

# Setting the Vision for a Country's Health-care System



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# CONTENTS

- **Overview of key questions**
  - Quality of health care
  - Access to health care
  - Financing the health system
  - Private/public provision

# KEY CHARACTERISTICS OF FUTURE HEALTH-CARE SYSTEM DEFINED ALONG FOUR DIMENSIONS

	Definition	Key characteristics (examples)	Rationale
<b>Quality of care</b>	<ul style="list-style-type: none"> <li>Degree of excellence of care in relation to actual medical knowledge, identified by quality tracers based on outcomes of care, as well as on structure and process</li> </ul>	<ul style="list-style-type: none"> <li>Quality is always the primary consideration</li> <li>Clear and equal quality standards for all providers</li> </ul>	<ul style="list-style-type: none"> <li>Health is precious and should not be compromised by cost concerns</li> <li>Highest quality guaranteed if rigorously enforced</li> <li>Creates equality in the system</li> </ul>
<b>Access to services</b>	<ul style="list-style-type: none"> <li>The right of patients to use and benefit from services provided by health-care providers.</li> </ul>	<ul style="list-style-type: none"> <li>All residents have access to same facilities</li> <li>Patients have free choice of providers</li> <li>GPs act as gate-keepers for hospital care, excluding accidents &amp; emergencies (A&amp;E)</li> </ul>	<ul style="list-style-type: none"> <li>Quality fostered by provider competition</li> <li>Most cases can be treated effectively and efficiently at GP/PHC level</li> </ul>
<b>Financing health care</b>	<ul style="list-style-type: none"> <li>The function of a health-care system concerned with the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively, in the health system</li> </ul>	<ul style="list-style-type: none"> <li>MoH with no role in financing. All residents covered by mandatory insurance</li> <li>Only treatments unavailable in country paid for abroad</li> </ul>	<ul style="list-style-type: none"> <li>Increase choice of providers, transparency, accountability, and active provider management</li> <li>MoH ensures highest-quality care in all areas with adequate volume</li> </ul>
<b>Public/private providers</b>	<ul style="list-style-type: none"> <li>State or privately owned and managed organizations and professionals who provide health care as part of their job responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>Provision transferred to private sector</li> <li>MoH* with no role in provision; government involvement in provision limited to absolute minimum</li> </ul>	<ul style="list-style-type: none"> <li>Focus on customer satisfaction and quality; better management</li> <li>To ensure access to care in parts of the country that are not attractive to private providers</li> </ul>

\* Ministry of Health. In this document we used MoH as an equivalent of any authority responsible for regulating and providing healthcare services

# KEY QUESTIONS TO DEFINE HEALTH-CARE VISION

## Elements

## Key questions (to be adjusted to local characteristics)

### Quality

- Quality
  - Standards
  - Research
- What comes first: quality or cost?
  - Will there be only one quality standard for each type of facility?
  - Is MoH willing to publicly set measurable improvement targets along quality and other performance dimensions?
  - Is any domain of clinical research out of scope?

### Access

- Eligibility for care
  - Travel time
  - Waiting time
  - Gatekeeper model
  - Patient choice
  - Access to information
  - Treatment abroad
- Will all residents have access to same health-care facilities?
  - Are there set maximum travel times to care facilities?
  - What waiting time is acceptable for residents?
  - Should all patients be forced to go to GPs before seeing specialists or hospitals?
  - To what extent can patients choose their own providers?
  - How transparent will provider performance be made to the public?
  - Should treatment abroad be covered if appropriate treatment is available in the country?

### Financing

- Level of subsidies
  - Savings account
- Who pays for non-nationals using health-care services?
  - To what extent is the government willing to subsidize health care for nationals/foreign nationals?
  - Do you want to put money aside today for future health-care costs?

### Private/ public

- Scope
  - Operation
  - Ownership/  
management
  - Safety net
- Are any health-care facilities or functions off-limits to private sector?
  - At what level will MoH be involved in operations in 10 years time (e.g., prevention, health education, hospital operations)?
  - Will MoH merely allow private management of public facilities or will public health-care facilities be sold to private investors?
  - Will there be a safety net to ensure minimum coverage with all health-care services can be maintained in all parts of the country?

- Questions to be defined according to local health system characteristics
- Definition of questions is an iterative process with extensive client involvement
- Further questions may be added in existing or new categories

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# WHAT COMES FIRST: QUALITY OR COST?



