some clients attend hospitals not because they are sick but to collect medicines that they then sell.

The poor and vulnerable are exempt from paying premiums. It has, however, proved difficult to identify those that qualify as most clients claim to be poor or vulnerable to avoid charges.

India

Ravindran Balakrishnan, FCCA



Organisation

International SOS

Position

Chief financial officer

Specialist interest in the workplace

Business strategy planning, process engineering and business partnering with other functions. This includes a continuous and integrated approach to re-engineering the finance process in line with business needs, resulting in the effective, efficient analysis of various aspects of the business.

RELEVANT NATIONAL GUIDANCE

<http://nihfw.org/publications/material/J164.pdf>

http://planningcommission.gov.in/reports/genrep/bkrap2020/26_bg2020.doc

http://mohfw.nic.in/WriteReadData/1892s/2612656526Operational_Guidelines_NPHCE_final.pdf

<http://wcd.nic.in/nationalguidelines.pdf>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN INDIA?

India employs the following payment systems:

- capitation (5%)
- fee for service/out of pocket (90%)
- co-payment (5%).

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN INDIA

The Indian healthcare system includes public and private hospitals as well as many semi-hospitals offering Ayurvedic and traditional Indian alternative medicines. There are also private doctor practices and clinics that obtain business through contacts and recommendations, etc.

The history of Ayurvedic and other traditional medicines dates back many centuries. The operation of these services is plagued by deeply embedded cultural and traditional values. These services are very popular and many people consider them to be the only possible method of treatment, rather than alternative therapies. Urbanisation and the resultant population growth is, however, working to dispel this myth and more and more people are now visiting hospitals that offer a more modern and up-to-date approach to health care.

Health insurance schemes have been established to fund health care provided by the hospitals – though this covers only hospitalisation and emergency costs. The increasing cost of specialist treatment has fuelled the growth of the insurance industry.

The insurance schemes are offered mostly as employee benefits, with the employer partially or fully funding the premiums. There are numerous health insurance companies in India; the majority of these run into problems when too many patients use their services. Co-payment schemes are also available, though these are not popular.

The Indian government has taken steps, albeit slowly and cautiously, over the past few years to bring stability and control into the Indian health insurance system. The

introduction of cross-over to other insurance providers, while keeping the same insurance cover, and strict compliance procedures adopted by the Insurance Regulatory Development Authority (IRDA), have contributed to this but much still needs to be done.

A patient attending hospital must first check in at the hospital insurance table or kiosk to ensure that his or her insurance policy covers the cost of the care required at that hospital. For those services that are covered, the patient is required to pay a cash deposit to the hospital; the patient then claims this back (less an administrative fee) from the insurance company after treatment. Any expenses not covered by the policy must be paid direct by the patient to the hospital.

Patients, particularly those employed in smaller organisations, generally have no choice of provider or insurer; a single insurer will have been chosen by the employer and the name of the health care provider will be specified by the insurer. Larger companies, however, do generally offer a choice of insurers.

India has come a long way since independence. The government has taken steps to ensure that affordable and timely health care is available to the whole population, whatever their class. There is, however, still much more to be done, especially in rural areas where both public and private hospitals are virtually non-existent (only 3% of the registered doctors reside in rural India).

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN INDIA?

The main advantage of the funding system is peace of mind for the user; the cost of basic and enhanced health care is covered by the insurer so patients can just concentrate on getting better.

The main disadvantage is that insurance schemes are not fully comprehensive, they generally have pre-existing disease exclusion clauses, and do not cover all ailments.

The insurance schemes are not user friendly, the patient usually has to pay a deposit to obtain treatment, and then has a very long and anxious wait for reimbursement.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM INDIA?

Healthcare tourism has increased in India over the last 20 years, not just from developing countries, but also from countries where the costs of treatment are relatively high. There are two main reasons for the surge in visitors. The first is cost related; health care is more affordable in India than in most Western countries. The second is to do with infrastructure; the hospitals and practices are equipped with state of the art, cutting-edge technology, which helps to minimise both treatment time and cost.

Government intervention is not necessarily the answer to all health care needs; there has to be a mix of public-private partnerships to ensure the availability of affordable health care for the population. Public-private partnership models are being used in India to encourage more physicians to set up practices in rural India.

Mauritius

Ramkumarsing Emrith, FCCA



Organisation

The Medical and Surgical Centre Limited
(Fortis Clinique Darné)

Position

Finance manager

Specialist interest in the workplace

Managing and motivating my team to get the best out of every member so as to achieve excellence.

RELEVANT NATIONAL GUIDANCE

The Ministry of Health and Quality of Life website for its annual reports on the healthcare sector in general:

<http://health.gov.mu/English/Statistics/Health/Mauritius/Pages/default.aspx>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN MAURITIUS?

Mauritius employs the following payment systems:

- fee for service
- co-payment.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN MAURITIUS.

Health care is provided in Mauritius by the government as part of the welfare state. There is also a cluster of private hospitals, locally called clinics, which provide medical services for payment. It is interesting to note that the government hospitals and private clinics work together and share information and resources as necessary to provide medical care to patients.

Medical services are provided free in government hospitals or for a fee in private clinics. Patients treated in a private clinic may return to the government hospitals at any time; use of a private facility does not affect their rights to free services.

The main payment systems used by the clinics are:

- direct payment by patients and
- a cashless system, supplemented by co-payment, operated through tie-ups with healthcare plans and administrators.

The proportions of direct payment and use of the cashless system are approximately 50:50, with the expectation that the cashless system will increase in the years ahead.

The private clinics offer a wide range of care at primary, secondary and tertiary levels, covering everything from medical management and minor surgery to major surgery. They provide the facilities and nursing care; very few clinics directly employ doctors. This makes the private healthcare sector very much doctor driven; patients choose their preferred doctor and then the doctor chooses the clinic.

