The Public-Private Mix and Health System Performance

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iHEA 8th World Congress Symposium on

The Private Sector in Health

Toronto
July 9, 2011

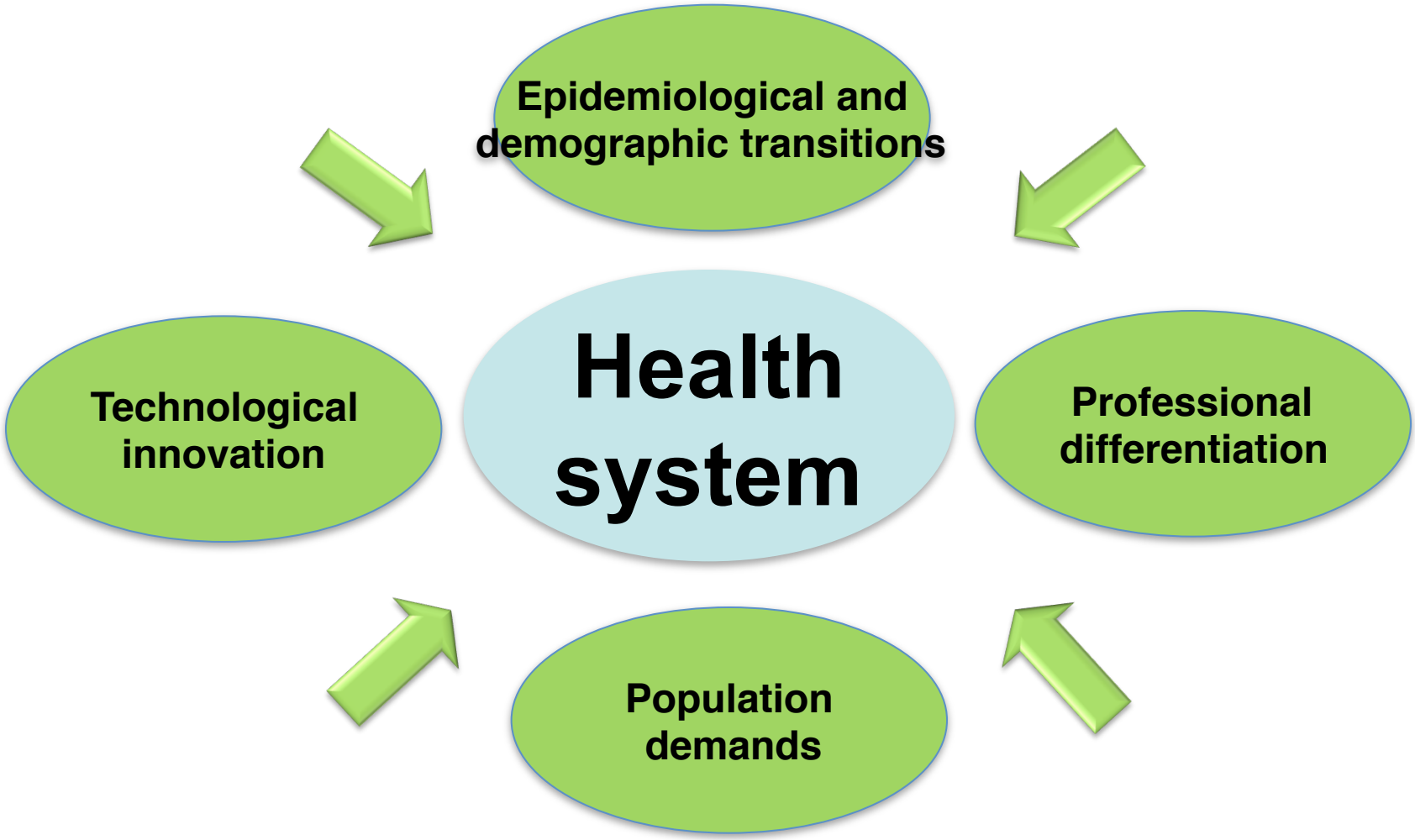
Content

1. The Context: Health System Performance
2. The Construct: Public-Private Mix
3. The Case: Comprehensive Reform in Mexico

A unique moment in history

- Growing importance of health in the global agenda for development, security, democracy, and human rights
- Unprecedented level of funding for global health
- Increasing awareness about the importance of health systems

