



Health policy in times of austerity—A conceptual framework for evaluating effects of policy on efficiency and equity illustrated with examples from Europe since 2008



Martin Wenzl*, Huseyin Naci, Elias Mossialos

LSE Health, London School of Economics & Political Science, Houghton Street, London WC2A 2AE, United Kingdom

ARTICLE INFO

Article history:

Received 9 August 2016

Received in revised form 20 April 2017

Accepted 11 July 2017

Keywords:

Healthcare reform

Equity

Efficiency

Economic crisis

Europe

Denmark

England

France

Italy

Netherlands

Portugal

Spain

ABSTRACT

The objective of this paper is to provide a framework for evaluation of changes in health policy against overarching health system goals. We propose a categorisation of policies into seven distinct health system domains. We then develop existing analytical concepts of insurance coverage and cost-effectiveness further to evaluate the effects of policies in each domain on equity and efficiency. The framework is illustrated with likely effects of policy changes implemented in a sample of European countries since 2008. Our illustrative analysis suggests that cost containment has been the main focus and that countries have implemented a mix of measures that are efficient or efficiency neutral. Similarly, policies are likely to have mixed effects on equity. Additional user charges were a common theme but these were frequently accompanied by additional exemptions, making their likely effects on equity difficult to evaluate. We provide a framework for future, and more detailed, evaluations of changes in health policy.

© 2017 The Authors. Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

The need to “bend the cost curve” and lower the rate of growth in healthcare spending has been acknowledged across many high-income countries. The post-2008 economic crisis, which precipitated a sovereign debt crisis in Europe and squeezed public budgets, added particular urgency to longer-term concerns of cost containment.

Questions policy makers face in an environment of short-term pressures to contain costs may include: Where should cost containment be targeted to avoid undermining health system performance? Should policies aim at controlling prices or volumes? Which measures can generate short-term savings and what are their long-term implications? Which measures require significant up-front financial investment or are technically demanding? Which measures are politically difficult to adopt?

The intended or unintended consequences of policy changes in response to external shocks can be evaluated against overarching health system goals. Protection of high-need and vulnerable populations, such as the elderly, people with low incomes or social minorities, who tend to be characterised by lower health status and a disproportionate prevalence of illness, remains a priority across all three of these. Although evidence on the effects of economic crises on health and the demand for healthcare remains ambiguous [1], the number of vulnerable people likely increases with economic downturn and increasing unemployment. At the same time, declines in government revenue and private incomes cause pressure on public and private budgets available for healthcare [2]. In deciding which policy responses to adopt, equitable financing and access to healthcare are particularly important to protect vulnerable groups.

The objective of this paper is to provide a framework for evaluation of health policy changes against overarching health system goals. The first section develops the framework. We then extract from prior studies policies implemented in a sample of European countries since 2008. We evaluate and discuss the likely effects of these policies to illustrate our framework. A wide range of changes

* Corresponding author.

E-mail address: m.wenzl@lse.ac.uk (M. Wenzl).

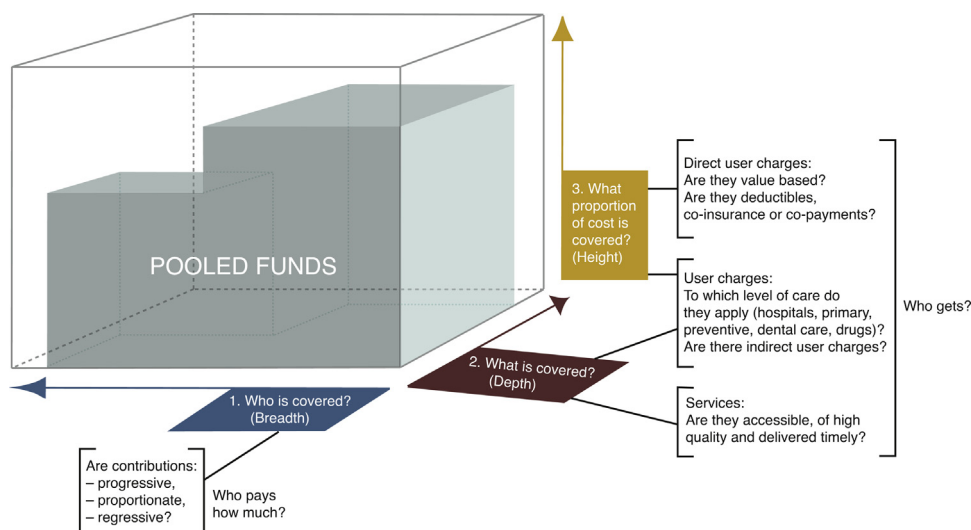


Fig. 1. The three dimensions of health insurance coverage.

were made in this period, either in response to the economic crisis or in continuation of existing priorities [3,4], providing a rich sample of policies to illustrate our framework.