The uniqueness of each clinic, in terms of facilities offered and pool of available doctors, means that prices are not standardised; they vary by clinic.

The clinics rates cover room fees, theatre costs and paramedical services such as radiology and pathology services. Drugs prices are controlled by the government. Doctors' fees, which are negotiated and set by the doctors and insurance companies are paid separately.

The concept of fixed package rates for specific surgeries, like bypass surgery, is in its infancy and it is likely to be some time before more surgical procedures can be priced in this way.

The insurance companies and administrators agree rates with each individual clinic. The amount paid for treating a patient will depend on the type of policy in place and the nature of the illness. The insurance companies employ medical personnel and administrators to check the reasonableness of claims.

Cash-paying patients have no control over the rates charged by the clinics so they tend to shop around to ensure that they get the best deal.

Private healthcare is nevertheless seeing its patient base increase through two main routes.

The government, by providing income tax deductions for medical insurance premiums, gives the population indirect incentives to shift to the private sector. It is expected that the taxpaying members of the population will take advantage of this deduction, thereby increasing the number of people with access to private health care.

Employers in the private sector are increasingly offering employees healthcare plans. This is now becoming a standard fringe benefit and so has further increased the number of people with access to private health care.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN MAURITIUS?

The private sector is considered to be a premium product; people aspire to use its facilities. By choosing to go private, patients have a choice of doctor and clinic and, in respect of elective procedures, the timing of admission to hospital.

This sector also provides doctors with a conducive environment for starting new services in their respective fields, and several instances have been noted where doctors have teamed up with foreign doctors to provide medical care or to perform medical procedures not previously undertaken in this country.

The private sector is relatively small; the number of persons insured, as a percentage of the country's population (which stands at just over 1.2 million), hovers at around 10%. Funds generated in the private sector, therefore, are low and so all clinics are not able to invest in 'high-tech' medical equipment on a regular basis. Instead, the focus is on hospitality and on providing the best-quality patient care within the available resources.

This sector is, however, evolving through partnership arrangements with international health care providers. These have helped bring in fresh capital for investment in medical equipment and to allow local clinics to tap into foreign expertise. This has helped to increase services and raise levels of care.

One of the disadvantages of the government's efforts to encourage private health care is that it will erode the welfare state; the majority of the population cannot afford private health care and so rely on public sector hospitals. This erosion is somewhat counteracted, however, by the government's continual investment in the renovation of its pool of hospitals and medical resources.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM MAURITIUS?

The coexistence and cooperation of the public and private healthcare sectors in providing health benefits to the entire population.

New Zealand

Gordon Ngai, FCCA



Organisation

Mid Central District Health Board

Position

Finance manager

Specialist interests in the workplace

Health care funding and financial information systems.

RELEVANT NATIONAL GUIDANCE

<http://www.midcentraldhb.govt.nz/Pages/Home.aspx#>

<http://www.health.govt.nz>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN NEW ZEALAND?

New Zealand employs the following payment systems:

- capitation for primary healthcare organisations (this covers GP visits)
- fee for service for disability support services and pharmacy
- co-payment for drugs and GP visits
- payment for quality of primary healthcare organisation performance
- capacity funding for some services
- fixed price contract for laboratory tests.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN NEW ZEALAND.

The current structure of the healthcare sector was set up under the Health and Disability Act 2000, which created 21 district health boards (DHBs) to oversee funding for both primary and secondary care. In 2005/6, population-based funding was introduced. Subject to the Operational Policy Framework of the Ministry of Health, the DHBs have the power to determine what and how services are to be provided to the local population.

The government has no plans at present to change the existing structure.

The structure of the healthcare sector enables each DHB funder, subject to nationally driven contract negotiation, to experiment with different payment methods to providers. The following is a basic description of the payment method used by one of the DHBs.

Payments to the hospital arm are either capacity funded whereby, for example, the funder pays a fixed amount to provide an emergency service, or by a modified fee for service, where the full price is paid for a set number of procedures and marginal cost for anything over and above this.

Primary health organisations (PHOs) are funded by DHBs on a capitation basis; this takes account of the number of enrolled patients and their demographics. Patients are required to make a co-payment for both GP appointments and for drugs, but New Zealand citizens who are enrolled with a GP who belongs to a PHO pay lower fees when accessing GP services.

Payment to non-governmental organisations (NGO) can be fee for service, fixed price, price volume capped or capacity funded.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN NEW ZEALAND?

Advantages

The single-funder payment system for primary and secondary health care supports more effective health care design. It encourages innovation and so supports the planning of services, and it brings economies of scale locally. Overall the single-funder system helps achieve value for money.

Disadvantages

The key disadvantage is that, as DHBs own the hospitals, there is always pressure on them to allocate more funding to hospitals than to the NGO sector. Another issue is that DHBs, being relatively small, are not able to enjoy very large economies of scale.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM NEW ZEALAND?

Every country is on a journey, trying to find a better way to improve the health of its citizens. Each country is taking a different route and some are closer to their destination than others – but no one has found the silver bullet yet.

Our experiment of using a single funder for a small section of the population shows that:

- it takes about 10 years to move people's focus away from hospital care to pathways of care
- the healthcare system will only be more patient focused when the patients have a higher level of health care knowledge and assume a more leading role in their care.

One new area that is attracting interest in New Zealand is the work of Professor Clayton M. Christensen on disruptive innovation.

Accountants have an important role in cost-effective, sustainable healthcare system, as recognised by the cost effectiveness component of the Triple Aim model of the Institute of Healthcare Improvement.

Northern Ireland

Lesley Mitchell, FCCA



Organisation

Western Health and Social Care Trust

Position

Director of finance and contracting

Specialist interests in the workplace

Private finance initiative schemes, staff development and professional accreditation

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN NORTHERN IRELAND?