Emerging Challenges to Health Systems



Three common misconceptions around health systems

Health system as a **black box**

Health system as a **black hole**

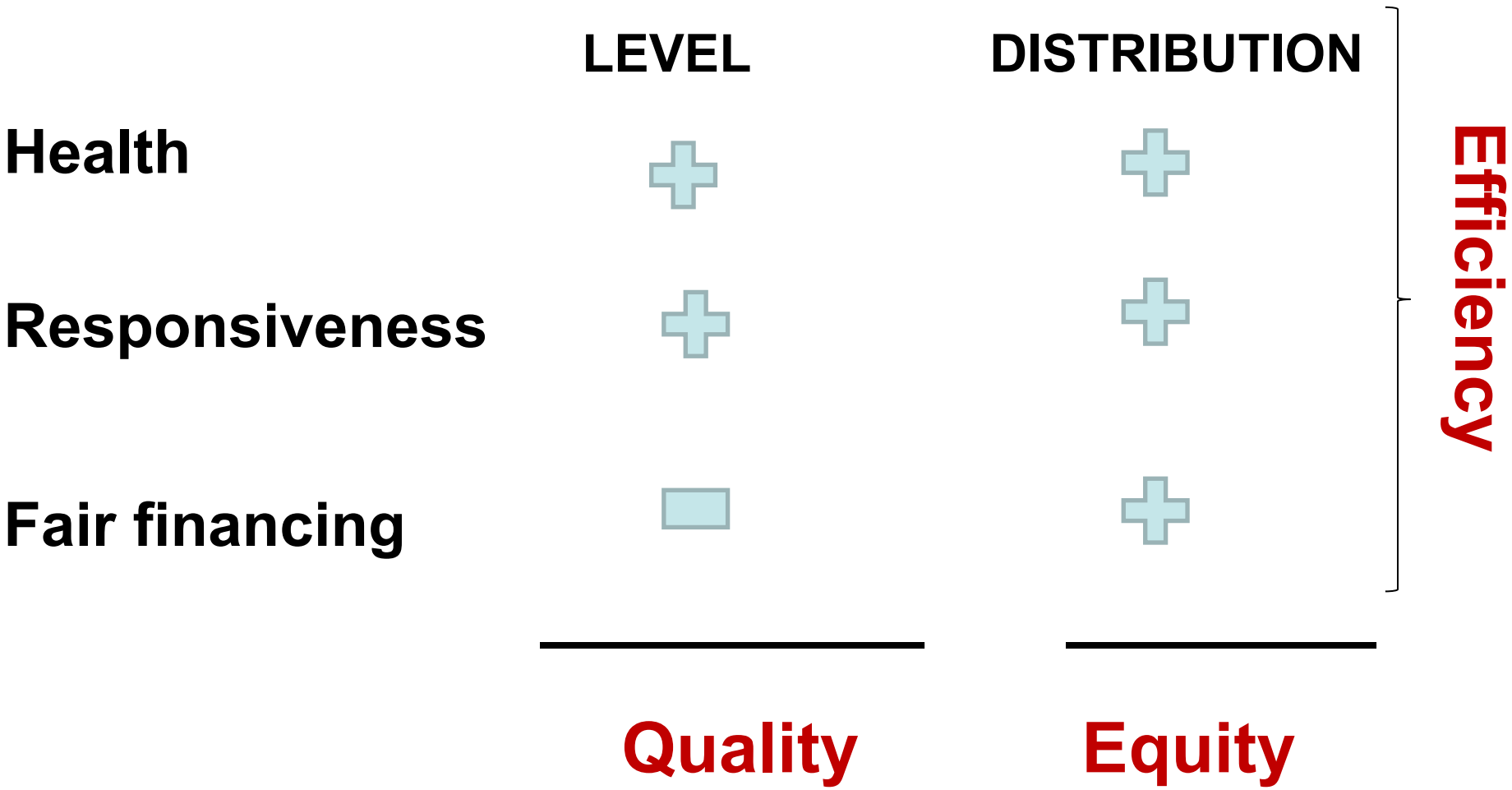
Health system as a **laundry list**

Five Key Questions to Understand Health Systems*

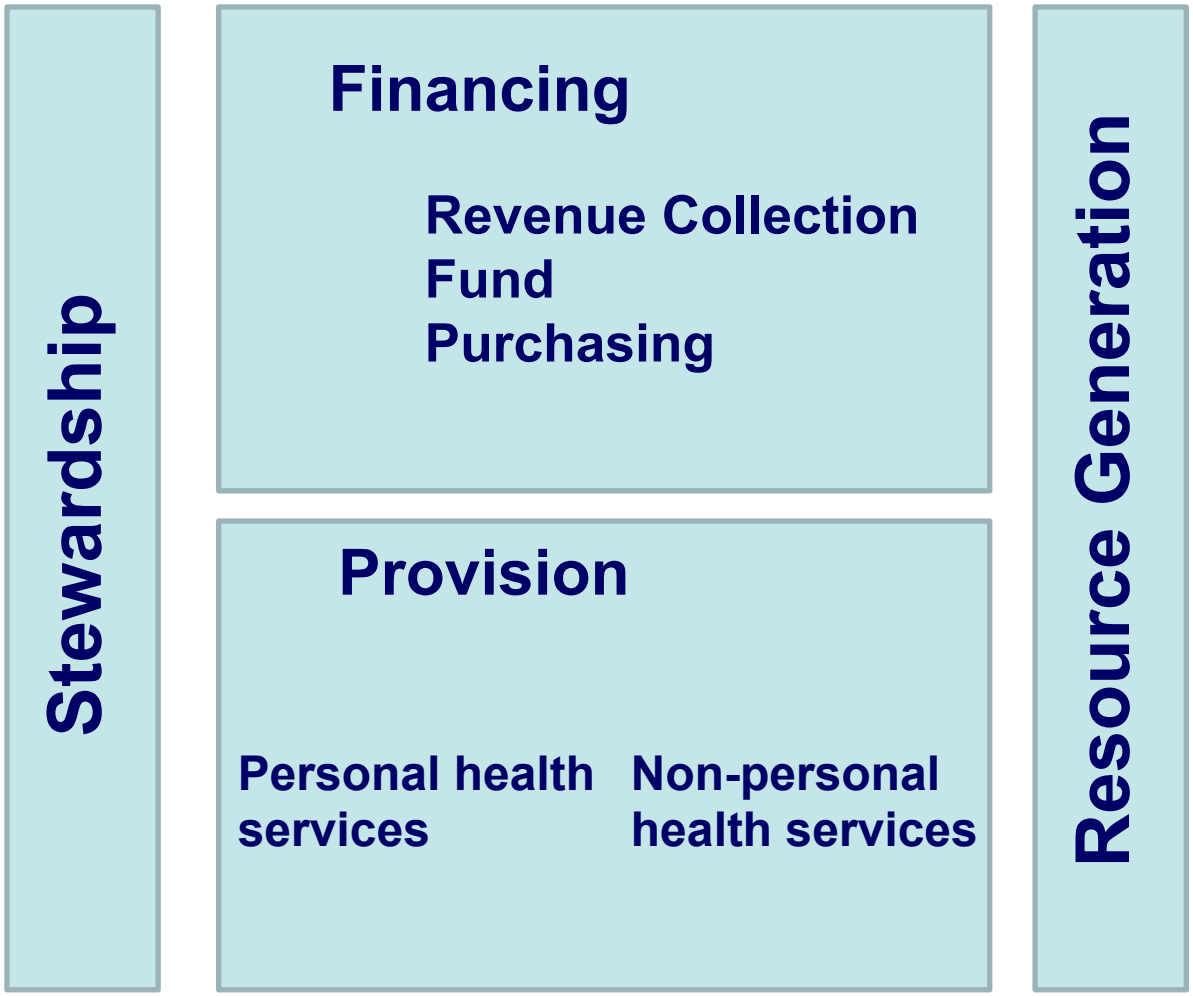
- What is a health system? (Boundaries, actors, relationships)
- What are health systems for? (Goals)
- What is the architecture of a health system? (Functions)
- How good is a health system? (Performance)
- How can we relate health system architecture to performance? (Science of health systems)

*Based on: Murray CJL, Frenk J. A Framework for assessing the perfomance of health systems. *Bulletin of the WHO 2000*; 78: 717-731

