Health system financing: Tips for emerging markets

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Many countries with emerging economies are considering health system financing transformation. Five no-regrets tips can help them build a strong foundation for their future health system.

In countries around the world, healthcare expenditures are growing faster than GDP. Recent estimates suggest that global expenditures on health could rise from US $8 trillion in 2018 to over $18 trillion in 2040.¹ The increased spending is forcing many governments to tighten their belts, use available financial resources more efficiently and, in some cases, prioritize which services are delivered. Although these challenges are present in most nations, they are especially acute in countries with emerging economies. (See the sidebar below as an example.)

As Ethiopia’s example illustrates, the financing struggles countries with emerging economies face are easy to diagnose, but there is no readily available and implementable solution. In other words, there is no clear right path. If, however, a country did wish to transform its health system financing, many of the decisions it would need to make to define the future financing model are likely to lead to tough, country-specific, and ideologically charged debates. Among the issues that could be debated are these: What is the appropriate split between the public and private sectors in providing healthcare and health insurance? How much choice should patients have? Which health services should citizens be entitled to? How can out-of-pocket spending be lowered and families be protected from catastrophic financial expenditures? How can health system financing be provided sustainably?

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² The “informal sector” refers to employment for which no income taxes are paid, in contrast to the formal sector, in which taxes are paid. In Ethiopia the informal sector is estimated to be account for more than 40% of the country’s economy. (Medina L et al. The informal economy in Sub-Saharan Africa: Size and determinants. International Monetary Fund. June 10, 2017.)
Given the complexity of the questions and, often, the lack of consensus among policymakers and academics, it is hardly surprising that many countries become trapped in a state of paralysis, without a clear vision of how to move forward. An additional complication is that national health priorities may shift following elections if the political party in power changes. As priorities shift, it can become even more difficult to achieve broad consensus among policymakers and politicians about health system financing goals.

Nevertheless, our international experience has shown that the real challenge in health system financing transformation in countries with emerging economies is not finding the single right path—rather, it is putting together a set of building blocks to create a coherent system that delivers the greatest value for a country’s citizens. Different countries have made different systems work. For example, the United Kingdom and Germany both provide universal health coverage with similar objectives but use very different financing models. Often, the financing design a country uses is tied to historical factors and regional trends. For example, the former Soviet Union and most Eastern European countries have transitioned to a centralized social health insurance model. By contrast, Latin American countries typically have a mix of social health insurance and a national health service, reflecting the historical agreements between political leaders and different social groups.

The good news is that the basic building blocks are common to all health system financing transformations, regardless of the specific model being built (Exhibit 1). Using these blocks is a no-regrets move that ministries of health—or other responsible health authorities—can take to build momentum for the transformation. By “no-regrets,” we do not mean that the steps are easy or uncontroversial, but rather that they are necessary irrespective of the model being built. These building blocks allow countries to accelerate health system transformation by creating tangible economic benefits and collecting new data to inform the ongoing policy debate.

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3 The main difference between a social health insurance system and a national system is in the way money is raised to run the system. Social health insurance systems rely primarily on dedicated health contributions derived from the monthly payroll of employees, whereas national health insurance systems are financed through general taxation.
Before you begin: Establish transformation leadership

Successful health system transformation requires strong and committed leadership. For example, dedicated leadership and political support were main drivers of Thailand’s success when it instituted universal coverage in 2001\(^4\)\(^,\)\(^5\) and Zambia’s successful removal of user fees for primary care services in 2006.\(^6\)\(^,\)\(^7\)

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The first step is to set up a transformation office with a strong political mandate and a core team of three to ten people. This office should be led by someone with sufficient sector experience to be credible and who is not afraid to make changes. The office, which is typically housed at the ministry of health, should be empowered to track and support progress across all parts of the transformation, including the provider side.

In addition to tracking and supporting progress, the transformation office should lead the overall communication strategy. The strategy should be based on a solid understanding of the needs, expectations, and fears of key stakeholder groups, including patients, medical professionals, employers, and politicians. This understanding will inform the change story, which needs to compellingly communicate the benefits of the transformation and directly address concerns. However, the stakeholder analysis should also mark the start of an ongoing dialogue that the transformation office should manage through the transition (typically, using thematic working groups and workshops to engage the key stakeholder groups on specific issues).