Northern Ireland has an integrated health and social care system which is funded by central UK government. Health care in Northern Ireland is provided by six Trusts which receive funding based on the population in their geographical area adjusted for factors such as age, deprivation and rurality. This system of allocation is known as the Capitation Formula.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN NORTHERN IRELAND.

Northern Ireland is part of the UK and monies to Northern Ireland (NI), Scotland and Wales are allocated using the Barnett Formula. The Assembly in NI then determines how much to allocate to the each government department, including the Department of Health, Social Services and Public Safety. Monies are then allocated to the six Health and Social Care Trusts on the basis of a capitation formula.

There are no plans to reform the payments system at this stage as it is viewed as a fair and equitable means of distributing funding.

Health care is provided free at the point of care but there are charging arrangements in place for clients using residential and nursing-home care.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN NORTHERN IRELAND?

The advantage of capitation funding is that it provides each healthcare organisation with the assurance that it will receive funding in accordance with the number and needs of its resident population. Over recent years, however, there have been significant shifts in population across the country. As a result, some organisations have received too much funding and others too little. The dilemma is how to shift funding, when it has already been invested in services, from one hospital trust to another without destabilising the service.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM NORTHERN IRELAND?

The healthcare system in Northern Ireland is unique in the UK; health and social care are fully integrated, providing more seamless services to users.

Pakistan

Ayaz Ahmed, FCCA



Organisation

Ziauddin Group

Position

Manager finance

RELEVANT NATIONAL GUIDANCE

<http://www.jpma.org.pk/>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN PAKISTAN?

Pakistan employs the following payment systems:

- capitation
- fee for service
- funding from non-government organisations (NGOs).

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN PAKISTAN.

In many developing countries health care is still considered to be a luxury as only a few can afford effective treatment. People in Pakistan and other south Asian countries are reluctant to spend their time and money on health care; the general perception is that it is the government's duty to look after its people. With the population having this mindset, it was decided that capitation would be the most appropriate method of funding health care.

Capitation is said to be the oldest form of payment method used for health care. It involves paying a physician or a group of physicians a set amount for each person enrolled with them over a particular period of time – whether or not that person seeks care. The amount of remuneration is based on the average expected healthcare service use by that patient. The rate paid for each patient is dependent on age, race, sex, medical history, type of employment and geographical location. These factors all typically influence the cost of providing care.

Capitation as a payment method, however, has its faults; there is no incentive, for example, for physicians to provide high-quality health care. With no benchmarking of performance or measurement of output, some physicians are not as attentive as they should be and patient care suffers. Despite these issues, capitation remains the main funding method in Pakistan.

Other payment systems in operation in Pakistan are a fee-for-service system and through help provided by NGOs.

In the fee-for-service system, rather than receiving a regular salary, the practitioner is paid for providing particular services during scheduled or on-call hours of work.

The fee-for-service payment method is expensive and is unaffordable for many. The majority of Pakistan's population are poor and live in rural areas where it is difficult and costly to provide health care. The government targets its health provision at the more urban areas (Karachi, Lahore, Peshawar, etc.), providing services to not more than 15–20% of the population.

It is difficult for those in rural areas to travel to urban areas for health care and, owing to the unstable economy, physicians are reluctant to move outside the larger towns and cities. These two factors make providing countrywide health care a real challenge.

Non-government organisations (NGOs) are helping address this issue by opening facilities in rural areas and charging patients minimal or no fees. Clinical staff in these facilities are well funded and their performance is monitored. This helps motivate them and encourages more effective and efficient working.

Today the majority of health care in Pakistan is provided by the NGO sector: accounting for approximately 80% of all outpatient visits. Some of the better-known NGOs in the health sector are:

- Aahung
- All Pakistan Women's Association Health and Economic Welfare
- Shaukat Khanum Memorial Cancer Hospital & Research Centre
- Behbud Association
- EHSAS (Education, Health, and Social Achievement Services).

Although not the top priority of Pakistan's government at the moment, health has not been ignored; its importance to economic progress (poverty), education (especially women's education), justice, security and the emotional and spiritual well being of a person and community at large is well recognised.

The government is attempting to address some of these issues through healthcare initiatives that include the Social Action Programme (SAP), the national strategy to revamp primary health care through the government of Punjab health

reform initiative, the North West Frontier Province's WISHpad legislation to make hospitals autonomous, the Pakistan Initiative for Mothers and Newborns (PAIMAN), and the introduction of Continuing Medical Education by the College of Physicians and Surgeons.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN PAKISTAN?

Capitation system

In many ways, capitation seems to offer a win-win solution for all. A health plan pays providers in carefully structured networks a fixed fee, in advance, for each person enrolled. Costs are reasonable and predictable. Providers assume most of the risk, but in return they receive a guaranteed, predictable revenue stream and a ready-made patient base. This predictable flow of funds enables them to invest in more sophisticated care-management methods and IT than is possible for fee-for-service providers. Where capitation models have been in existence for some time, large integrated provider systems have emerged that have made substantial investments in electronic medical records, decision-support systems, and electronic prescribing.

Other benefits of capitation include that:

- it helps clinicians build a strong relationship with their patients as they are responsible for providing most of their care
- it helps lower the risk that patients will be over-treated since physicians, being paid on a fixed fee basis, will only prescribe necessary treatments
- treatment costs are spread across a large patient base, which helps reduce overall costs.

Capitation systems consistently outperform the more fragmented fee-for-service system; it is for this that they are often advocated as the payment method of choice.

Capitation does, however, have some major disadvantages, the main one being the exclusion of patients with complex conditions from enrolment in the capitation plans.

The high cost of treating such patients would erode a physician's income.

Other disadvantages of capitation include:

- lack of choice – patients are not permitted to choose their health care provider; they must register with the nearest physician or group of physicians
- physicians may not always provide optimal care as the more services they provide, the lower their income.

