Who captures efficiency gains?

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Motivation

- We are assuming that “efficiency savings” are a means to enable a greater degree of progress towards UHC from a given level of funding.

- Need to explore the policy conditions under which this is true (or false).

- Does it matter? I think it is an important part of creating a policy framework for efficiency improvement (but needs more thinking)

- Get your feedback as to whether this is a meaningful/important line of policy exploration
In principle, improving efficiency should be equivalent to generating more revenues

Source of slide: Evetovits, modified after Reinhardt 1984
## Ten leading sources of inefficiency

Ref: World Health Report 2010, Chapter 4

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicines</strong></td>
<td>under-use of generics and higher than necessary prices</td>
</tr>
<tr>
<td><strong>Medicines</strong></td>
<td>use of sub-standard and counterfeit medicines</td>
</tr>
<tr>
<td><strong>Medicines</strong></td>
<td>inappropriate and ineffective use</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>inappropriate hospital size (low use of infrastructure)</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>medical errors and sub-optimal quality of care</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>inappropriate hospital admissions and length of stay</td>
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<tr>
<td><strong>Services &amp; products</strong></td>
<td>oversupply and overuse of equipment, investigations and procedures</td>
</tr>
<tr>
<td><strong>Health workers</strong></td>
<td>inappropriate or costly staff mix, unmotivated workers</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td>inefficient mix / inappropriate level of strategies</td>
</tr>
<tr>
<td><strong>Leakages</strong></td>
<td>waste, corruption, fraud</td>
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So if, e.g.:

- Unnecessary tests are reduced, or
- Use of appropriate referral channels improves, or
- Skill mix improves…

- How does this become “savings”?  
- And where does the savings go?
Empirically-derived hypotheses

- “Savings” retained and recycled within a health facility, agency, or program, enabling better/more services to be provided within a budget year

- Savings retained within the health system but reallocated (at least in part) to support other services (e.g. hospital efficiencies support more/better PHC)

- Savings in the form of unspent funds go back to the government Treasury/MOF

- Some combination
A real (and “easy”) example: high fixed costs in the ex-USSR countries

<table>
<thead>
<tr>
<th></th>
<th>Moldova 2000</th>
<th>Kyrgyzstan 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and social benefits</td>
<td>47%</td>
<td>52%</td>
</tr>
<tr>
<td>Utilities</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Drugs and supplies</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>Food</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Capital and repairs</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td></td>
</tr>
</tbody>
</table>
This input mix with public funding also a source of growing out-of-pocket payments

- Small budgets left over for key treatment inputs such as drugs and medical supplies
- Patients discover that when they get to health facilities, they have to pay for these or provide their own.
- =>inefficient input mix led to greater dependence on out-of-pocket payments, with inequitable results
Important drivers of this

- **Provider payment mechanism**
  - Hospital budgets driven by inputs (number of beds)
  - Rigid line item budgets, no autonomy

- **System structure (fragmentation)**
  - Organized by level of government, not population
  - Integrated financing and delivery

- **Process of wider economic transition**
  - Energy prices in particular started to rise

- **Fiscal collapse after 1990 and slow recovery**
The Kyrgyz financing reforms as a response to this

- Initiation of “Single Payer” reform in 2001, in 2 regions
  - Definition of guaranteed benefit package for entire population, including formal co-payments and exemptions
  - Eliminated pool fragmentation and separated purchaser from providers, sourced mainly from budget revenues
  - Change in the purchasing methods to population and output based payment, linked explicitly to benefit package
  - Gradual increase of provider autonomy in management

- Year 1 results
  - Reduction of informal payments, growing awareness of benefits
  - Efficiency gains through massive downsizing of unneeded infrastructure enabled reduction of fixed costs
Efficiency gains from new incentive structure

Percent reduction in capacity in 2001 relative to 2000 levels

Source: Socium Consult (2002)
Measurable gain in technical efficiency of input mix following reform

Source: Mandatory Health Insurance Fund
Transparency improved: reduced informal payments

Average expenditures by patients in Issyk-Kul hospitals

Source: WHO surveys of discharged hospital patients
The public sector financial management response, Year 2

- Reforms led to both less infrastructure and more transparent reporting of patient payments

- Although evolving, overall budget formation with MOF had not yet changed sufficiently
  - Budgets still prepared according to number of beds
  - So 2002 budget envelope was reduced (fewer beds interpreted as "less need", so efficiency gains were punished)

- Success in formalizing informal payments also “rewarded”
  - Newly visible “revenues” taken into account in budgeting, causing reduction in public funding, punishing transparency

- More positively, ongoing engagement with MOF led to better alignment in later years
Creating the right environment: not just fiscal space, but “fiscal rules”

The Health System

Source/collection
- Oblast, rayon and city administrations
- Ministry of Finance

Pooling
- Oblast Department of the Mandatory Health Insurance Fund

Purchasing
- Health care facilities with increased financial and managerial autonomy

Provision

Population
- Population of each Single Payer oblast

input-based budget formation

Output-oriented health financing system
Highlighting a broader issue: how to create a policy environment for efficiency

- Not only coordination across the health system

- Need to align with wider environment of public finance
  - Separation of budget setting (overall envelope of funding) from internal sectoral allocation policies and reforms
  - Shift accountability mechanism from “control of inputs” to reporting on agreed outputs, while ensuring there is accounting for all resources used

- Regardless of specific mechanism, can large bureaucracies (like governments and WHO) facilitate:
  - Managerial flexibility (at the margin)
  - Ability to adapt to changing circumstances and local conditions (as in Ethiopia, for example)
  - Capacity and mechanisms for learning and adapting
Last thoughts

- How do efficiency problems (or improvements) manifest themselves? How do we know?
- Should we ever use the word “savings”?
- It seems to be important to ensure that efficiency gain is rewarded rather than punished
- Relevant to synthesis?
Reduction in fixed costs under Single Payer

Comparison of utility costs with and without restructuring in 8 investigated hospitals, Kyrgyz Republic, soms