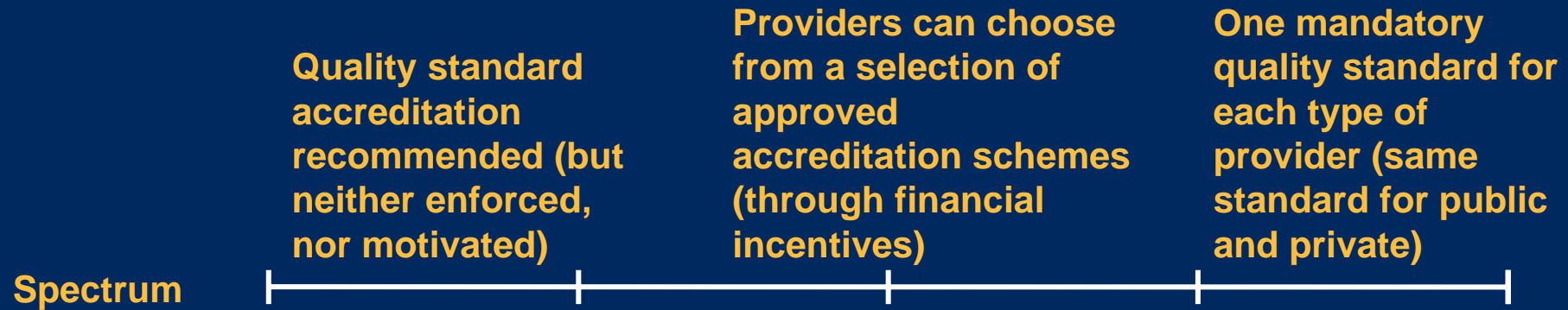
## Supporting arguments for selection

- Get the best care (at least minimum quality) within a certain budget or price range
- Health is precious and should not be compromised by cost concerns

## Consequences

- Force the best hospitals to reduce cost to remain competitive
- Give away the worst-performing hospitals to world-class partner

# WILL THERE BE ONLY ONE QUALITY STANDARD FOR EACH TYPE OF FACILITY?



## Supporting arguments for selection

- Easiest way to attract new investment in private health-care provision
- Low risk of quality issues if rigorously enforced

## Consequences

- Wide variance in quality of care and outcomes; can only be justified in conjunction with enforced public quality reporting to allow patient choice
- Capacity shortages due to closures unavoidable

# IS MoH WILLING TO PUBLISH MEASURABLE IMPROVEMENT TARGETS ALONG QUALITY AND OTHER PERFORMANCE DIMENSIONS?

Quality monitored and inspected but no disease or service-specific improvement targets

Providers constitute independent quality committees and set their targets collectively

Quality and other performance targets set by MoH, publicized, motivated, monitored, and independently reviewed

Spectrum



## Supporting arguments for selection

- Minimum standards enforced through licensing of facilities and professions; competition coupled with outcomes; transparency will promote improvements
- Allows clear focus on specific needs of population

## Consequences

- Strong differentiation opportunities for providers along clinical and/or non-clinical dimensions
- Considerable number of providers will not be able to keep pace, leading to capacity shortages

# IS ANY DOMAIN OF CLINICAL RESEARCH OUT OF SCOPE?

QUALITY



## Supporting arguments for selection

- Self-control principle applied in many countries
- Flexible boundaries promote innovative research

- Need to focus on many other things first
- No risk of public opposition
- No cost

## Consequences

- Attractive stable environment for international research partnerships and ambitious doctors
- Risk of public opposition in some areas (stem cells, embryo, genetics, some drug trials)

- Difficulties recruiting and retaining top medical professionals will remain
- Inadequate environment for university hospitals

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# WILL ALL RESIDENTS HAVE ACCESS TO THE SAME FACILITIES?

**All licensed care providers can be accessed by all population segments**

**Some licensed providers are reserved for specific patient groups**

**Strict segregation of specific patient groups at all points of care**

**Spectrum**



## Supporting arguments for selection

- Lacks critical mass for complete dual system
- Meets WTO requirements

- Different tastes for different population segments

## Consequences

- One single health-care system for all
- Differentiation only based on hotel services