Fee-for-service system

The fee-for-service system brings choice but the patient must pay a high price to get that freedom; there is the premium for the health plan and then, for each consultation, an out-of-pocket payment to the doctor. The patient must pay whatever is charged even if the charge is in excess of what is normal.

In addition to choice, the advantages of fee-for-service payment include:

- improved productivity – it encourages better provision of care and the maximisation of patient visits
- flexibility as a payment mechanism, as it can be used regardless of the size or organisational structure of a physician's practice, the type of care provided (eg clinic visit, surgery, therapy session), the place of service (eg physician's office, nursing home, hospital, surgery centre), or the geographical location of care
- accountability for patient care, although this is limited to the scope of the service a particular physician provides.

The disadvantages include:

- lack of innovation – fee-for-service health care is provided through face-to-face visits; innovations, such as phone consultations or email contact, are not used
- physicians may be encouraged to provide unnecessary services to boost their income.

In summary, both capitation and fee-for-service payment systems have their advantages and disadvantages and it is impossible to choose one method over the other.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM PAKISTAN?

In developed countries, health care is a top priority but in developing countries it's probably the last thing people think about. Times are changing, however, and health is beginning to make its way up the agenda in Pakistan.

I consider there to be great benefits in sharing ideas between countries. One innovation in Pakistan that may be of interest to others is Basic Health Units (BHUs).

Pakistan has around 5,000 BHUs. Each provides health services for a population of 5,000–10,000 people and covers an area of 15–25 square miles. Each BHU comprises an office building and residences for the doctor and staff. The land is donated by local residents. They are staffed by a medical officer (doctor), a medical assistant or technician, a female health worker and support staff.

BHUs are designed to provide primary health care. This includes:

- treatment and medication of the rural population
- health education
- carrying out vaccination programmes
- provision of basic health and antenatal care for women and children
- implementation of national programmes related to the eradication of diseases such as polio.

In the modern scientific age, measures such as infant and maternal mortality, incidence of communicable diseases, number of immunisations, etc have become proxies for the health standards of a country. Something vital gets lost in these statistics, however: the spiritual dignity of people and freedom from fear in pursuing our dreams are among the bases of good health. There is no measure for these.

The statistics, though important, also ignore the critical impact of socio-economic and legal injustice on the primary health of a community. Instead the focus, supported and encouraged by foreign aid, is on specific targets. No wonder sustained improvement remains elusive.

It is ultimately the responsibility of the state to improve the health status of its people. Healthy people are the foundation of economic, social and educational success of a nation. Until now, the State of Pakistan has been the regulator, financier and provider of health services and it has failed to provide effective health care for the masses.

Devolution and decentralisation are now helping to broaden the provider base and are encouraging wider collaboration: NGOs, not-for-profit organisations (NPOs), universities, and other social welfare sectors are beginning to work together.

A great example of that collaboration is the Pakistan Initiative for Mothers and Newborns (PAIMAN): a collaboration between governmental organisations, NGOs, universities and other agencies. Other examples include the Agha Khan Primary Health Program, the tuberculosis programme in Bangladesh, the Jamkhed Comprehensive Rural Health Project of Maharashtra and the Kerala State implementation of primary health care through decentralisation. Initiatives such as these help spread the burden and extent of the task and can make it more cost-effective.

Pakistan suffers from a severe shortage of well-educated and experienced health professionals as so many have left the country to practise overseas. It is hoped that the devolution of the healthcare market will encourage them to return to Pakistan, thereby solving the staffing crisis.

Scotland

Claire Wilkinson, FCCA



Organisation

The Scottish government

Position

Financial controller

Specialist interest in the workplace

NHS Scotland health boards' financial performance

RELEVANT NATIONAL GUIDANCE

<http://www.scotland.gov.uk/topics/health>

<http://www.nrac.scot.nhs.uk>

<http://www.tagra.scot.nhs.uk>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SCOTLAND?

Scotland's NHS boards are allocated financial resources largely on a formula basis. The formula determines at a macro level the overall allocation that each health board receives, but it is for each board to decide how to spend its allocation in providing health care to its local population. The NHS Scotland Resource Allocation Committee (NRAC) formula covers funding for hospital and community health Services, and general practitioner (GP) prescribing. This amounts to almost 80% of the total healthcare budget.

Services outside the formula calculation include elements of primary care services, general dental services, general ophthalmic services and community pharmaceutical services, as well as a number of centrally allocated funds for specific national services and various government policy initiatives. These services are funded on the basis of historical spend.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SCOTLAND.

The funding made available for the NHS in Scotland comes from the public money voted to Scotland by the UK government.

Following the removal of an initial 'top-slice' for national services and programme initiatives, a formula is applied to determine the resource funding allocations for each NHS board. Since 2009/10 the NRAC formula has been in place and aims to ensure that funds are allocated on a fair, transparent and equitable basis nationally. In practice, health boards receive a percentage uplift each year with additional funding being allocated to those boards that are below their NRAC share in order to bring them closer to 'parity'.

The challenges faced in Scotland include providing services for the smallest health authority population in the UK (NHS Orkney) to the largest (NHS Greater Glasgow and Clyde) and for the largest geographical area in the UK (NHS Highland) to the most remote (NHS Shetland). There are also wide socio-economic disparities between boards; NHS Greater Glasgow and Clyde has over half of Scotland's most deprived areas concentrated within its boundaries, a significant fact given the links between deprivation and levels of morbidity and mortality. These differences bring special challenges to the provision of health care in Scotland and to the equitable distribution of the funds needed to provide that care. The

formula must therefore strive to reflect the impact of Scotland's extreme regional variations on health care needs.

