Efficiency incentives:
expected and observed changes following the implementation of the National Integrated Health System of Uruguay

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Efficiency problems previous to the SNIS

• Assignative inefficiencies

• Fragmented and segmented health system

• Inequities in financing, expenditure and access: health attention wasn’t guided by health needs
Causes of the efficiency problem

Main causes:

• Payment mechanisms, human resources profile and working model, curative healthcare model

Focus of the study:

• Incentives to improve the efficiency in the SNIS
• 5 dimensions: Institutionality and governance, payment mechanisms, human resources, health technologies, and provision of health services
Consequences of the efficiency problems

• Public sector per capita expenditure, was one third of private sector expenditure with more health needs in the first one, making the gap even more critical
• Curative and medical hegemonic healthcare model, with no significant promotion and prevention actions, leading to an inefficient allocation of resources and poor health results

Distributional consequences

• The regulation of the private sector providers allowed cross subsidies between social health insurance payments and private payments.
• Corporatism acted in two ways: physicians with the double condition of being health enterprises owners and workers, and high income workers in general, privileged with more comprehensive coverage plans financed by their employers
National Integrated Health System and National Health Insurance in Uruguay

SNIS and SNS

- Three pillars of the reform: changes in the management model, in the health care model, and in the financing model of the system

- Changes in the financial model were successfully implemented, gradually, since 2007

- Changes in the healthcare model are more difficult to implement, as they imply cultural and organizational transformations. However, there are a lot of actions that contribute to this objective

- Concerning the management model changes, social participation was encouraged, and at central and local levels, users and workers participation, start to work.
Three pillars of the SNIS

Changes in the financing model

• National Health Insurance financed by workers, active and retired workers, employers, pensioners and fiscal contributions; a unique benefit package; risk adjusted payments, payments by result.

Changes in healthcare model

• Networks Organization, by care levels according to the users' needs and the complexity of the services, based on a primary health care strategy, and prioritizing the first level of care

Changes in management model

• New institutional framework with broad social participation, and strengthening of the steering role of the Ministry of Public Health.
The SNS is administered by a National Health Board, the JUNASA, in the Ministry of Health, with health workers and beneficiaries participation.

It signs management contracts with providers.

It pays adjusted capitation and performance payments.

A participative model of governance provides possibilities and mechanisms for encouraging a more efficient performance in the health system.
The National Health Insurance (SNS)

CONTRIBUTIONS: The State, Employers and Households

PAYMENTS:
- Capitation adjusted by age and sex
- for performance

INTEGRAL PLAN OF BENEFITS (PIAS)

INCOME RELATED CONTRIBUTIONS

Population/beneficiaries

Integral Providers

ASSE
IAMC (39)
SEGUROS PRIVADOS (6)

National Health Fund
FONASA

MANAGEMENT CONTRACTS
BY JUNASA
Evolution of SNS - FONASA coverage

The SNS, financed by FONASA, gives coverage to 70% of the population and makes risk adjusted (age and sex) capitation payments.
**FONASA Payment mechanisms**

- Capitation payments adjusted by age and sex
- Payment for compliance with healthcare goals

**PIAS**

- Goal 1 - Child and woman health
- Goal 2 - Reference Physician
- Goal 3 - Old adult health
- Goal 4 - High Dedication Positions

The same plan of benefits for all the population
High dedication positions

- Goal 4 stimulates the creation of high dedication positions in general medicine, family medicine, pediatrics, gynecology, intensive care for adults and pediatrics and neonatology and internal medicine in the health institutions.
- It was agreed by the wages council in November 2012.
- Implies a reference population for the physician.
- Tends to reduce multiple employment with positions of 40 to 48 hours a month.
- They must include hours for urgent and emergency cases, home care, inpatient care and home visits, which may not exceed 75% of the total workload, with hours of direct polyclinic care (which may not be less than 20% of the total workload), inpatient visits, as well as health education and promotion activities and hours of institutional activities that do not involve direct patient care.
Effects of the reform on the efficiency problems

• **Capitation risk adjusted payments** by FONASA to the integral providers, together with the SNS coverage extension, and management contracts, led to a better resource allocation and discouraged risk selection.

• An **additional payment for complying with a set of care goals** promoted changes in the healthcare model.

• The discussion of a **new working model** for physicians and the **High Dedication Positions**, are proving that quality care and better health results, require a more efficient use of health human resources.

• **Complementation policies** of health services and actions between public and private providers, have achieved a more rational use of resources, mainly in low frequency use services and in rural areas.
Some difficulties and challenges

• Problems with capitation calculation methodology based on historical costs of private providers and its incentives to efficient production

• The articulation of payment and financing mechanisms of the SNIS, including the FNR, emerges as a need

• It is necessary to advance in the use of economic evaluation techniques and prioritisation criteria that allow for more efficient and equitable decisions about the inclusion of new services or technologies in the PIAS
Policy implications and lessons learnt

- Relevance of combining and coordinating different policies and instruments

- A participative design, implementation and control of the policies, makes the process slower and leads to conflicts, but gives more transparency and support

- Need for progress on regulatory and control capabilities, strengthening the stewardship role of the Ministry of Health

- Need of quality information systems and technologies in order to measure providers and system performance
THANKS!!!