Health system goals



Functions of health systems



Components of Stewardship

- ***Health policy formulation*: defining the vision and direction for the entire health system; setting priorities; advocating intersectoral action for "healthy policies".**
- ***Regulation*: setting fair rules of the game with a level playing field and protecting consumers.**
- ***Intelligence*: assessing performance and sharing information.**

Components of Financing

- ***Revenue collection:*** **mobilizing money from households, firms and donors.**
- ***Fund pooling:*** **accumulating revenues for the common advantage of participants by sharing financial risks.**
- ***Purchasing:*** **allocating money to providers in order to deliver interventions.**

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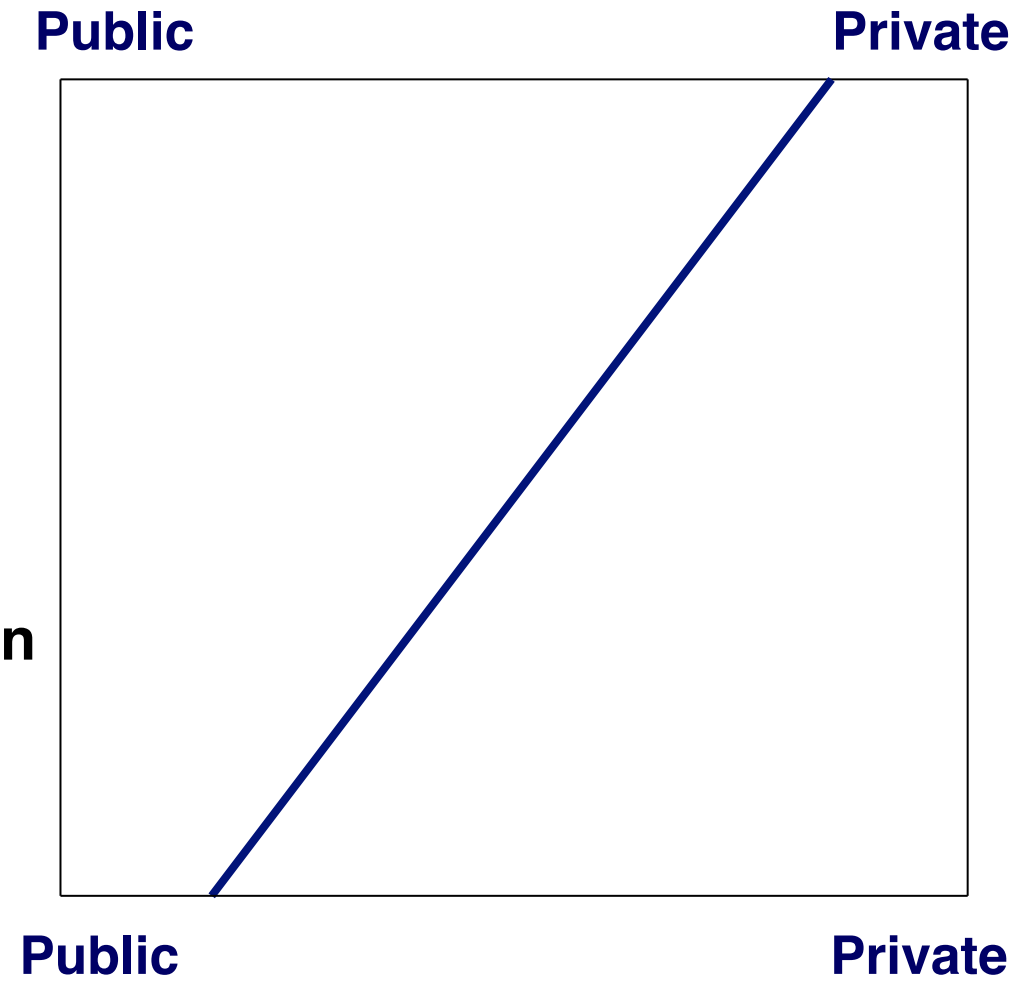
“Family and household aside, the world's two big organizing institutions are indeed state and market.”

Charles E. Lindblom
Politics and markets, 1977

The Public–Private Mix and Health System Functions

- **Stewardship**
- **Financing**
  - Revenue collection
  - Fund pooling
  - Purchasing
- **Service provision**
- **Resource generation**



Key Challenges in Stewardship

- Weak capacity in ministries of health
- Rigid and ineffective regulations
- Critical lacunae
    * Facility accreditation
    * Provider licensure
    * Input quality
    * Intervention effectiveness
    * Consumer information
- Assymmetries among countries