The NRAC Formula replaced, and improved on, the Arbuthnott Formula (2000–2009), which was also a weighted capitation formula based on the size of population in each NHS board area (capitation) and factors that sought to adjust for each area's relative need for healthcare funding. Before Arbuthnott began in 2000, Scotland used the Scottish Health Authorities Revenue Equalisation (SHARE) Formula (introduced in 1977); this represented the first concerted attempt to allocate resources on the basis of estimations of relative need.

NRAC refined and extended the Arbuthnott Formula by evaluating new sources of evidence to determine health care needs in different groups of people and by using new information to identify items that influence the costs of health care provision. It also considered how the formula could be extended to cover other areas of health care expenditure (such as primary care dentistry, eye, and pharmacy services) and how changes to NHS services might affect resource allocation in the future.

The main objective of the formula is to provide the greatest possible equity of access to health care. Resources are distributed to health boards on the basis of relative population need, where use of services is used as a proxy for need.

Scotland uses an indirect approach to measure health care needs. This relies on health service utilisation data to measure need based on (i) the demographic profile of the population, taking into account the national average costs of providing services based on age and sex, and (ii) relative levels of morbidity and mortality, and the estimated relationship on the use of services for each type of service. A further factor that has to be taken into consideration during the resource allocation process is the unavoidable excess costs of service delivery.

The formula is run every year, with updated data where required, to show target allocations for each board.

NRAC also identified the need for continuous review of the formula to ensure that it is kept up to date as new methods and data become available. Hence the Technical Advisory Group on Resource Allocation (TAGRA) was established in 2008 to oversee the maintenance and development of the resource allocation formula. Membership includes a range of health board members (mainly finance directors), academics

and experts in the area, representatives from the NHS Information Services Division (ISD) and analysts from the Scottish government's Health Directorate.

As with previous changes to funding practices, the changes resulting from the NRAC formula have been phased in over a number of years in order to avoid large, de-stabilising variances to boards' finances. In line with previous updates to allocation formulae, boards were guaranteed that they would not be subject to any reduction in funding as a result of the changes.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN SCOTLAND?

The health and care policies of the Scottish government aim to ensure sustainable services that are safe, effective and person-centred as well as providing high-quality, world-leading health care to the people of Scotland. The NRAC formula, with its continuing development, is an important tool in achieving these aims.

The focus of the formula, in seeking to achieve fair and equitable distribution of resources, supports the Scottish government's emphasis on tackling health inequalities, and the need for resources to be used effectively and efficiently. The formula seeks to adapt to changing health care needs and priorities, for example in preventative care and dealing with long-term conditions. In developing a more rigorous evidence base, the particular circumstances of a number of healthcare services can be recognised within the formula and can be accounted for in an objective and transparent way. Providing health boards' funding in this way enables services to be tailored towards local need and grants boards control over their own resources. Thus services should be more responsive and patient focused.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM SCOTLAND?

Scotland is very proud of its healthcare system and, I believe, rightly so. The system for allocating financial resources for health care has been, and continues to be, developed through collaborative working across stakeholder groups, with the joint aim of continuous improvement in health care. NHS Scotland focuses on being person-centred, safe and effective, with the ultimate aim of achieving the highest-quality healthcare services and ensuring that these are recognised as being among the best in the world.

Singapore

Sito Hup Ying, FCCA



Organisation

Tan Tock Seng Hospital

Position

Deputy director

Specialist interests in the workplace

Accounting, reporting and financial analysis

RELEVANT NATIONAL GUIDANCE

http://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SINGAPORE?

Singapore employs the following payment systems:

- fee for service
- co-payment.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SINGAPORE.

Singapore has, and will continue to operate, a subsidised healthcare system based on co-payment, whereby the government and the patient each pay a certain percentage of the total bill.

The purpose of the co-payment system is to ensure that patients do not abuse the subsidised healthcare system: to encourage them to choose the most appropriate level of services and not the most expensive services.

Private healthcare, which offers improved facilities for patients who pay the full cost of care, is also available in Singapore. I think that the difference between subsidised and private services, in terms of accommodation and facilities, is, however, likely to reduce in future; subsidised wards may have air-coolers in addition to fans, for example, and the number of beds in wards is likely to decrease.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN SINGAPORE?

The advantages of the co-payment system include:

- encouraging patients to seek the most appropriate level of health care
- helping the government control health care costs across Singapore and ensuring that they don't spiral out of control as they appear to be doing in the US
- encouraging individuals to take good care of their own health so that they avoid the high medical costs of ill health.

The disadvantages of the co-payment system include that:

- hospitals are funded on an episodic basis, which works to discourage the right siting of patients. If hospitals right-site patients to ambulatory care (i.e. rather than admitting them to hospital, they treat them in the out-patients department or the day surgery unit) then the hospital will lose funding as its total inpatient numbers will fall
- the funding system does not take account of the ageing population, or the complexity of their diseases
- the funding system does not support sufficient investment in the training of doctors, nurses, allied healthcare staff or healthcare administration staff
- the funding system does not motivate doctors to spend time in research.

Other disadvantages include:

- there are too few good-quality nursing homes; this has resulted in high bed occupancies in government hospitals
- lack of collaboration; more collaboration between restructured and private hospitals would help address the problems of retaining doctors in public practice
- the healthcare system focuses on cure rather than prevention. There need to be more educational/preventive measures established to improve patients' knowledge and understanding of their health.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM SINGAPORE?

The benefits and operation of a co-payment healthcare system.

The benefits and operation of Medisave, a national saving scheme that citizens use to fund medical expenses; Medifund, a national scheme to help fund the care of patients who cannot afford to pay for health care; and Medishield, a national insurance scheme to help protect against catastrophic illness.

Means testing of patients.

The structuring of services to ensure that every region has an acute hospital operating in collaboration with general practitioners (GPs), a nursing home, private hospital and day surgery centre.