- Dual health-care system
- Human rights debates

# ARE THERE SET MAXIMUM TRAVEL TIMES TO CARE FACILITIES?



## Supporting arguments for selection

- Small, densely populated country with good transportation infrastructure

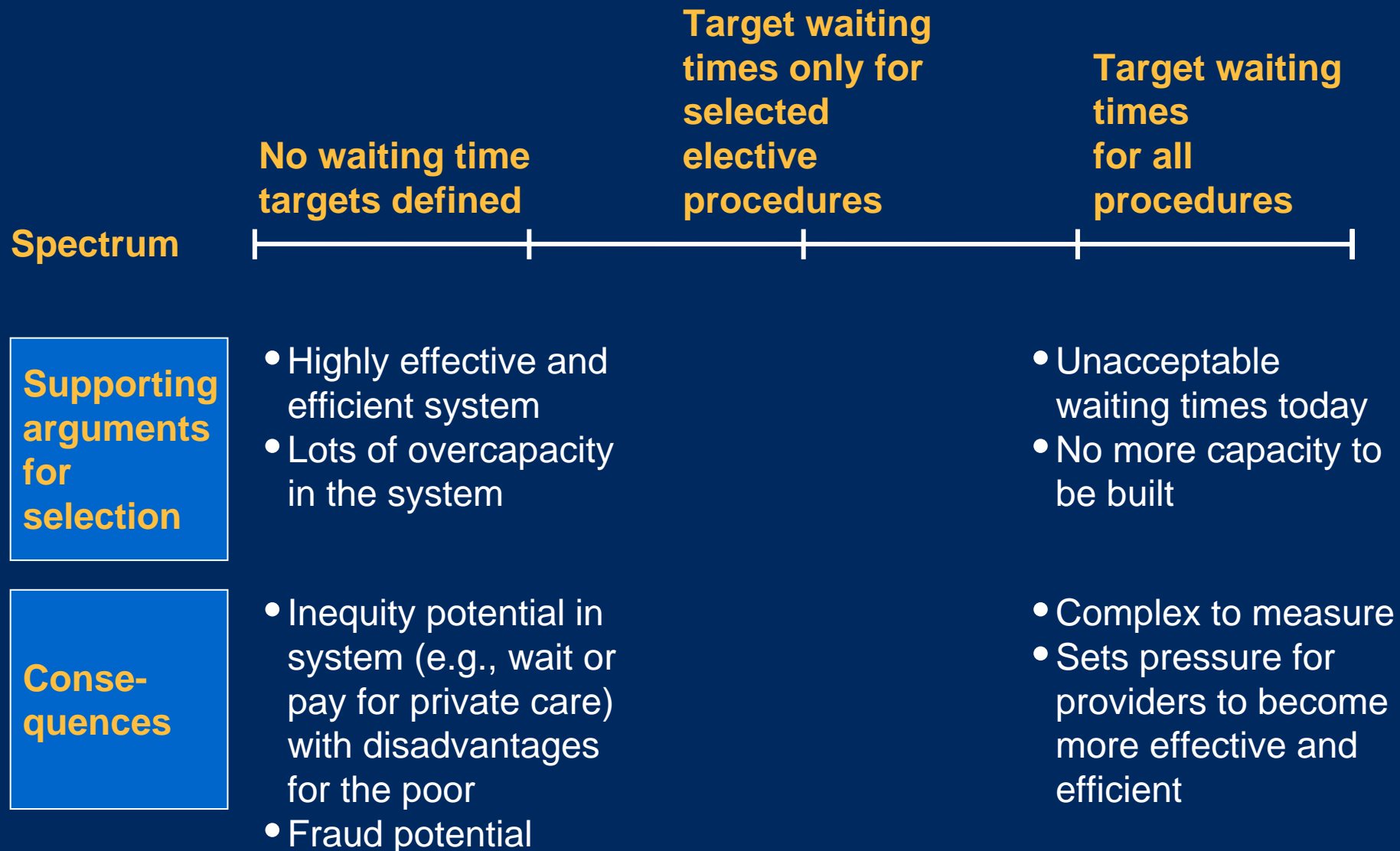
- Population scattered, so distance to nearest provider is key

## Consequences

- Population in remote areas are at risk of reaching care institutions too late

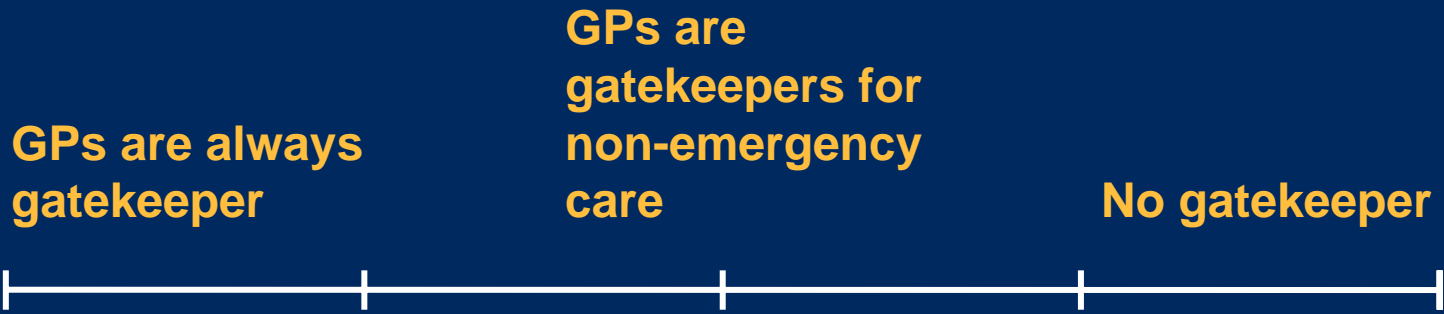
- Different logistics needed in very remote areas
- More costly