Key Challenges in Revenue Collection andFund Pooling

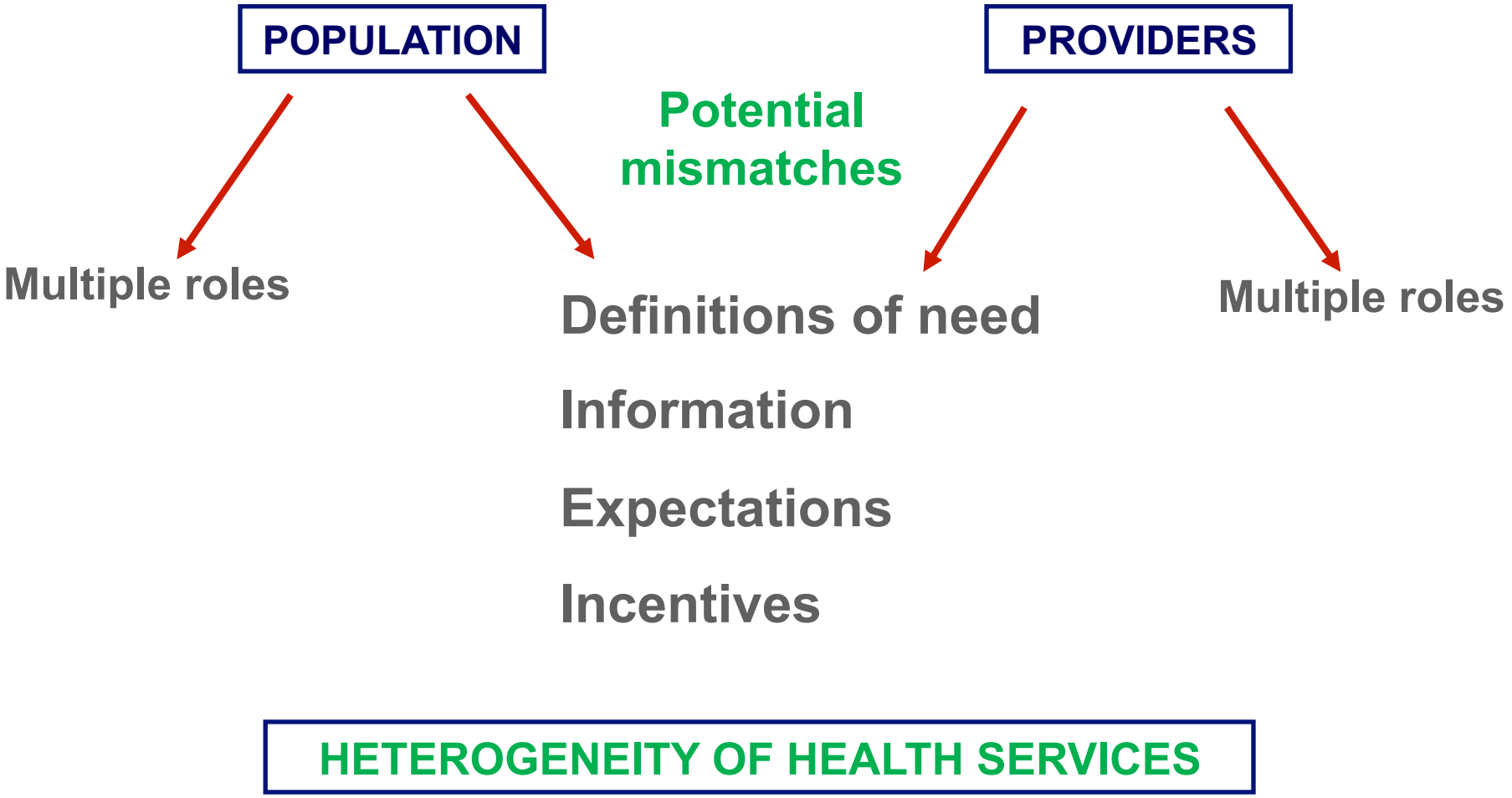
- Regressive and inefficient collection mechanisms
- Fragmentation of risk pools
  - * Linkage of social insurance to formal employment
  - * Segmentation by income
  - * Exclusion of poor people from pre-payment
- Weak solidarity

Key Challenges in Purchasing

- Lack of transparent, evidence-based priority setting
- Intertial budgeting by inputs
- Unstructured purchasing at point of service

→ ***MORE HEALTH FOR THE MONEY***

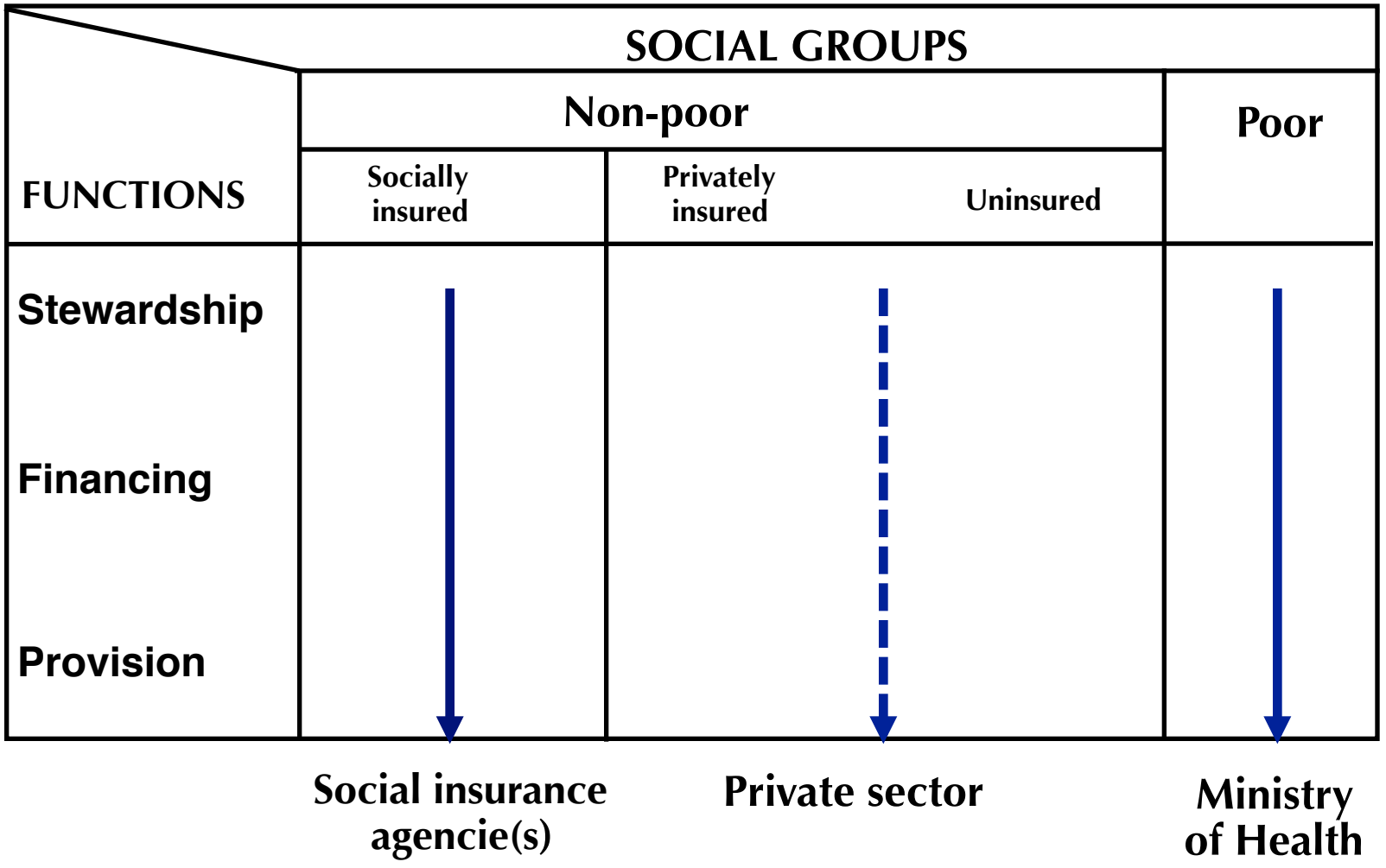
Key Challenges in Health Services Provision