Significant training will likely be required for the transformation office staff, as well as any staff people from the ministry who are heavily involved in the effort and key hospital managers. It should cover the technical elements of health system transformation—through residential courses, online training, and learning secondments—but also the softer skills of transformation management. Macedonia’s Ministry of Health expanded its six-weekend training program to reach more than 900 stakeholders, including hospital managers and doctors, creating an opportunity to communicate the change story as well as provide technical training. More recently, the Kingdom of Saudi Arabia’s Ministry of Health embarked on a large-scale training program anchored by a new leadership model. It plans to train more than 24,000 staff in support of the ongoing transformation.

**Show me the money: Define the sources of funding**

Whether the objective of financing transformation is to expand coverage, increase quality of care, or improve financial sustainability, additional sources of funding will likely be required,

1. Calculate the “fiscal space”

2. Identify and quantify potential sources of additional funding

3. Align on changes with the relevant stakeholders in advance

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8 Lazarevik V, Donev D. Public hospital system in Macedonia. (Chapter 8 in *Health Reforms in South-East Europe*. Editors: Bartlett W, Bozikov J, Rechel B. 2012.)
particularly if the health system is currently financed from general government revenues or
donor funding.

To address this issue, the first step is to calculate the “fiscal space” for healthcare
spending—that is, how much room there may be in the government’s budget to sustain or
increase spending, both now and in the future. (This space may, in fact, be negative in the
future under the current model.) The fiscal space analysis includes a projection of healthcare
revenues and expenditures over the medium term (normally, five to ten years) based on the
historical evolution and an understanding of cost drivers, including epidemiological and
demographic trends. This analysis can be an important tool for moving healthcare up the
government’s agenda.

The second step is to identify and quantify potential sources of additional funding, testing
each for technical and political viability. One option may be as simple as improving the
operations of existing collections systems. For example, a Middle Eastern country recently
identified opportunities to improve collections and reduce leakage; the combined impact
was worth more than 5% of the government’s health expenditures. Once the potential
options for additional funding are identified, a range of scenarios can be modeled to
assess both their fiscal impact on the health system and possible side effects on wages,
employment, exports, and GDP growth. Any significant new revenue source, such as payroll
contributions, will typically require a gradual rollout, and the rollout plan should be agreed to
in advance by key employer and employee representatives and political stakeholders.

Once the preferred source(s) have been selected, the third step is to align with relevant
stakeholders and then implement the chosen strategy. This should include communicating
to the broader population through the media, drafting the necessary legislation, and defining
roles and responsibilities (e.g., whether the revenues will be collected by the tax authority or
another agency).

Intelligent customer: Establish a purchasing entity
Regardless of the future model chosen, one or more organizations must be given
responsibility to strategically purchase the healthcare services being funded so that the
“payer” and “provider” functions are effectively separated. Introduction of a strategic
purchaser entity makes it possible to clarify responsibilities across usually rigid healthcare
systems, and it opens the door for the introduction of market forces and performance-
based competition across providers.9 Although developed countries have long experience
with the split between payers and providers,10 governments in emerging markets must often
institute such an approach. For the payer function, they can choose to establish a public
purchasing (or commissioning) entity or use private health insurers (if present in the country).
During the initial transition, most countries opt for a public purchasing entity to maintain
control over costs—Colombia’s attempt to move rapidly to a competitive health insurance
market resulted in a 26% increase in total health expenditures between 1995 and 1997.11

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11 Pinto D, Hsiao WC. Colombia: Social health insurance with managed competition to improve health care
2007.)
The process for setting up a healthcare purchasing entity is similar to that for any public—or even private—entity: define the operating model, design the organizational structure, establish the governance and oversight model, empower the entity through the relevant legislation, and ramp it up through hiring and contracting. The key decision about the operating model is to define the extent of outsourcing. For countries with established third-party administrators, outsourcing will usually be an attractive option for back-office operations, but the entity should keep the strategic payer functions in-house. In other countries, all functions may have to be developed in-house, which could result in a longer ramp-up time.

There is no need to reinvent the wheel: the operating model and organizational design of the purchasing entity can be based heavily on international best practice\(^\text{12}\) and benchmarking. However, it is unlikely that a “copy/paste” approach will work; rather, benchmarks should serve as starting points for adaptation through workshops with local stakeholders.

**Get inside the black box: Develop provider coding capabilities**

Much of the real legwork in health system transformations is in creating transparency into provider activities by introducing activity-coding systems. In many countries that pay providers based on historical block budgets, the purchasing entities have very little visibility into what services different facilities provide, how much the services cost, or how much variation there is across the system. The transition to a provider payment system designed to incentivize efficiency and quality requires that providers develop coding capabilities, and that purchasers develop auditing capabilities to control data quality.