Slovakia

Martin Hrežo, FCCA



Organisation

Svet zdravia, a.s.

Position

Chief finance officer

RELEVANT NATIONAL GUIDANCE

<http://www.health.gov.sk/>

<http://www.nczisk.sk/>

<http://opz.health-sf.sk/>

<http://www.uvzsr.sk/>

<http://www.ezdravotnictvo.sk/>

<http://www.udzs-sk.sk>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SLOVAKIA?

Slovakia employs the following payment systems:

- capitation – used for ‘first contact care’, including that involving general practitioners, outpatient care, gynaecologists, and stomatologists
- fee for service – the majority of healthcare services are reimbursed using this payment system.

The system is based on recognition of ‘limited’ and ‘unlimited’ healthcare services.

With ‘limited’ services, the health insurance companies allocate a certain amount of financial volume (so called ‘contractual limits’) to health care providers. Each of these ‘limited’ services is individually priced and the quantity to be provided is agreed. This works as a revenue cap (for inpatient, outpatient and diagnostics) as hospitals will only receive payment up to the limits assigned.

With unlimited services, the cost, but not the quantity, is fixed in advance. For these services (which include various surgical procedures, certain diagnostics, one-day care and ambulances), the more the hospitals do then the greater their income.

Under co-payment all medical services are reimbursed by the health insurance companies. Sometimes, however, patients have the option of making an additional co-payment to get a higher standard room, for being able to select their doctor, for higher-quality medical materials, etc. The price and extent of these extra services is not standard: it is determined locally by each hospital.

The majority of drug costs are only partially reimbursed by health insurance companies; the balance is paid by the patient.

Under payment for outcomes, certain services have defined outcome measures/ criteria; when these are achieved the provider is paid a premium by the health insurance company.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN SLOVAKIA.

The current system in Slovakia is based on the constitutional right of every Slovak citizen to free healthcare services. The roots of the system are in the socialist era when all health care providers were state owned, including the health insurance organisations.

Owing to limited public resources, however, 'unlimited' consumption (accessible and free health care) is not achievable and, therefore, the provision of free access to healthcare services remains an illusion.

As a result, co-payments have become part of the norm. They have spread with limited control or oversight from the government. Statistics suggest that the volume of private payments increases each year and currently represents roughly one-third of total healthcare expenditure.

Attempts have been made to restrict access to services by introducing standard and fixed payments for hospital and doctor visits. These, however, have not been successful and have failed owing to wide public rejection and political contests.

The health system is based on a triangle: patient – health insurance company (HIC) – health care provider. The HIC collects funds from mandatory health insurance payments that are made by every citizen. These funds are then allocated to the network of health care providers, which may be state owned (eg large university hospitals) or privately owned (eg outpatient clinics, some smaller hospitals). In Slovakia, there are three HICs, the largest is state owned (holding approximately 64% of the market share), the other two are privately owned (holding approximately 28% and 8% of the market share). The vast majority of health care providers have a contractual relationship with at least one HIC, preferably with all three. Even so, there are also rare occasions where a health care provider has no contract with none of the HICs and where all services are paid for directly by all the patients.

The reallocation of funds collected through health insurance payments from the citizens is to a large extent non-transparent and influenced by corruption.

Providers are paid a fixed fee per inpatient case, with different prices for each specialty. Outpatients and diagnostics are paid on a point basis; the Ministry of Health assigns a different number of points to each activity and the health insurance companies then decide how much to pay per point.

Citizens have free choice of their HIC but, as contribution levels are fixed by the government, there is no impact on the size of insurance payments if they transfer between companies. There is also no opportunity to pay an increased premium to obtain, for example, higher-quality services. Therefore, although citizens have free choice of their HIC, changing has limited benefit.

The government recently declared its intention of introducing a unitary health insurance system with just one, state-owned, HIC. Opinions on this proposal vary and there is now intense public discussion about whether to restrict or extend the competition on the healthcare insurance market. There are, however, no plans for the introduction of voluntary, additional health insurance payments for improved benefits; before that could be done it would be necessary to define minimum standards for basic-level care.

Another planned reform is the implementation of a DRG (diagnosis related group) system. This is expected to bring greater transparency to the allocation of funding to health care providers.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN SLOVAKIA?

Advantages include:

- wide accessibility of health care
- HICs have introduced an electronic account for each patient, which allows patients to monitor and control (through internet portals) the services provided to them and the cost of their care.

Disadvantages include:

- an unstable legislative environment
- lack of transparency; there are no clear rules for contractual negotiations with HICs or for the transparent distribution of funds to health care providers

- uncontrolled demand for services
- limited resources; the hospitals are in poor condition with missing or obsolete medical equipment
- financial problems; it is not unusual for hospitals to be unable to pay their debts
- dissatisfaction of medical personnel; many are seeking positions in other countries that offer better conditions
- there are no inbuilt quality measures for benchmarking service provision or to support a payment system linked to quality.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM SLOVAKIA?

The Slovakian system offers excellent accessibility of healthcare services to people of all income levels. I believe, however, that there is currently more that Slovakia can learn from other countries.

United Arab Emirates

Jawad Jamil, FCCA



Organisation

Gulf Healthcare International

Position

Head of finance

Specialist interest in the workplace

Strategy and corporate planning; restructures; mergers and acquisitions (M&A) activity.

RELEVANT NATIONAL GUIDANCE

<http://www.colliers.com/en-gb/unitedarabemirates/services/healthcare>

<http://www.haad.ae/haad/tabid/136/Default.aspx>

<http://www.dha.gov.ae/EN/AboutUs/Pages/StrategicGoals.aspx>

http://www.khaleejtimes.com/kt-article-display-1.asp?xfile=data/nationhealth/2013/October/nationhealth_October2.xml§ion=nationhealth

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTHCARE IN UNITED ARAB EMIRATES (UAE)?