# WHAT WAITING TIME IS ACCEPTABLE FOR RESIDENTS?\*



\* To initial consultation and procedure

# SHOULD ALL PATIENTS BE FORCED TO GO TO GPs BEFORE VISITING SPECIALISTS OR HOSPITALS?



## Supporting arguments for selection

- Most cases can be effectively treated at the less-costly GP level
- Majority of self-referred emergency care cases are not real emergencies

- Patient knows best where to seek treatment
- GP of trust is not accessible at all times

## Consequences

- GP of trust is not accessible at all times
- Empowerment of primary health sector

- Patients might use facilities inappropriately
- Risk of provider shopping and hopping

# TO WHAT EXTENT CAN PATIENTS CHOOSE THEIR OWN PROVIDERS?



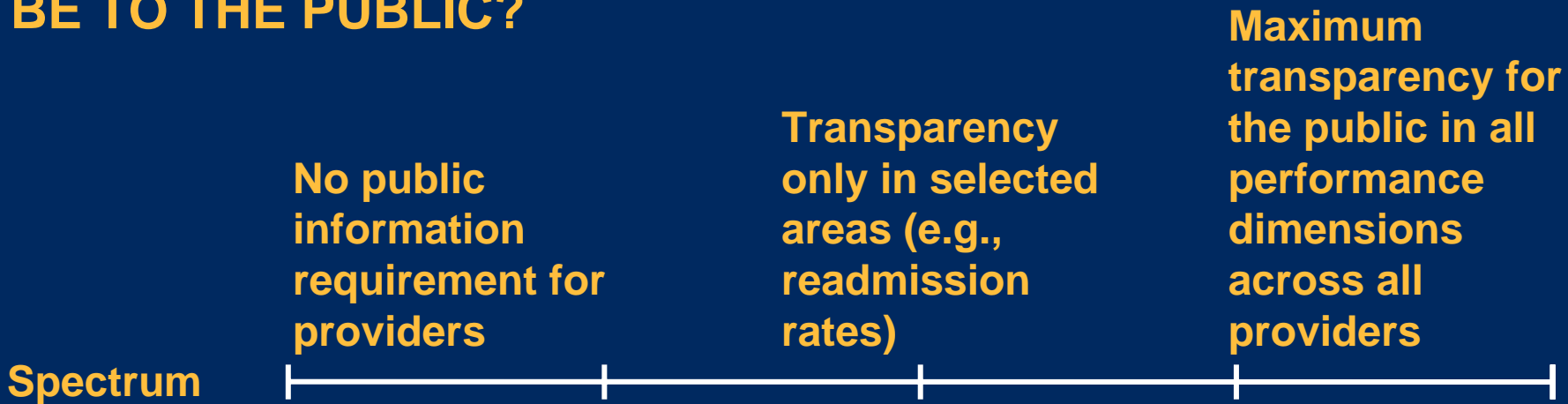
## Supporting arguments for selection

- Patients do not know where to get needed treatment
- Quality will be fostered through market mechanism

## Consequences

- Unsatisfied patients
- Strong quality regulation on care providers needed
- Best providers have long waiting lists
- Additional costs if patients switch too much

# HOW TRANSPARENT WILL PROVIDER PERFORMANCE BE TO THE PUBLIC?



## Supporting arguments for selection

- Balanced use of all facilities
- All facilities with exactly the same standards as today
- Helps patients make informed decisions regarding the choice of provider

## Consequences

- Lack of incentive for providers to improve quality of care continuously
- Patients make choice of providers based on perceived quality
- Risk of increasingly long waiting lists for treatment at best providers
- Fosters provider consolidation in the long run