Depending on the current state of the IT infrastructure in the country’s hospitals, achieving these goals may require an upgrade to the IT hardware and systems. Benchmarking against other countries can help determine what is needed and help balance the trade-offs among performance, time, and cost. The first step in benchmarking is to choose appropriate peers so that a baseline for comparison can be established. The selection of baseline countries should be based on geographical and cultural comparability, the aspirational status of the health system, and economics (the countries should be in a relatively similar situation). Introducing coding requires purchasing (or developing) the selected coding system, translating and adapting the system to the local context, training the provider staff, and establishing the data quality control framework.

Achieving a fully functioning coding system is not simply a technical task; it requires active adoption by provider staff. For example, Andalucía, Spain, initiated a dialogue with medical staff through weekly satisfaction surveys to identify and troubleshoot problems quickly.\(^\text{13}\) In Denmark, early adopters served as role models for their peers through demo sessions; their progress was then publicized to create peer pressure among other providers, and financial incentives were used to reinforce the pressure.\(^\text{14}\) Active stakeholder engagement by the transformation office can make or break a successful transition to a more transparent, data-driven system.

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12 Examples of best practices can be found in *Purchasing to Improve Health System Performance*. Editors: Figueras J et al. 2005.


Pay for what you get: Transform provider reimbursement and contracting

Payment mechanisms are the most powerful lever purchasers have to influence provider behavior. Most countries with emerging economies that embark on health system financing transformation start with a block budget system for reimbursing providers, based on historical spending. However, this approach fails to incentivize efficiency—and could create perverse incentives if providers who overspend are effectively rewarded with a larger budget for the following year.

A state-of-the-art reimbursement model incentivizes providers to provide quality healthcare services in an efficient, cost-effective manner. For example, a public purchaser in the Middle East supplemented its existing fee-for-service payments with performance-based bonus payments to incentivize efficiency and quality, using an automated model to identify and adjust for population risk factors.  

Accountable Care Organizations

An example of innovation to incentivize population health management is the introduction of accountable care organizations (ACOs) in the United States. Primary care clinics and hospitals can group together to form an ACO that receives payments on a capitation basis (with quality-based bonuses) rather than through the traditional fee-for-service model. This approach gives providers an incentive to reduce costs and, more important, to invest more in preventative and primary care services to reduce the number of patients in need of hospital care. However, the performance of the ACOs across USA has varied; one of the primary factors influencing results is the type of risk-sharing models adopted (one- vs. two-sided risk).

Regardless of the healthcare delivery and financing model selected, the transition to the new payment mechanism must, of necessity, be gradual and will require the build-up of capabilities among both purchasers and providers. The transition plan should thus include an interim payment mechanism that is simple enough to be implemented within three to five years. Once the end-state and interim mechanisms are defined, the transformation office will need to ensure that the necessary technical capabilities (as described below) are developed. Even after providers have developed these capabilities, it will likely be necessary to introduce a period of shadow billing to understand surpluses and deficits at the provider level under the new mechanism, and then to take action as needed to adjust fee schedules and address provider performance.

Take off the shackles: Increase provider autonomy

Payment-mechanism transformations can’t change behaviors in isolation. Hospital and clinic managers need the freedom and authority to actively manage their facilities. In most

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15 Health Authority–Abu Dhabi 2010 Annual Report.
countries with emerging economies, where public providers operate with block budgets from the ministry of health or another relevant health authority, providers often have limited autonomy: typically, budget limits are set at the line level, providers cannot raise funds from borrowing or asset sales, and staff are civil servants. Thus, governments commonly increase provider autonomy in parallel to transforming payment mechanisms.

Autonomy can be granted in three broad areas: financial management, personnel management, and the delivery of social services. In practice, the level of autonomy granted to providers will vary from country to country and is often more of a political than a technical decision. In granting more autonomy, the government relinquishes control and makes providers more responsive to the incentives defined within the financing system (although financial autonomy also presents the risk of provider bankruptcy). To define the degree of autonomy, the ministry of health should create a small dedicated senior team, either within the transformation office or separately, that coordinates the dialogue and decision-making process with relevant stakeholders. Once this is defined, this same team can oversee implementation, including forming provider governing boards, drafting legalization, developing a communication strategy, and offering capability-building support for providers in financial and personnel management.

Conclusion: Start building
Health systems financing transformation requires many complex and politically sensitive decisions. Defining the right model takes time and, if it is to be sustainable, needs to be built on political debate and consensus. However, this need not lead to paralysis: irrespective of the end model, ministries of health can put in place a leadership team to implement the five “no-regrets” building blocks of the transformation. By doing so, these ministries will invest in success—building a strong foundation for their future healthcare system so that when the design is finalized, all the pieces are already in place.

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