UAE employs the following payment systems:

- fee for service
- co-payment
- insurance coverage.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN UAE.

The UAE is a country with a relatively small population, having an estimated 9.2m inhabitants. Only 12% of the population are UAE nationals; the rest are expatriates. For a market of this size, the health market is quite fragmented.

The country is split into three regulatory zones for the purpose of healthcare administration. Each zone oversees all regulation, administration and all medical and financial affairs within its boundary.

The three zones are:

- Abu Dhabi (HAAD) responsible for the State of Abu Dhabi, with an estimated population of 3 million
- Dubai Health Authority (DHA) responsible for the State of Dubai with an estimated population of 3.2 million
- Ministry of Health (MOH) responsible for the remaining five states in the UAE and an estimated population of 3 million.

The predominant healthcare funding mechanism is self-payment by the patients, with a small, but significant, population having access to health insurance through their employer.

Employee health insurance is an evolving initiative. Mandatory health insurance laws are expected in the short to medium term. These laws will require employers and sponsors to provide insurance cover for their employees and dependants.

The health insurance model received a major push in HAAD when mandatory healthcare insurance was introduced in the State of Abu Dhabi in 2009. This ensured 100% population coverage. It also proved to be a key driver for health care; following the introduction of the law, demand increased by 40%.

A similar growth phenomenon is expected in Dubai when DHA introduces mandatory healthcare insurance over a three-year period (starting in early 2014). Currently it is estimated that only 30% of the population of the state is covered by health insurance.

Health insurance does not cover all services. The majority of schemes do not cover dental services, cosmetic dermatology or obstetrics, for example, so these are generally cash-based services with costs borne by individual patients.

Before the implementation of mandatory health insurance, the use of health services was low, with a large proportion of the expatriate population travelling to their home countries for care. The expansion of mandatory insurance, however, will give the yet-untapped sector of the population overnight access to almost all healthcare facilities and benefits. The use of hospital beds and primary clinics will increase dramatically.

The increased demand for health services, brought about by the introduction of compulsory insurance coverage, will challenge the healthcare infrastructure, which is already behind international standards. Further pressures will come from the growth in population and the government's proactive approach to setting up a medical tourism centre.

The UAE government has nearly doubled its budget allocation for health care, raising it to (USD) \$12bn in 2012.

The government sector holds 73% of the hospital bed capacity in the UAE. It is the private sector, however, that plays the biggest role in health care provision; two-thirds of patient encounters are registered in the private sector. This is primarily owing to the high use of outpatient services. According to *Colliers International Report*, just 3% of hospital visits relate to inpatient treatment; 97% of patient hospital visits are for outpatient appointments.

The UAE lags behind the global developed nation averages and GCC (Group of six Arabian Gulf Countries) averages in

the number of hospital beds, physicians and nurses. UAE has 1.5 physicians, 2.7 nurses and only 1.1 hospital beds per 1000 population. This is around half the number of more developed nations.

Although UAE has a relatively young population there is a high prevalence of lifestyle diseases: coronary disease, Type 2 diabetes, liver disease and obesity-related illness. Children are also affected: a recent study found that 40% were obese. With such diseases requiring regular management and screening, the demand for doctors and primary care and secondary care services will increase.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN UAE?

The disadvantage of the fee-for-service dominated model was that the majority of the population stayed away from private sector healthcare facilities as the cost was a big limiting factor.

With mandatory insurance roll out that particular limitation is removed. The increase in patient base, however, will then introduce major economic viability concerns as insurance providers fear unsustainable coverage levels. This arises from a number of causes, including inadequate underwriting and the overuse and misuse of insurance policies by both service providers and patients. Where such roll-outs have been completed, as in Abu Dhabi, the loss ratios for some insurance companies have been significant. Another factor that affects losses due to higher-risk portfolios is the operations of TPAs (third-party administrators) who are running health insurance books that are not properly underwritten and therefore create a large exposure not backed by a cost patron.

This issue has been closely monitored by the regulators, and they have taken significant steps to improve health regulations, bringing about practice and infrastructure reforms. Examples of such steps include:

- mandatory online pre-approvals and submissions of claims
- monitoring of use by insurance providers

- monitoring patterns of service for each doctor and facility
- establishing a single price list for the region for all services
- linking price to quality of services, facilities, patient base and doctor utilization.

Dubai has proactively implemented these reform measures and improvements before rolling out mandatory insurance, with the aim of ensuring economic viability while also introducing a significant improvement in the quality of services.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM UAE?

Despite having a small proportion of nationals (only 12% of the total population) and a significant dependency on the expatriate population, by adopting a proper planned and strategic approach, UAE has been able to develop and introduce a qualitative healthcare environment. The main reason for this is the focused and honest leadership of the country, which has, despite UAE's youth as a country (becoming independent in 1971), considered the health of its citizens and residents as a priority. A lot of developing countries with huge populations can adopt such a vision and focus on improving their healthcare systems.

Another positive aspect of health care in UAE is a rigorous credential verification system, whereby all health professionals are tested and their qualifications and experience verified before they are given a licence to practice. This has eliminated the risks of employing unqualified or under-qualified medical practitioners.

Zimbabwe

Maurice Dube



Organisation

Premier Service Medical Investments PVT Ltd

Position

Financial manager

RELEVANT NATIONAL GUIDANCE

http://www.parlzim.gov.zw/attachments/article/101/MEDICAL_SERVICES_ACT_15_13.pdf

<http://ahfoz.co.zw>

WHAT PAYMENT SYSTEMS ARE USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ZIMBABWE?

Zimbabwe employs the following payment systems:

- fee for service
- co-payment
- cash payment.

PLEASE PROVIDE A QUALITATIVE COMMENTARY ON THE PAYMENT SYSTEM USED FOR MEETING THE DIRECT PROVISION OF HEALTH CARE IN ZIMBABWE.