# SHOULD TREATMENT ABROAD BE COVERED IF APPROPRIATE TREATMENT IS AVAILABLE IN THE COUNTRY?

Treatment abroad subsidized by govt. even if treatment is available

Treatment abroad subsidized by govt. only if not available in home country

Spectrum



Supporting arguments for selection

- Some patients may never trust quality of providers to same extent as they trust those in some Western countries/institutions

- MoH will endeavor to ensure that all facilities meet highest quality standards

Consequences

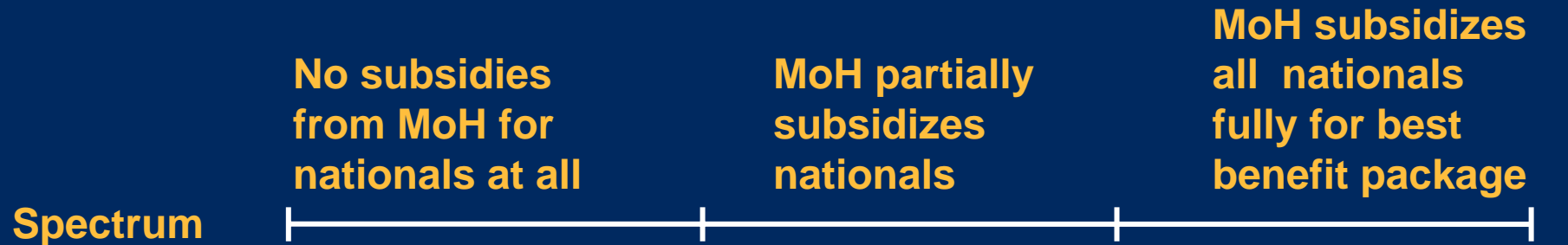
- Duplication of services and higher costs

- Only patients with very rare diseases would need to be treated abroad

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# TO WHAT EXTENT IS MoH WILLING TO SUBSIDIZE TREATMENT OF NATIONAL PATIENTS?



