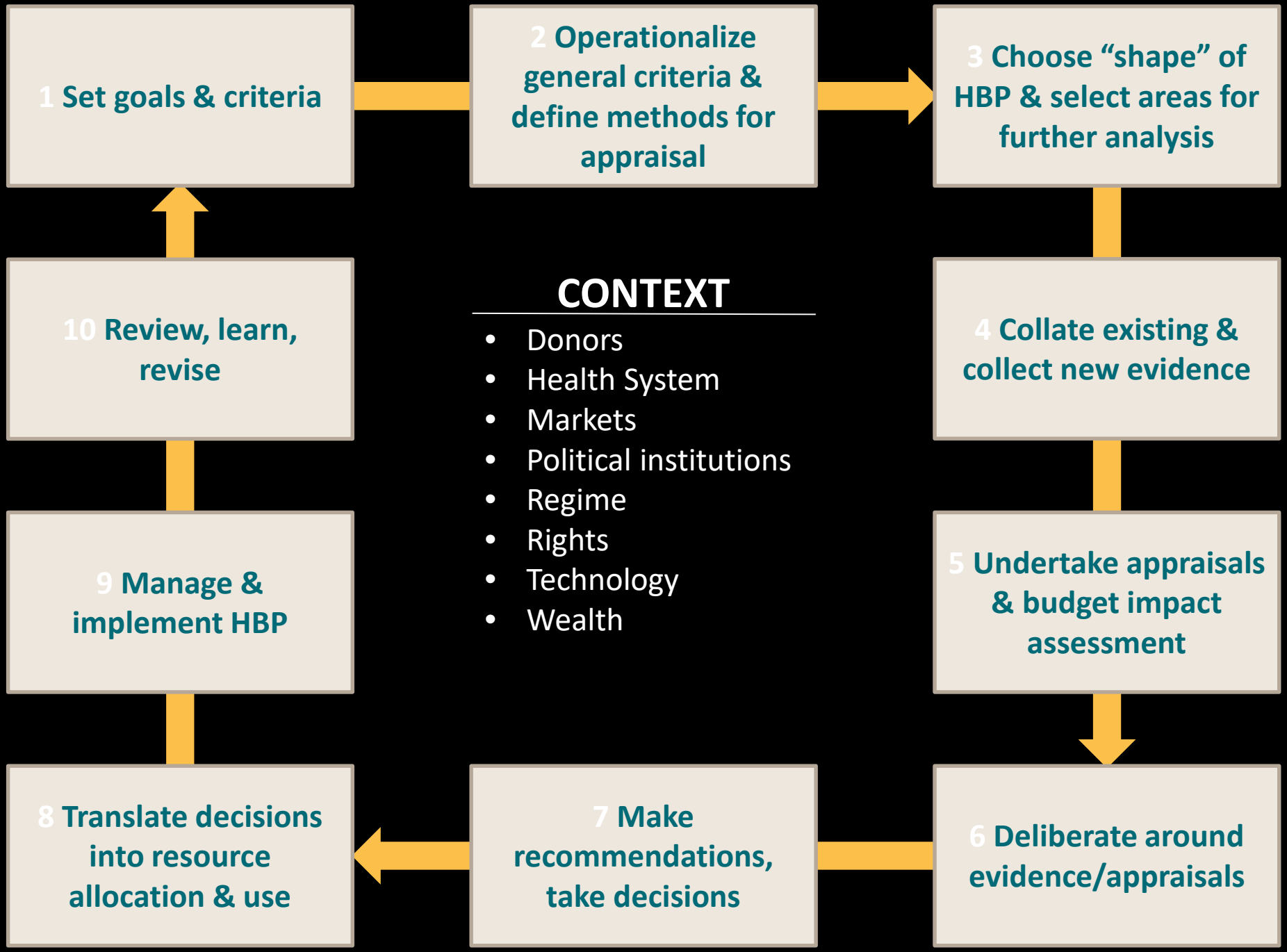
Fiscal and budgetary issues for HBP

March 6, 2017

Amanda Glassman

Center for Global Development


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

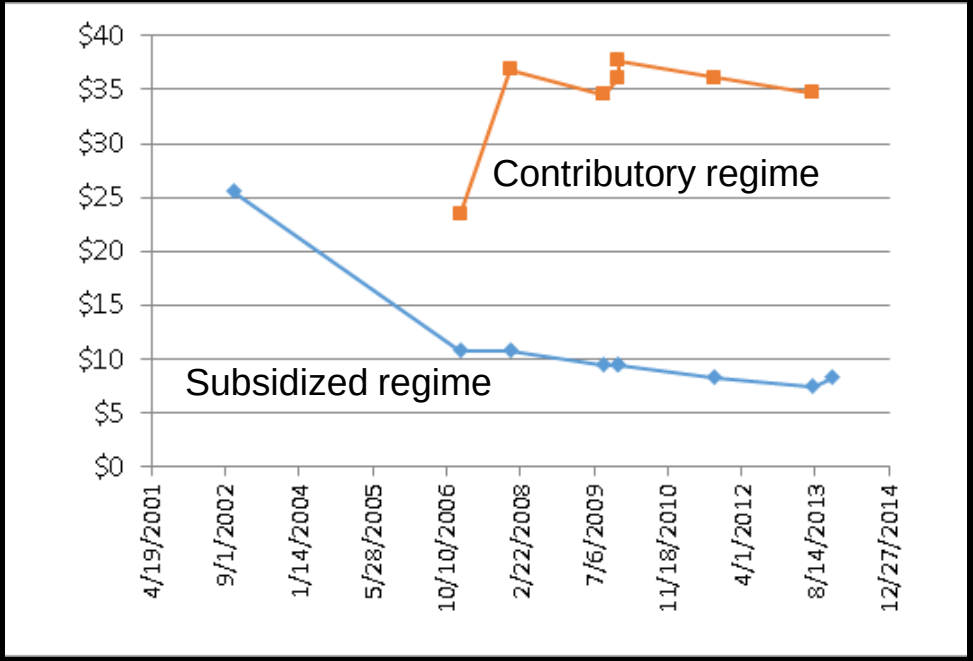
Why worry: budget-plan mismatches

- 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

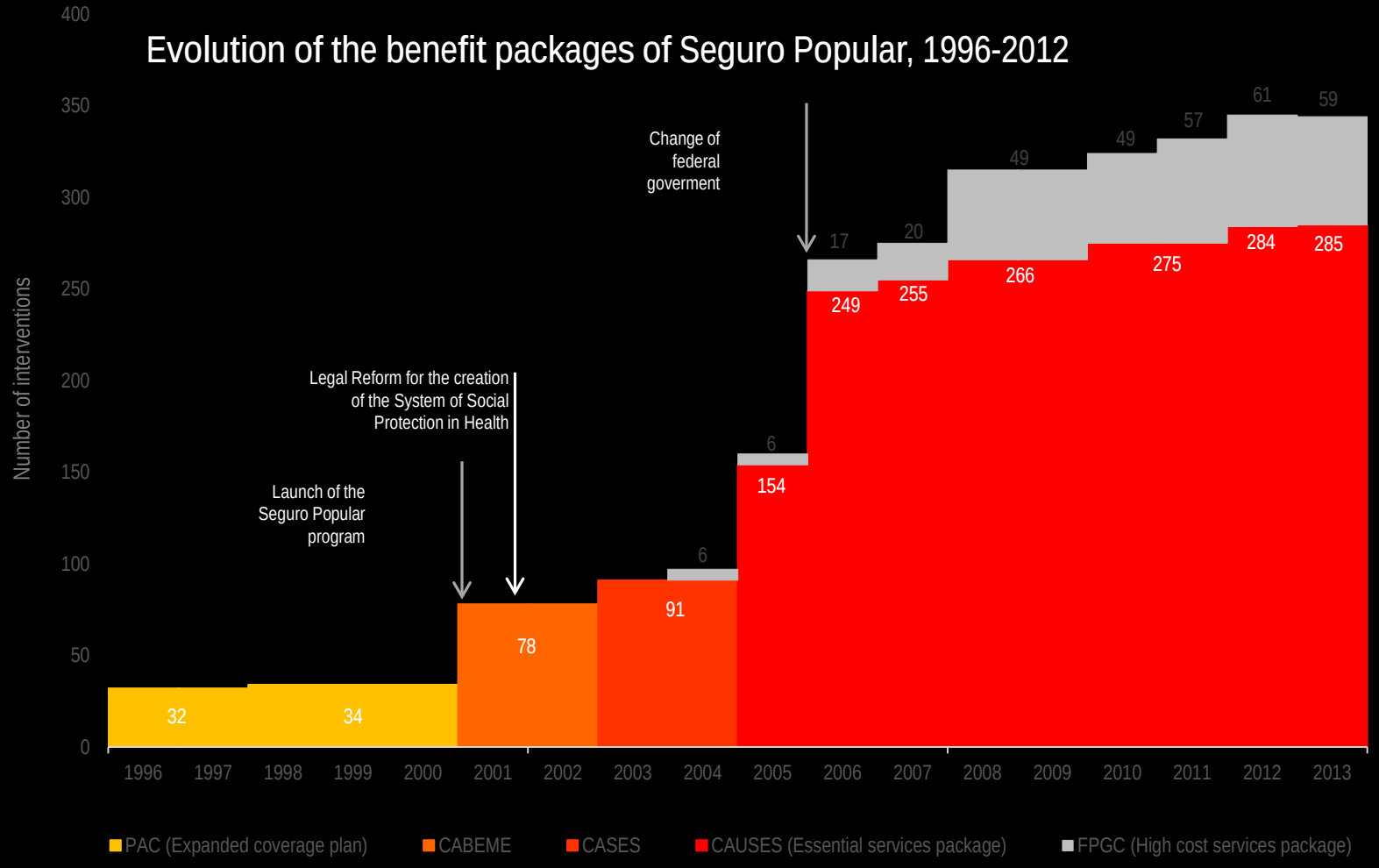
In Uganda, a package of services costing **$41** dollars was expected to be delivered at a per capita actual expenditure of **$12.50.**
Source: Tashobya et al 2003

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



Source: Panopoulou for 2013, Sistema de Protección Social en Salud. Informe de Resultados, 2013.

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

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

Worry less: adjust capitation for inflation and related

Country	Approach	Frequency	Issues
Israel	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	Annual	Did not reflect changes in hospital costs (such as per diem rate) when inpatient care represented 40% of all spending
Mexico	Financial and actuarial valuation of CAUSES and high-cost interventions packages (FPGC), established by law	Annual	No published methodology, no published evaluations
Uruguay,	Formula that reflects price changes in inputs using CPI, exchange rates and wages	Biannual	Changes in actual utilization and expenses not fed into formula, no published methodology, no published evaluations

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 size c… of costing and yr-to-yr adjust… ent formula
- Applies to any budget risk…
  - Sub-national governments… re covered by national gover…
    - 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

Countries, for example	Allocating entity	Budget risk-holding entity
Mexico – Seguro Popular	Ministry of Finance	State governments
Colombia, Israel, Netherlands	Ministry of Health (FOSyGA in Colombia; XX)	Public or private insurers
Chile, Estonia, Thailand, Mexico – IMSS	Government general revenues, earmarked taxes	National government or single public or social security payer agency
US Medicare	Government general revenues including earmarked taxes	Federal public payer agency (CMS)
Germany		Sickness funds (quasi-public insurers)

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 indcations, 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