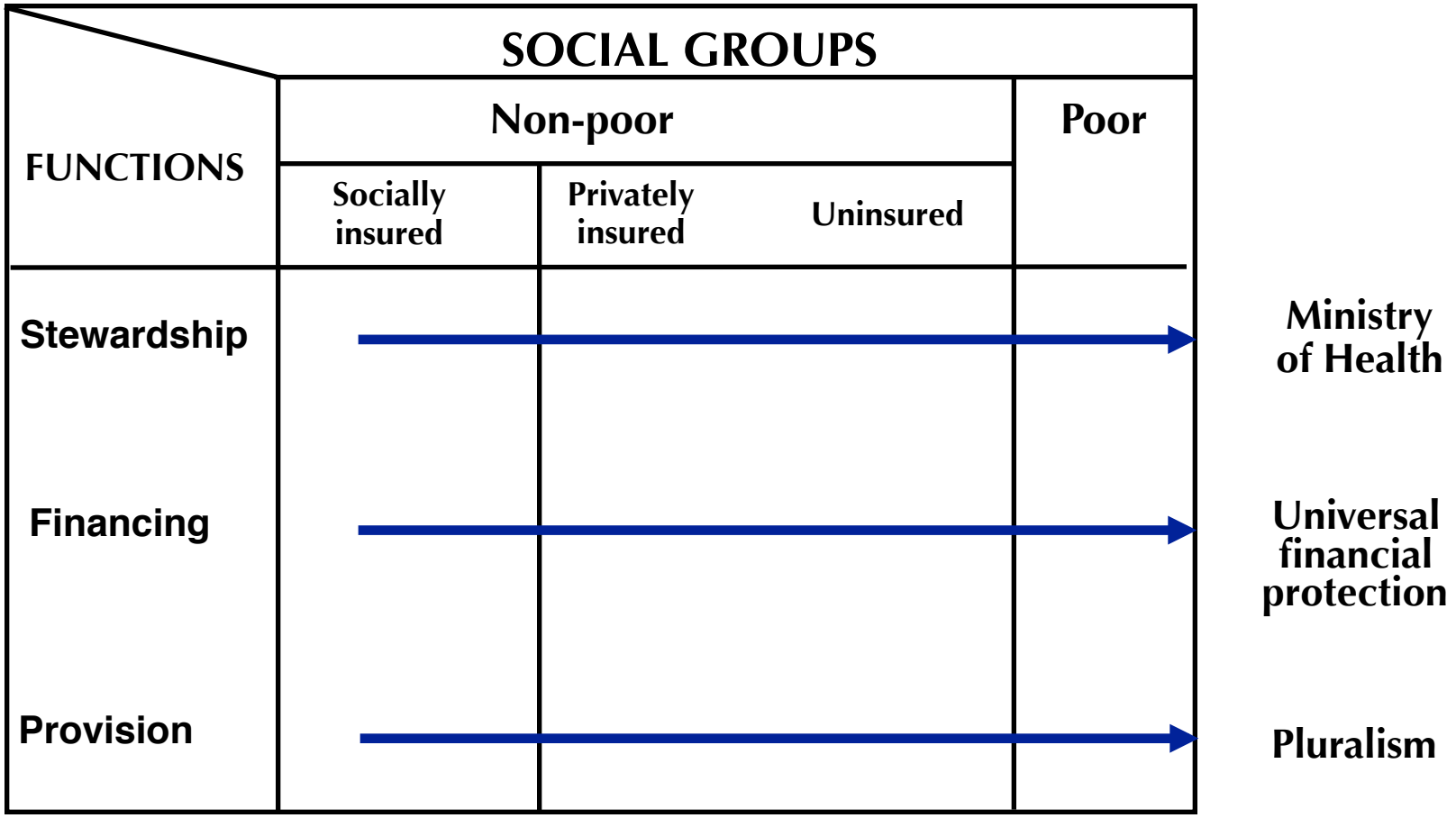
Key Challenges in Resource Generation

- Imbalances between resource supply and population needs
- Insufficient investments

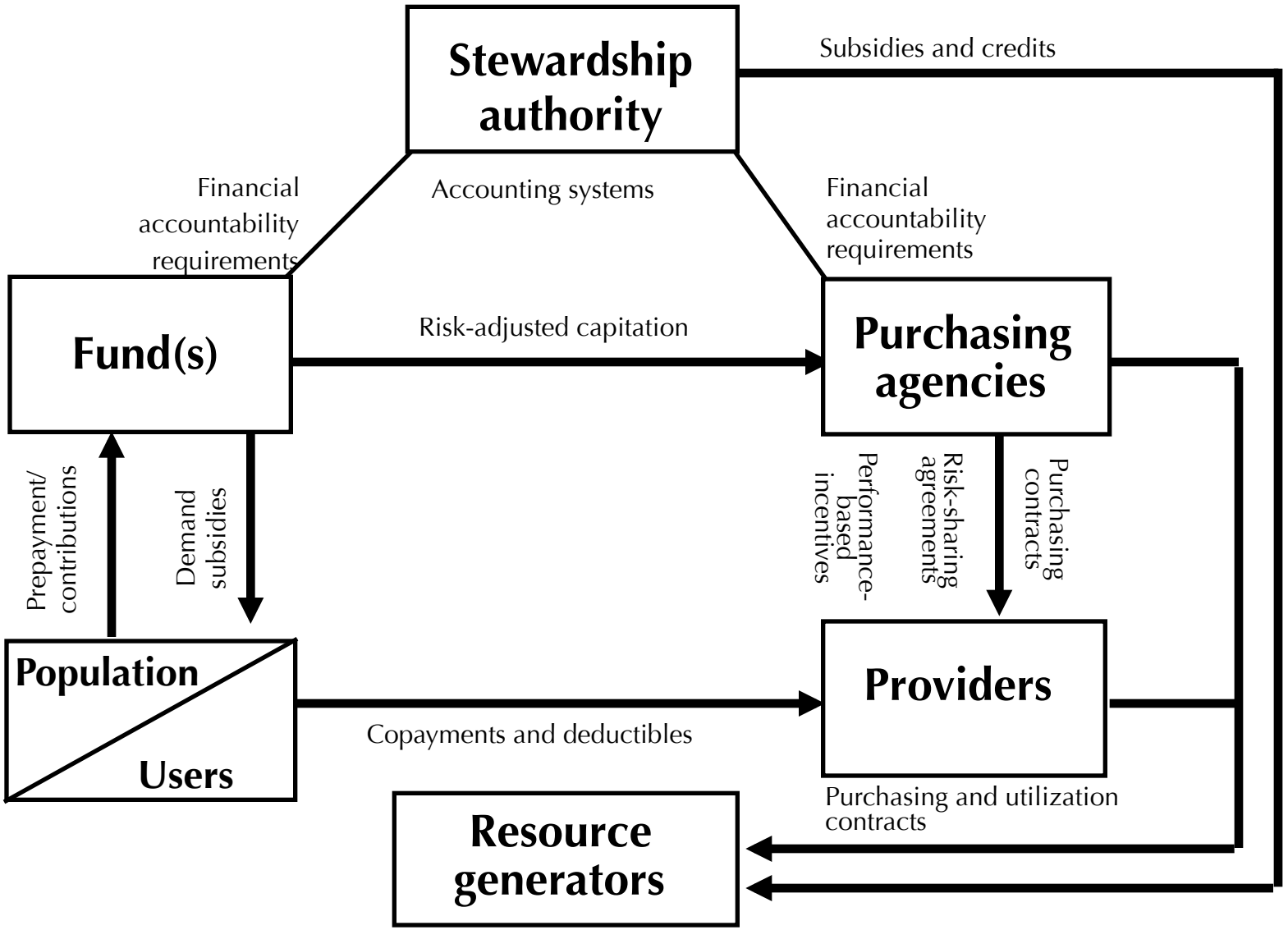
Dominant Health System Design
(Segmented Model)