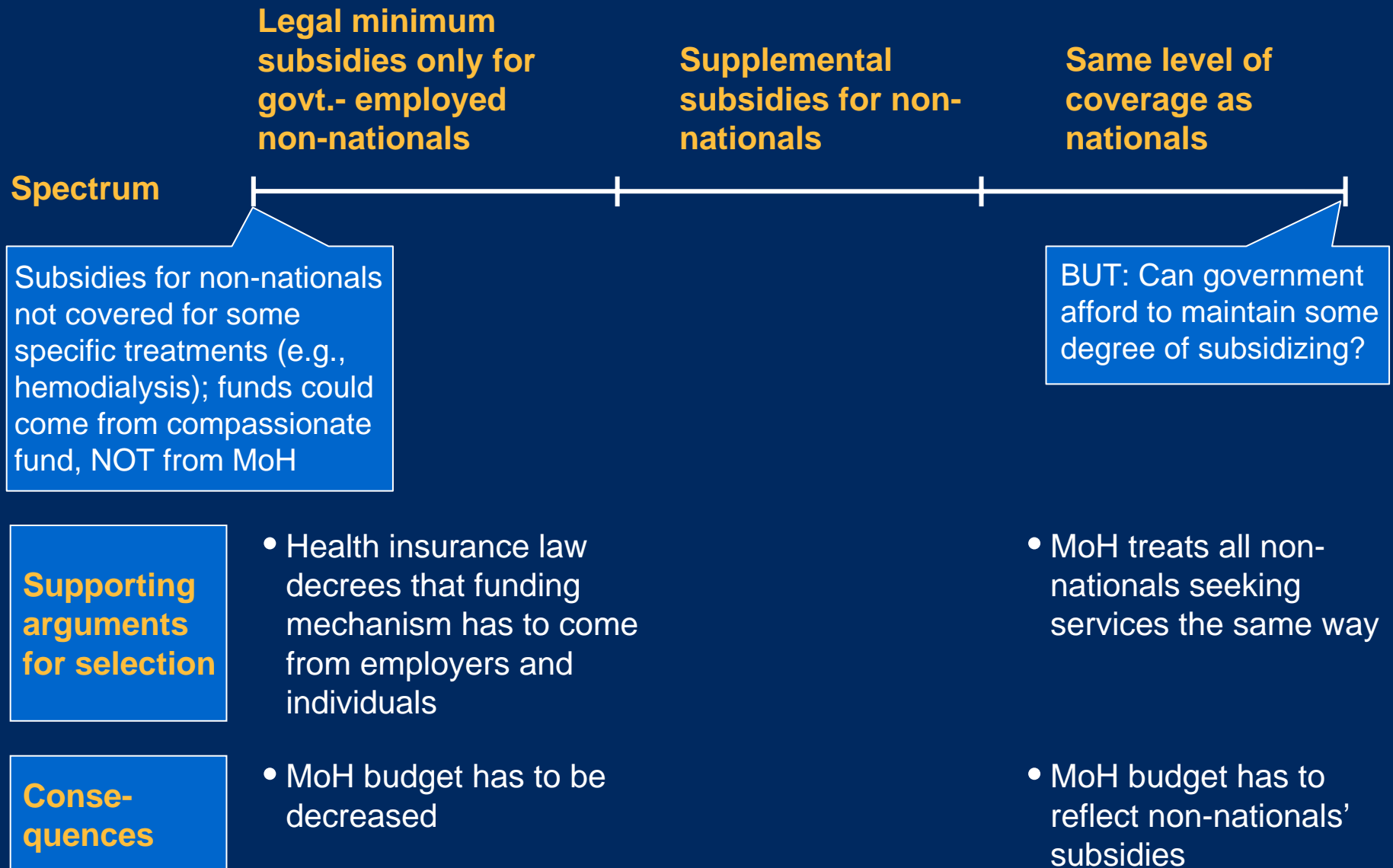
## Supporting arguments for selection

- Financial health-care cost burden shall be split between employers and individuals
- All nationals should always get the best of the best

