Fiscal and budgetary issues for HBP

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1 Set goals & criteria

2 Operationalize general criteria & define methods for appraisal

3 Choose “shape” of HBP & select areas for further analysis

4 Collate existing & collect new evidence

5 Undertake appraisals & budget impact assessment

6 Deliberate around evidence/appraisals

7 Make recommendations, take decisions

8 Translate decisions into resource allocation & use

9 Manage & implement HBP

10 Review, learn, revise

CONTEXT
• Donors
• Health System
• Markets
• Political institutions
• Regime
• Rights
• Technology
• Wealth
Structure

• Why worry about
  – Budget-plan mismatches in the medium term
    • MTEF?
  – Budgetary conventions
    • Decentralized countries?
  – Earmarked donor resources
  – (provider payment)
BUDGET-PLAN MISMATCHES
Why worry: budget-plan mismatches

• If plan costs are larger than available budget, priorities won’t convey
  – Adjustment for changing costs/inflation
  – Adjustment for new inclusions
  – “Grandfathering” is easy at first but becomes problematic quickly
  – Adjustment for economic cycle
Why worry: examples of budget-plan mismatches

In Uganda, a package of services costing $41 dollars was expected to be delivered at a per capita actual expenditure of $12.50. Source: Tashobya et al 2003

Capitation payments to provide BP in Dominican Republic
US$, constant, 2001-2014

Source: Giedion et al 2014
Budget-plan mismatches: inclusions increase but funding only adjusted for inflation

**Evolution of the benefit packages of Seguro Popular, 1996-2012**

- **Launch of the Seguro Popular program**
- **Legal Reform for the creation of the System of Social Protection in Health**
- **Change of federal government**

Frequently:
no budget impact analysis at all, no link to budget decisions

- ProVac supports country CEA for vaccines and recommends adoption based on cost-effectiveness, but does not assess budget impact (Glassman et al 2014)
- WHO model list of essential medicines does not include analysis of affordability (Glassman & Chalkidou 2012)
### Worry less: set out macro strategies to fit budget to plan over time

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Adopt cost-sharing for lower priority services</td>
<td>• China increases co-pay for IV injections</td>
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<tr>
<td>including financial caps, VBP</td>
<td>• Colombia uses comparator price of cost-effective generic for reimbursement, not actual price</td>
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<td>Plan to smooth cyclical effects, unexpected</td>
<td>• Estonia health insurance reserve fund disburses automatically when contributions fall to cover package obligations</td>
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<td>expenditures</td>
<td>• Mexico fund for budgetary contingencies to cover shortfalls associated with excess demand or state budget crunches</td>
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<td>Improve efficiency</td>
<td>• Implement financial / performance risk-sharing</td>
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<td>• Collect data on production of HBP-services and conduct operational research to identify areas for efficiency gains, etc.</td>
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<td>Adjust benefits</td>
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Worry less: adjust capitation for inflation and related

<table>
<thead>
<tr>
<th>Country</th>
<th>Approach</th>
<th>Frequency</th>
<th>Issues</th>
</tr>
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<tbody>
<tr>
<td>Israel</td>
<td>Health cost index intended to adjust for changes in prices of inputs, composed of other indices (CPI, average wage of health care providers, average wage of public servants), published methodology and evaluation</td>
<td>Annual</td>
<td>Did not reflect changes in hospital costs (such as per diem rate) when inpatient care represented 40% of all spending</td>
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<tr>
<td>Mexico</td>
<td>Financial and actuarial valuation of CAUSES and high-cost interventions packages (FPGC), established by law</td>
<td>Annual</td>
<td>No published methodology, no published evaluations</td>
</tr>
<tr>
<td>Uruguay</td>
<td>Formula that reflects price changes in inputs using CPI, exchange rates and wages</td>
<td>Biannual</td>
<td>Changes in actual utilization and expenses not fed into formula, no published methodology, no published evaluations</td>
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Worry less:
make sure budget impact analysis is part of any analysis

• Build budget impact analysis (BIA) into your decision-making process, adopt and publish standard methodology / reference case
• Require BIA with investment cases and cost-effectiveness analyses, comparisons with current standard of care
Worry less:
Include HBP in the Medium Term Expenditure Framework
BUDGETARY CONVENTIONS
Why worry: budgetary conventions

• How budget is transferred (or payment paid) affects the effectiveness of HBP
  – How “much” of the budget runs through HBP
    • If marginal, won’t make any difference
  – Grafting a package onto an input-based budget can be counterproductive
    • “Priorities stop at the state border.”
  – Multiple budgetary conventions can dilute power of priorities
Why worry: budget risk-holders with perverse incentives

- Budget risk depends on size of budget holder, quality of costing and yr-to-yr adjustments, and risk adjustment formula.
- Applies to any budget risk-holder:
  - Sub-national governments make decisions but costs are covered by national government.
    - Moral hazard
    - Spending escalation
  - National governments provide fixed payment to sub-national governments which pay full marginal costs.
    - Underfunding at the sub-national level, can hardwire inequity.
    - Examples Canada and Australia.

Budget risk-holder: the entity that financially manages and absorbs the results of any higher- or lower-utilization or disease incentive/prevalence than those anticipated during calculation of the HBP capitation.
Who is a budget risk-holder, for example

<table>
<thead>
<tr>
<th>Countries, for example</th>
<th>Allocating entity</th>
<th>Budget risk-holding entity</th>
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<tbody>
<tr>
<td>Mexico – Seguro Popular</td>
<td>Ministry of Finance</td>
<td>State governments</td>
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<tr>
<td>Colombia, Israel, Netherlands</td>
<td>Ministry of Health (FOSyGA in Colombia; XX)</td>
<td>Public or private insurers</td>
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<tr>
<td>Chile, Estonia, Thailand, Mexico – IMSS</td>
<td>Government general revenues, earmarked taxes</td>
<td>National government or single public or social security payer agency</td>
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<tr>
<td>US Medicare</td>
<td>Government general revenues including earmarked taxes</td>
<td>Federal public payer agency (CMS)</td>
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<tr>
<td>Germany</td>
<td></td>
<td>Sickness funds (quasi-public insurers)</td>
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Worry less (maybe):
Consider budget reform ahead of HBP and payment reform

- DRGs are not just for payment and quality measurement, but a structure for coding and billing
  - Only hospitals

- Medicines on EML should be linked to indications, clinical guidelines or DRG
Worry less:
Minimize budgetary risk, prevent risk selection, maximize equity

• Continually improve the quality and regularity of epidemiological and costing data
• Use formula-based risk adjustment to reflect characteristics of the locality, distinguishing between “legitimate” and “non-legitimate” drivers of budget risk
  – Legit: poverty, age structure
  – Non-legit: anything related to policy or management actions
Why worry: donor earmarks (in LIC)

• Covers many key (cost-effective) interventions,
• Creates entitlements where reallocation is difficult
• Requires co-financing
• Is unpredictable one year to the next

• And therefore, usually left out of domestic HBP
Worry less (maybe):
Dealing with donor money / conditions pro-actively

• Include donors as stakeholders in HBP process
  – Ethiopia and Rwanda models? Not Latin American models.
  – Is this really feasible?
• Even if earmarked, push for HBP approach in donor investments
  – Clear criteria and decision-making for inclusion, consistent with local criteria and data, some process agreed
  – Optimization of impact, limit opportunity costs to extent possible
• Plan for risk of donor downscale
  – Donors to do more on HBP/priority-setting support, earlier attention ahead of aid transition
  – Price negotiation / pooling arrangements