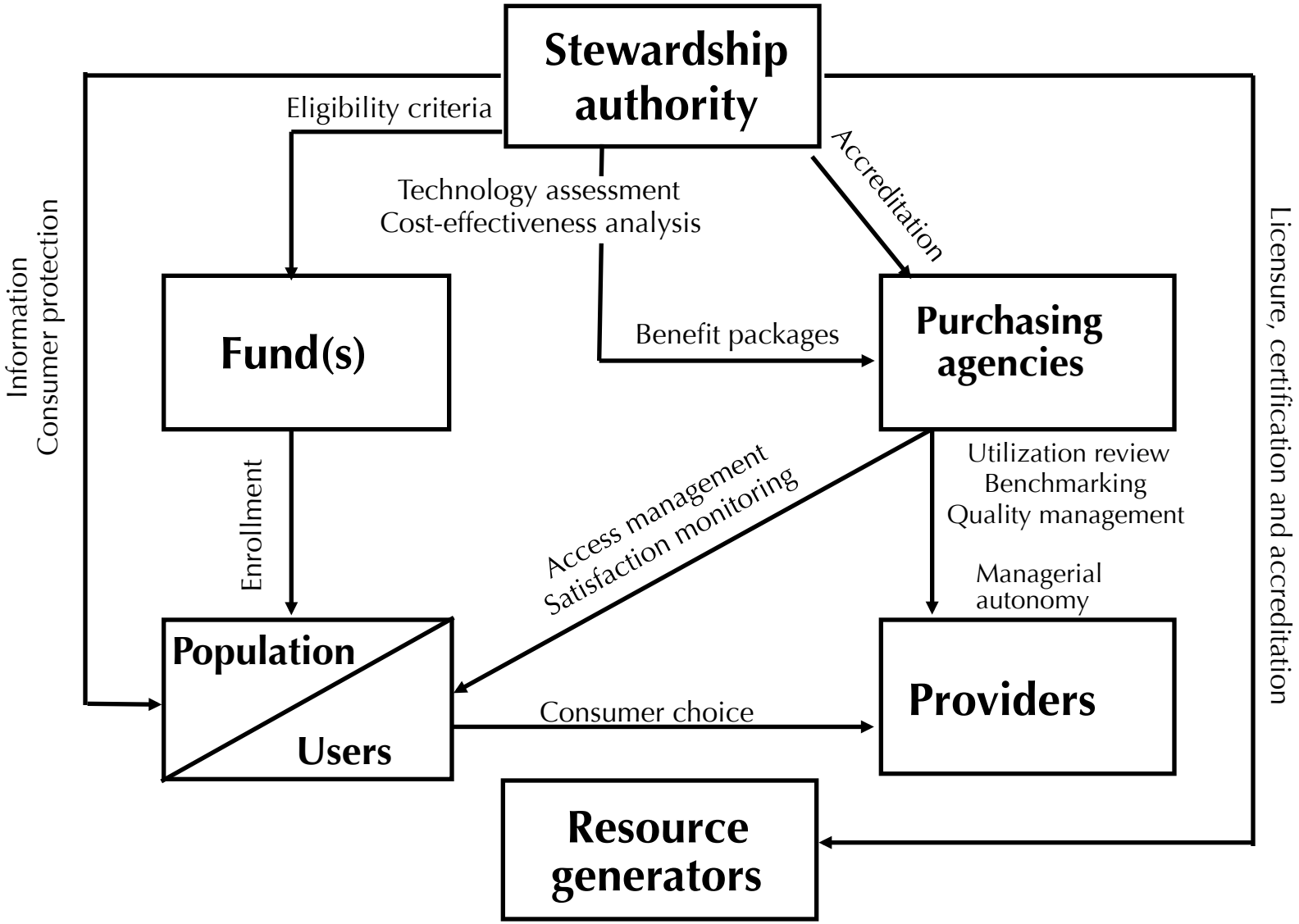
Proposed Health System Design
(Structured Pluralism Model)