The liberalisation of the economy in the early 1990s provided the momentum for amplified investment into medical aid societies and medical insurance through greenfield investments, acquisition and expansion. The fee-for-service payment system, which forms 80% of private health care providers' income, first came into being in 1969 when the Association of Healthcare Funders of Zimbabwe (AHFoZ) (formally the National Association of Medical Aid Societies) was founded.

The AHFoZ is a voluntary organisation governed by a constitution and code of ethics. It is not a regulatory body per se but has put in place a peer-review mechanism, and thus relies on self-regulation to maintain the standards of its members. It has the power to eject members that do not conform to its code of conduct.

The institution does not set prices for healthcare services but produces a schedule of tariffs, the Zimbabwe Relative Value Schedule (ZRVS), which guides funders and providers of health care on the fees they can charge. The ZRVS was decided by a tariff liaison committee comprising members from the AHFoZ and the Zimbabwe Medical Association (ZIMA).

AHFoZ and ZIMA have conflicting interests and, against the background of a hyper-inflationary environment, disagreements over tariff levels and the payment timeframe arose between the two organisations in 2003. The AHFoZ wanted the tariff to remain as low as possible and for payments to be delayed whereas ZIMA, representing the interest of healthcare service providers, wanted tariffs to be in line with inflationary pressures and for claim settlement

turnaround times to improve. The result was that ZIMA then formed its own tariff committee, independent of AHFoZ, and set its own tariffs, which were higher than the AHFoZ tariff.

The difference in values between the AHFoZ tariff structure and that of ZIMA led to the introduction of co-payments as a means of setting medical fees. The AHFoZ members would pay up to their published tariff with any shortfall being paid by the patient out of pocket.

Medical aid societies (MAS) in Zimbabwe cover 10% of the population and contribute 80% of private medical healthcare services' income. The schemes are not compulsory and deal directly with employers and consumers; they are not, therefore open to the unemployed or to those working in the informal sector.

Medical insurance coverage tends to be higher for working men and women and the wealthier groups, with lower coverage for women, those living in rural area and the less wealthy. Pensioners and the ageing population are generally refused cover by the MAS.

Zimbabwe has an unemployment rate of over 90% so a large proportion of the population has to rely on government-provided healthcare facilities. These are heavily under-resourced owing to the economic challenges bedevilling the country. Accessibility of healthcare services is a challenge for those not enrolled in MAS; the few who can afford to meet the medical costs pay in cash.

The MAS is urban based and not accessible to the less-privileged rural population, hence the latter often patronise traditional healthcare facilities where they pay either in cash or in kind (goats, sheep, maize, etc).

The services offered by each medical insurance plan depends on the level of contributions made by members; plans with higher rates naturally offer a wider range of services and senior employees enjoy more benefit than junior employees.

None of the medical aid plans cover gym and fitness classes. This is a notable limit on the extent of coverage since these services would lead to future benefits in the form of disease prevention.

The basis of calculation for provider reimbursement is determined mainly by the type of service. For diagnostic services reimbursement is by procedure while for hospitals

reimbursement is by surgery type, procedure and bed days.

Only 11% of beneficiary plans, however, give full reimbursement for services provided outside their managed care plans and most clients (59.5%) are required get approval from their MAS to use service providers other than those owned by the society.

Private hospitals are being established in urban centres but not in rural communities because of the administrative burden of running medical aid in rural areas.

Towards year-end, most medical aid members' benefits will have been exhausted so insurers will no longer fund the cost of care. This is a challenging period financially for health care providers and for patients it is a costly time to fall ill, as they will have to pay more for their care.

To limit the risk associated with much individually owned medical insurance there is now talk of introducing national health insurance.

WHAT DO YOU CONSIDER TO BE THE ADVANTAGES AND DISADVANTAGES OF THE PAYMENT SYSTEM IN ZIMBABWE?

The advantages of a fee-for-service payment scheme include that:

- it encourages correct patient care at the right time and in the right place
- it rewards productivity
- it compels service providers to report explicitly what they have done
- it allows for an administrator or payer to track use of service over time according to provider, provider type and service
- it encourages innovation as healthcare funders devise ways of monitoring health care providers to ensure that no unnecessary procedures are done
- health care providers are encouraged to be innovative as they try to improve both efficiency and quality of service.

The disadvantages of a fee-for-service payment system include that:

- it is volume driven, ie it offers substantial financial incentives for providers to see more patients and provide more services
- it may encourage providers to perform more procedures and tests than is justified by clinical diagnosis; these 'extras' will drive up health care costs
- it causes fragmentation in health care provision; collaboration with other health care providers and provision of more comprehensive services are not encouraged by a fee-for-service framework
- it does not encourage providers to spend more time with patients.

WHAT DO YOU THINK OTHER COUNTRIES COULD LEARN ABOUT HEALTH CARE PROVISION FROM ZIMBABWE?

Zimbabwe's healthcare sector is divided into public and private sectors. The government owns about 70% of healthcare facilities in the country, while the private sector owns about 30%. The fact that most of the healthcare facilities are in the public sector means that care is available to everyone at a very affordable price.

Government healthcare funding, however, constituted just 4.9% of the 2012 national budget; this low investment in the sector has resulted in the debasement of the healthcare facilities and no development of new ones.

Other countries can learn how to provide basic health care at low cost, how to reduce infant mortality rates and how to combat HIV and AIDS effectively through innovative financial initiatives such as the ground-breaking AIDS levy.

FURTHER READING:

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Conn, C. and Walford, V. (1998), *An Introduction to Health Insurance for Low Income Countries* (London: IHSD Ltd).

Government of Zimbabwe (1987/2001), *Insurance Act*.

Government of Zimbabwe (1971/1996), *Medical, Dental and Allied Professions Act*.

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