2. Framework development

The World Health Organization (WHO) health system goals of improving population health, maintaining health services and ensuring fair financing and financial protection from ill-health [5] are related to the more abstract concepts of efficiency and equity. Improvement of population health requires the provision of effective services. With any given amount of finite resources, their allocation to interventions that provide the greatest health gain will increase effectiveness and, by increasing health gains per unit of expenditure, efficiency.

Fair or equitable financing and financial protection are achieved by insurance that levies prepaid contributions progressively, based on ability to pay rather than risk of future service use, and leaving services free of charge at the point of use. Equity of access to services, that is, equal access for equal need regardless of ability to pay [6,7], ensures that services are responsive to population need. Overall, a healthcare system is redistributive if progressive financing is combined with equity of access, and incidence of public spending is higher in poorer population groups with higher need [8]. The criteria in an evaluation of equity are thus twofold, “Who pays (contributions)?”, and “Who gets (benefits)?”

A third and related question is, “Who gets paid?” This arises from the identity of aggregate revenue raised with aggregate healthcare expenditure and aggregate income of those working in the healthcare sector. Revenue and expenditure are equal to the volume of healthcare services delivered to the population multiplied by their average price and equal to the number of people working in health care multiplied by their average incomes [9].

We first extend the framework of the three dimensions of coverage by WHO [10] to analyse the effect of policies on insurance coverage (Fig. 1). As has been suggested by Roberts, Hsiao & Reich [11], the depth and height of coverage may vary across population groups so that a homogeneous coverage “cube” is of limited use in an analysis of equity. This may be particularly true in low- and middle-income countries but also applies in high-income countries if coverage depends on location or occupation [8] or certain population groups are excluded or can opt out of public coverage [12].

Therefore, policies are evaluated in terms of their effect on service and cost coverage for distinct population groups. Reductions in coverage overall or policies that increase the gap in coverage between population groups have a negative effect on equity; policies that increase coverage or reduce coverage gaps increase equity. Along the height of coverage we furthermore distinguish between value-based user charges that may facilitate efficiency gains and blanket charges, which reduce equity.

We then categorise policies according to where in the tri-partite relationship between patients, purchasers and providers [13] their effects lie (Fig. 2). In each of these health system domains, a set of criteria are used to evaluate the effect of policies on equity and efficiency. These include the breadth and depth of insurance coverage as criteria in financial flows from the population to purchasers (boxes 1 and 2). The height of coverage is the criterion in direct payments from the population to providers (box 3). Beyond coverage, the main criteria in risk adjustment between purchasers and in resource allocation to providers are incentives for risk-selection and for changing the volume and quality of services (box 4). The effect of these financial flows on provider behaviour (box 5) and on equity of access (box 6) are the main criteria in service provision to the population. A final domain is added for policies related to the health system in its entirety (box 7). The amount of administrative cost incurred for health system stewardship impacts efficiency in this domain.

Finally, we expand upon the framework proposed by Thomson et al. [14] and borrow from a framework referred to as the “cost-effectiveness plane” in the health economics literature [15]. This allows for a visualisation of the effects of policies on efficiency. While efficiency is frequently misconstrued as synonymous with cost reductions, the concept requires a measure of output as numerator in addition to a measure of cost as denominator. Health outcomes attributable to healthcare (such as amenable mortality) are appropriate numerators in measuring efficiency because increasing population health is an overall policy goal. However, the effect of healthcare is notoriously difficult to disentangle from the wider determinants of health. As a result, assuming that services are effective in improving health, aggregate volumes of services provided can be used as a surrogate measure.

The third element of our framework is presented graphically in Fig. 3. Policies are placed along the horizontal axis based on their effect on health expenditure. This is measured in terms of total

Download English Version:

<https://daneshyari.com/en/article/5723373>

Download Persian Version:

<https://daneshyari.com/article/5723373>

[Daneshyari.com](https://daneshyari.com)