Main Financial Instruments for Articulating the Public-Private Mix



Main Managerial Instruments for Articulating the Public-Private Mix



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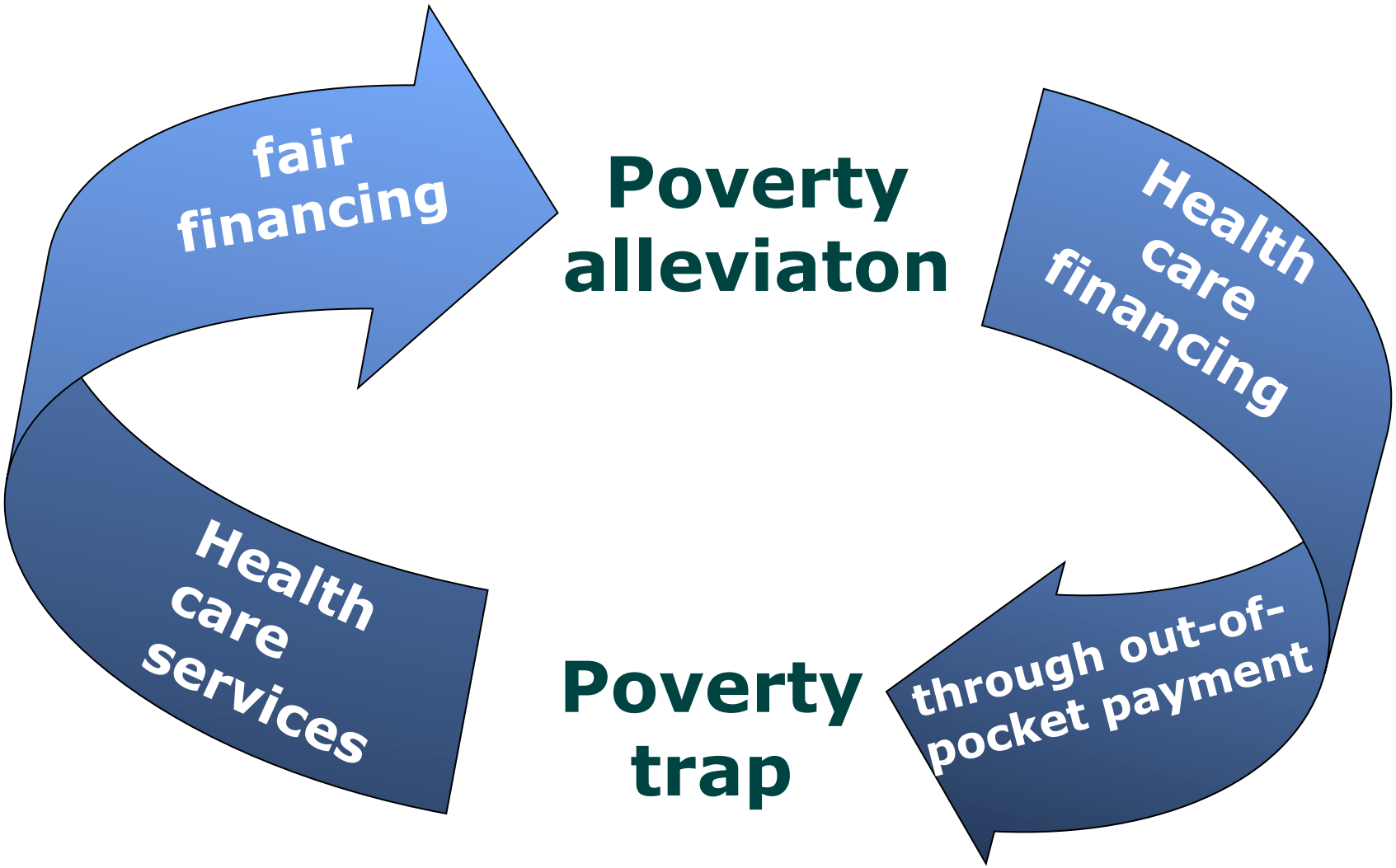
Health – Poverty: The Unacceptable Paradox



Problem

Almost half of Mexican households lacked health insurance, which limited access to care, reduced opportunities for risk pooling, and generated catastrophic expenditures.

Financial Imbalances in 2000

1. Level: insufficient investment (5.7% of GDP) vis-a-vis the dual challenge
2. Source: predominance of out-of-pocket payments (55%)
3. Distribution
    - 3.1. Among populations: more than three times between insured and uninsured
    - 3.2. Among states: 5 to 1 between the state with the highest and the lowest per capita federal expenditure
4. State contributions: 89 to 1
5. Allocation items: current expenditure *versus* investment

Objectives of the reform

1. Create a legal framework to increase public expenditure for health in a gradual, fiscally responsible, and sustainable manner.

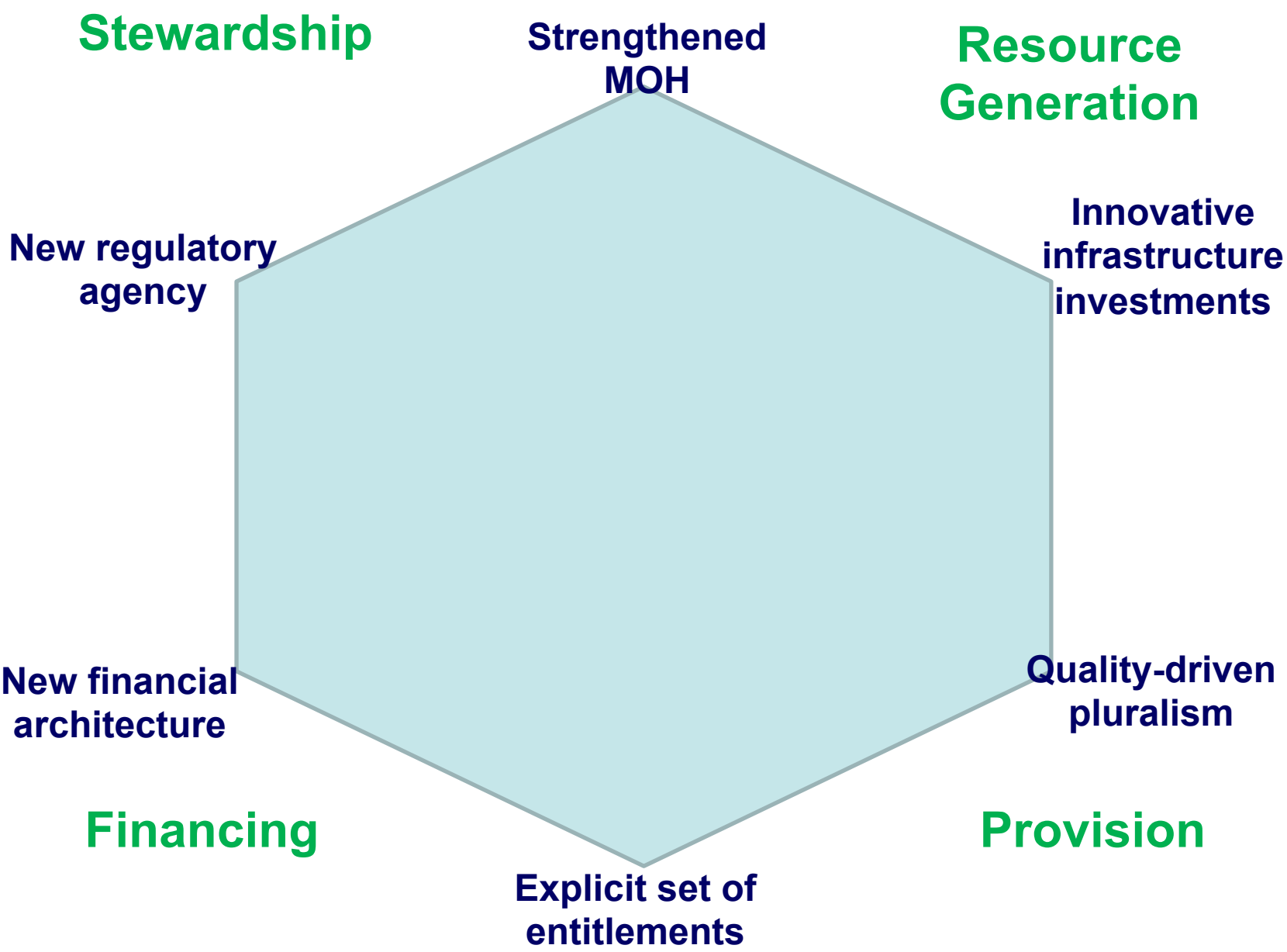
2. Achieve greater allocative efficiency by protecting funding for cost-effective community-based preventive interventions.