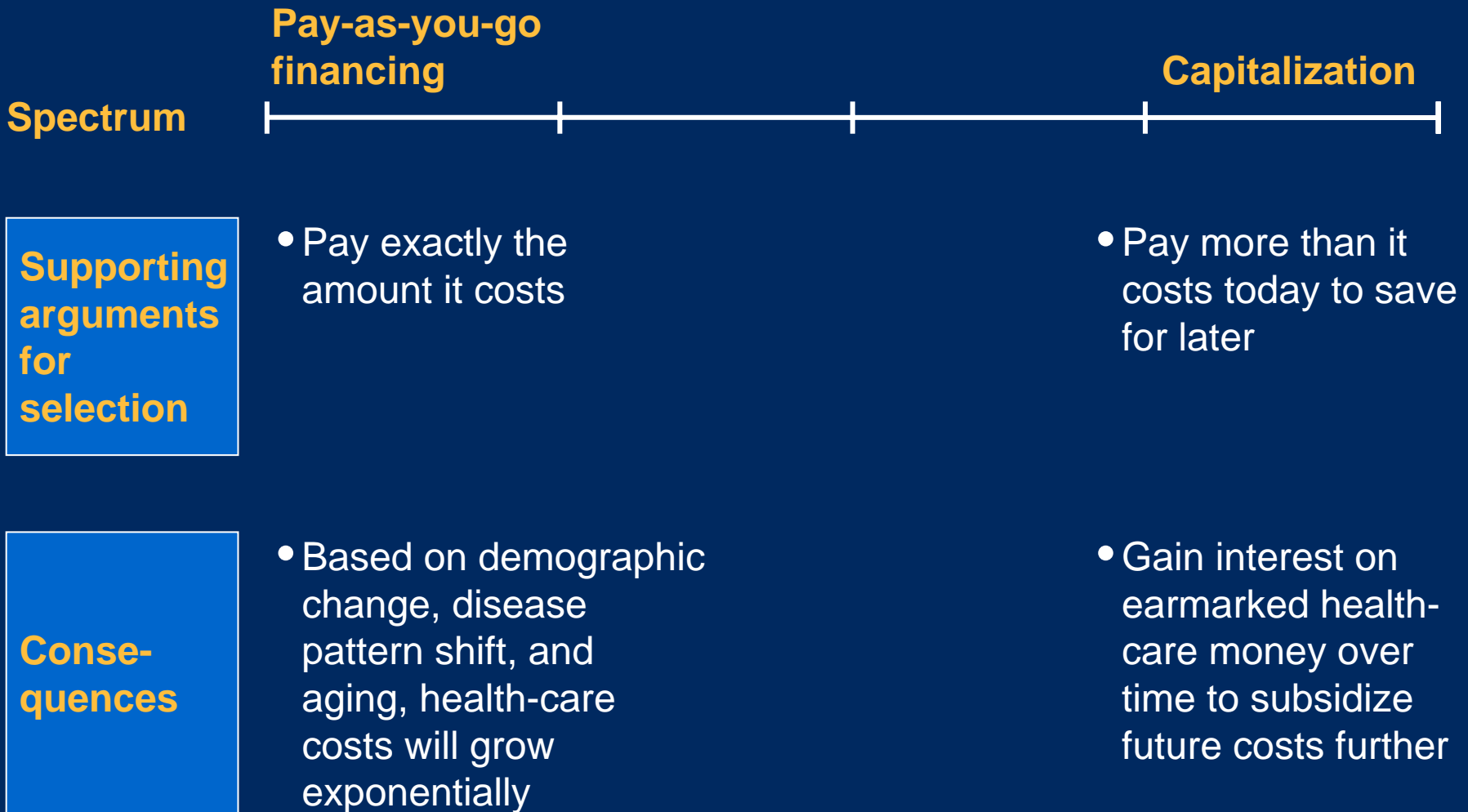
## Consequences

- MoH budget will decrease
- MoH pays for the best and most expensive product

# TO WHAT EXTENT IS MoH WILLING TO SUBSIDIZE TREATMENT FOR NON-NATIONAL PATIENTS?



# DO YOU WANT TO PUT MONEY ASIDE TODAY TO COVER FUTURE HEALTH-CARE COSTS?



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# ARE ANY HEALTH-CARE FACILITIES OR FUNCTIONS OFF-LIMITS TO THE PRIVATE SECTOR?

Selected domains must remain completely in public hands (e.g., infection control, prevention, psychiatric care, A&E, ambulance services, teaching hospitals)