3. Protect families from health expenditures by a collective mechanism to manage risks in a fair way.

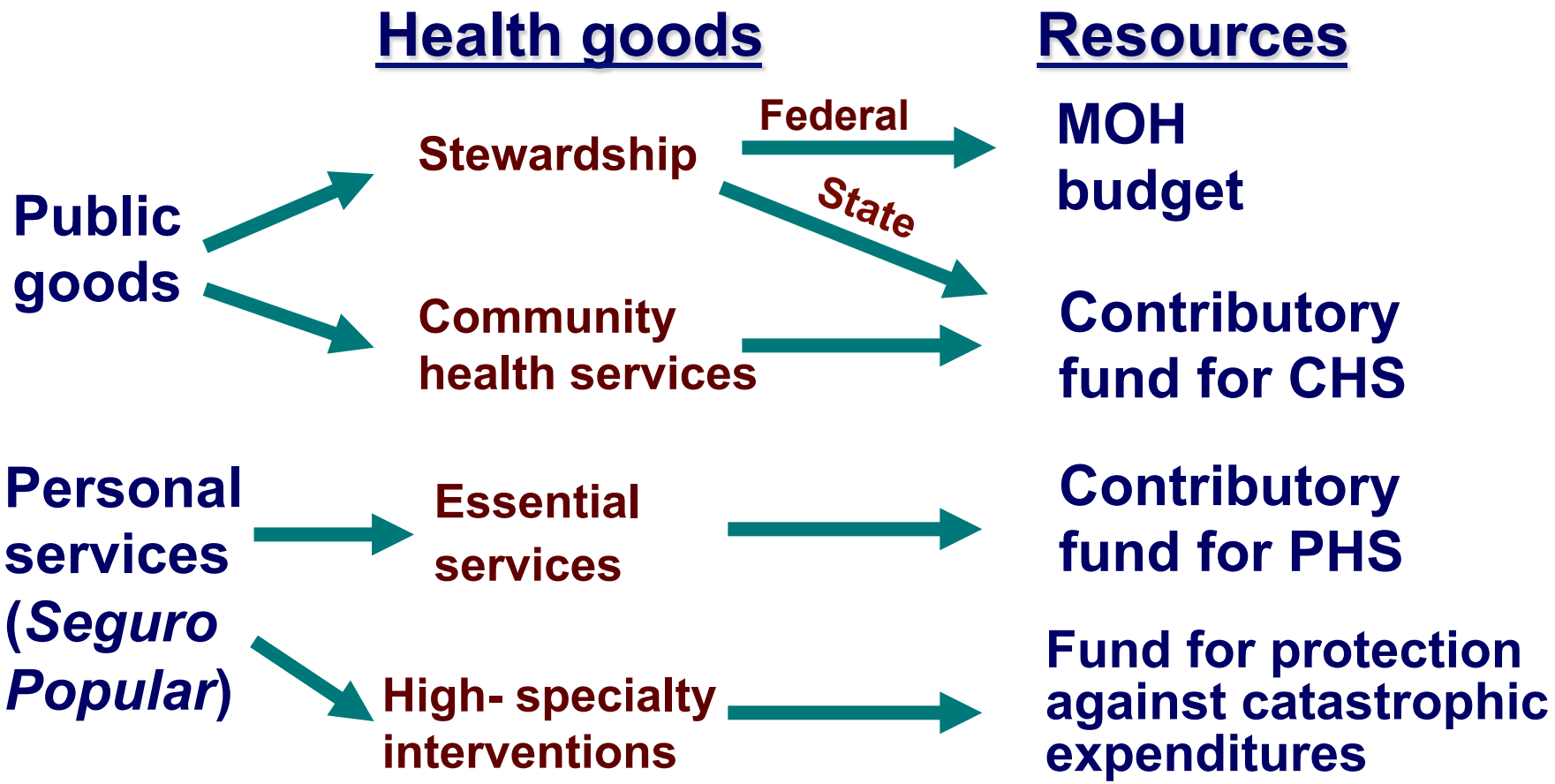
4. Transform incentives from supply-side to demand-side in order to promote quality, efficiency, and responsiveness to users in a pluralistic delivery framework.

5. Restructure the Ministry of Health away from direct provision of care for the poor and towards stewardship of the entire health system.

Major Innovations



New Financial Architecture for Health



Strenghthening the Supply Side: The other half of reform (Management reform)

Key Policy Transitions

Rigid regulation	→	Strategic stewardship
Segmented revenue collection	→	Solidarity-based prepayment
Limited fund pooling	→	Broad fund pooling
Inertial and unstructured purchasing	→	Active purchasing
Heterogeneous provision	→	Quality-driven provision
Imbalanced resource generation	→	Balanced resource generation
Dysfunctional public and private sectors	→	Harmonious public – private mix