Nothing is off-limits to the private sector

Spectrum



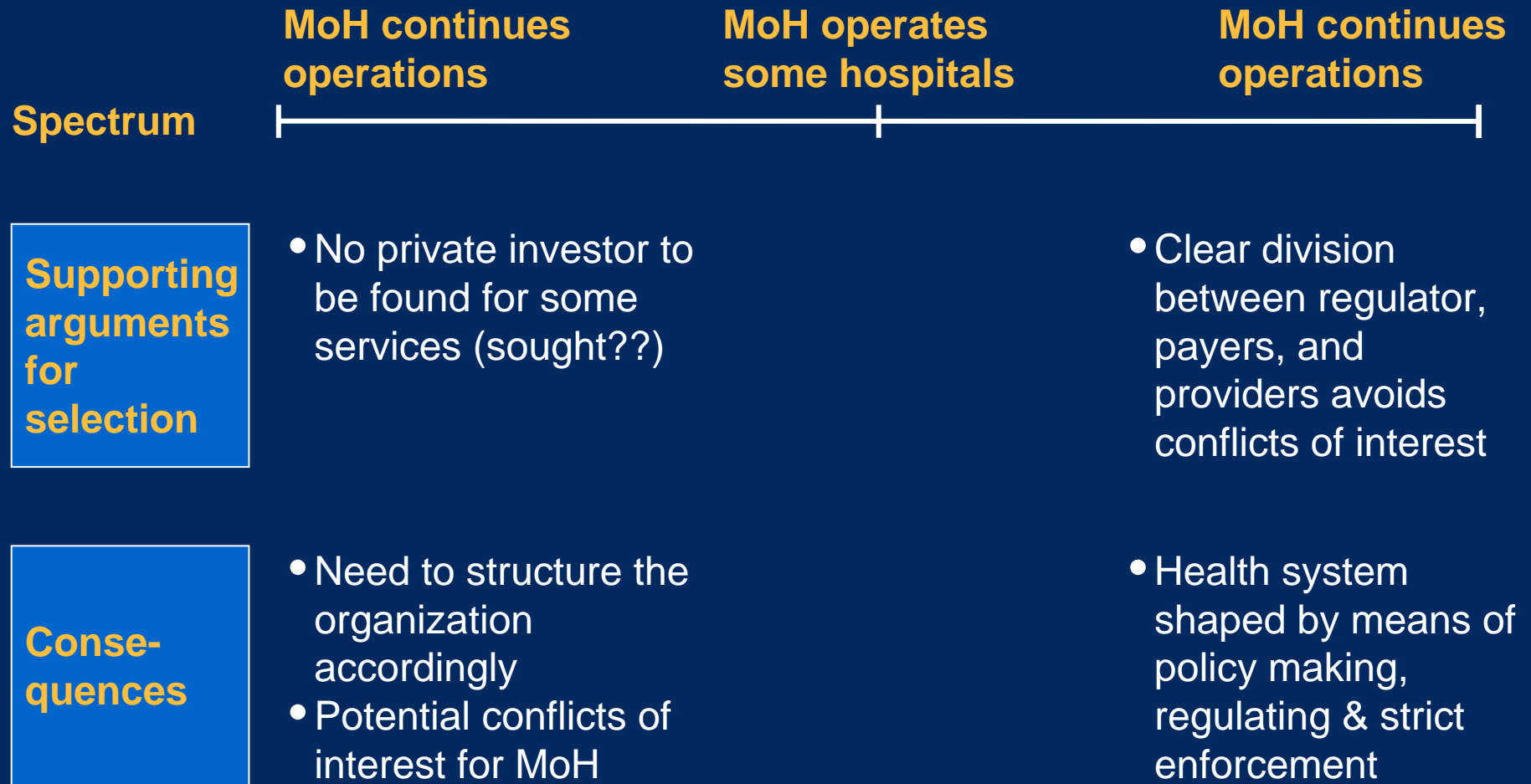
## Supporting arguments for selection

- Some essential services may deteriorate in quality or reliability if subjected to intensive competition
- Maximize new investment in the health-care system

## Consequences

- Need to allocate operational responsibility outside regulatory authority
- Strict enforcement of quality standards essential

# TO WHICH LEVEL WILL MoH BE INVOLVED IN OPERATING PROVIDERS IN 10 YEARS TIME?



# WILL MoH MERELY ALLOW PRIVATE MANAGEMENT OF PUBLIC FACILITIES OR WILL PUBLIC HEALTH-CARE FACILITIES BE SOLD TO PRIVATE INVESTORS?



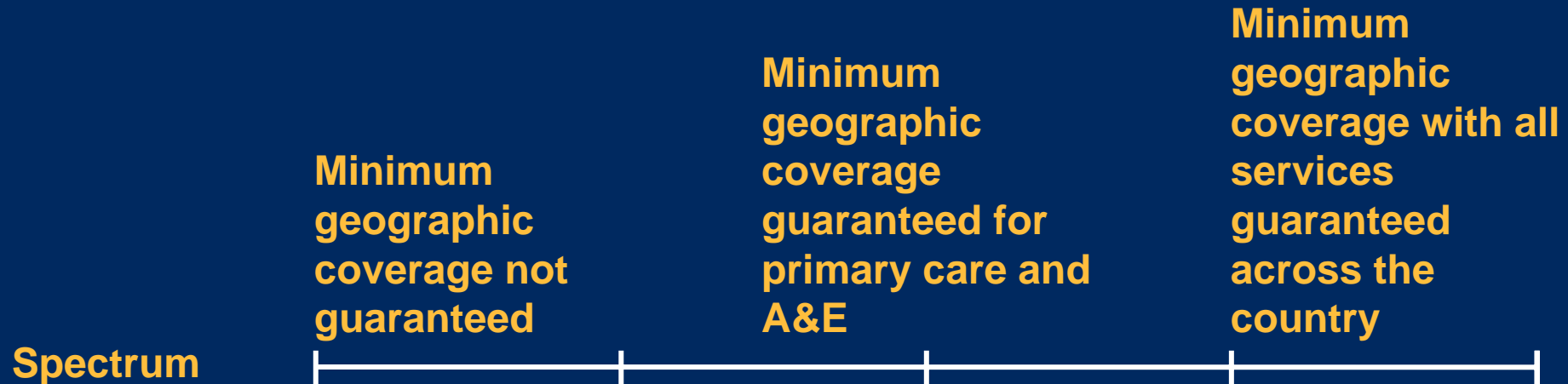
## Supporting arguments for selection

- Reduces risk of speculative deal-making
- More new investment attracted into the health-care system
- Encourages long-term focus

## Consequences

- Providers slow to introduce quality innovations
- Higher risk for investor

# WILL THERE BE A SAFETY NET TO ENSURE MINIMUM COVERAGE



## Supporting arguments for selection

- People are very mobile and won't necessarily go to the nearest provider anyway
- Obligation to provide basic services for everyone

## Consequences

- Disadvantages the less well-off
- Need for safety net to ensure continuity of minimum coverage of care in all geographic areas

# KEY CHARACTERISTICS OF A TARGET HEALTH-CARE SYSTEM – EXAMPLE

## Key characteristics

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### Quality of care

- Quality is always the primary consideration
- Clear and equal quality standards for all providers

### Access to services

- All residents will have access to the same facilities
- Patients have free choice of providers
- GPs act as gate-keepers for hospital care, excluding accidents & emergencies (A&E)

### Public/private providers

- Majority of provision transferred to private sector
- Public authorities role will be limited to regulation and policy-making functions; government involvement in provision limited to absolute minimum

### Financing health care

- All residents will be covered by mandatory insurance in the future
- Only unavailable treatments will be covered for abroad



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Payer/Provider practice document  
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