Health care financing

Social Care and Health Systems

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EVROPSKÁ UNIE
Evropské strukturální a investiční fondy
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Health care financing - introduction

- Information about financing is crucial for analysts
- Policy-makers obtain a picture of the structure and flows of funds
- Financing health care has evolved from personal payment to health insurance scheme

Health care financing - introduction

- Personal health care = hospital care, dental services, physician care and drugs
- Financing methods influence how people access health care
- Financing methods also influence distribution health care
- Differences in health care market

Health care financing - introduction

- Financing systems varies widely across countries
- Most of countries have implemented some kind of national insurance system (except US and South Africa)
- All developed countries have ensured their citizens access to health care services

Health care financing - introduction

- National health expenditures = health care services and supplies, research
- Governmental control over the size of health care sytem correlates with size of directly financing from public finance
- In some cases government directly controlled prices in health care system

Health care financing – forms of financing

Classification by Abel-Smith, 1984

1. indirect funding

- through public budgets: state and local
- through compulsory insurance
- voluntary insurance
- employee insurance
- philanthropy, charity
- foreign aid (especially for developing countries)

2. direct funding

- payments by service recipients

Health care financing – financing models

- In practice, there are fundamentally different combinations of financing forms that reflect the health policies of individual countries
- Depending on the prevailing financing form, the following three models can be distinguished:

1. Continental model
2. National Health Services (NHS)
3. Liberal model

Health care financing – financing models

1. Continental model

- Bismarck's model
- The predominance of compulsory public insurance, covering most of the population and the basic scope of health care
- Can be complemented by direct payments, private insurance as well as state budget funds
- Typical for European continental states such as the Netherlands, Germany and Belgium

Health care financing – financing models

2. National Health Services (NHS)

- Beveridge's´model
- financing health services through the state budget
- Financing from sources of taxation
- Patients have been required to contribute towards the cost of some specific services
- Typical for Great Britain

Health care financing – financing models

3. Liberal model

- Financing mainly on the basis of private (occupational) insurance
- Supplemented by state transfer and redistribution programs addressing the most serious market failure
- “Health care” refers to medical services, but not to a healthy state of being
- The right to health care is distinct from the right to health
- Typical for the US

Health care financing – Raising money

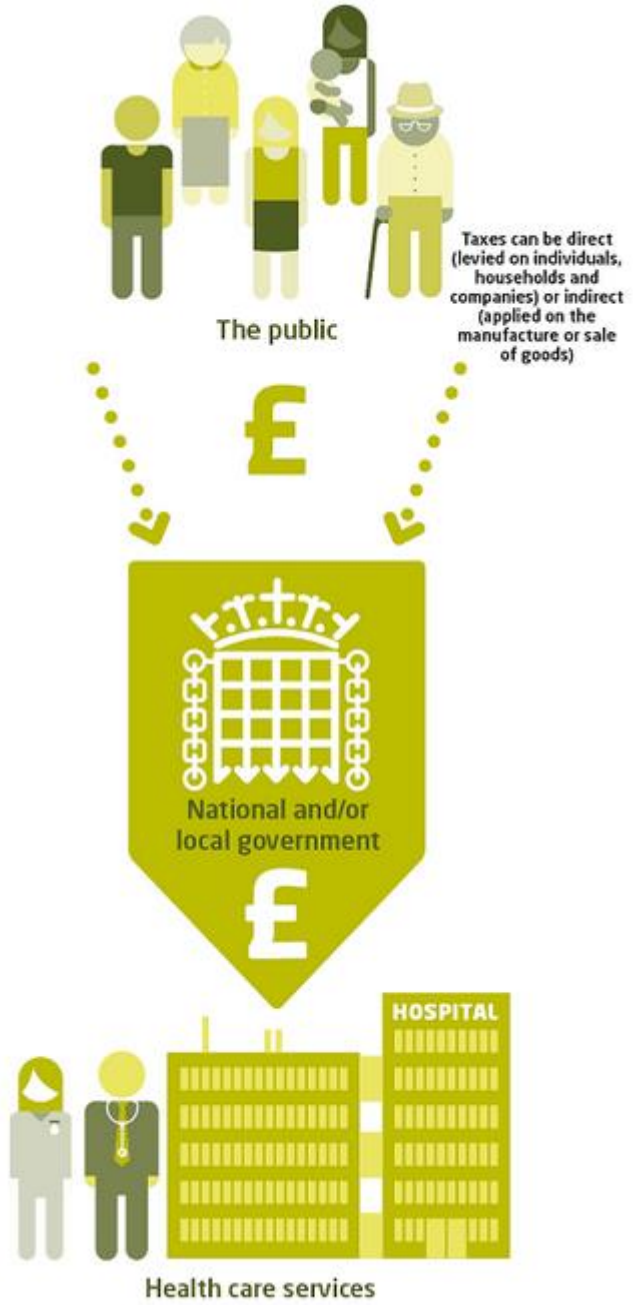
There are four main ways of raising money for health care:

- Taxation
- Health insurance contributions
- User pays (out of pocket, no reimbursement)
- Donor funding

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 1. Taxation

- Tax-based system is effectively pools health risks across a large contributing population
- In such systems, individuals contribute to the provision of health services through taxes on income, purchases, property, capital gains, and a variety of other items and activities
- It avoids many problems common to systems in which individuals and firms can choose whether or not to acquire insurance



Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 1. Taxation

- Contributions are usually spread over a larger share of the population than might otherwise be the case
- The scope for mobilizing resources may be larger for Tax-Based systems
- Tax-Based Systems can potentially capture revenues from rents, capital gains, and profits, and therefore may be more progressive than social insurance systems that rely predominantly on a share of formal workers' salaries
- It should reduce individual responsibility for one's own health and as reducing the accountability of health care providers to the people who use their services

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 1. Taxation

- Different ways in taxation - Should we tax income or consumption? Should we rely on national or local taxes?
- OECD countries tax more than 30% of GDP to support public programs and rely on income taxes
- Developing countries tax 15% of GDP on average and rely on consumption taxes
- Britain relies on general income taxes and national taxes
- Finland, Norway, and Sweden rely on regional or local taxes

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Practise of Taxation – Great Britain

- In 1911 – introduce national insurance fund for low-income workers (inspired by Germany)
- The Beveridge Report allowed the adoption of a universal health care system
- Introduce a financing system in which individuals would pay a contribution to a national insurance fund after WW II.
- Contribution in proportion to citizens needs
- It was a revolutionary change in health care system

Practise of Taxation – Great Britain

- Aneurin Bevan (the new Health Minister after WW II.) proposed to create a single centralized National Health Service financed from general taxes
- Bevan won after making a number of concessions to doctors.
- National Health Service (NHS)
- Britain taxes about 40% of its national income and dedicates some 15% of that to the NHS
- The funds derive from national revenues that include both income and consumption taxes

Source: WHO, Tax-Based Financing for Health Systems: Options and Experiences, 2004

Practise of Taxation – Great Britain

- The outcome of establishing the NHS was quite positive in many ways
- Coverage became universal in a short time and health outcomes continued to improve
- Successive governments tried to contain costs, but even so, by comparison with most OECD countries, the NHS takes a relatively modest share of GDP
- Under the Thatcher government, no one questioned the principles of universality and tax funding for the NHS
- Most reforms in the last two decades have focused on the management of the system, changing payment schemes, reorganizing services, and decentralizing many functions

Source: WHO, Tax-Based Financing for Health Systems: Options and Experiences, 2004

Practise of Taxation – Sweden

- By 1885, some 10% of the working population had joined "Friendly Societies" that would pay out sickness benefits when a member fell ill
- Employers also began to create sickness funds for their workers
- Unions followed suit, hoping to increase their member's independence by reducing their reliance on employer-based schemes
- Universal health coverage created in 1946 and implemented in 1955
- The public perception of the system remains favorable and the commitment to the principles of universal access is quite strong

Source: WHO, Tax-Based Financing for Health Systems: Options and Experiences, 2004

Practise of Taxation – Sweden

- Sweden's health service system is successful
- The system covers all the population with comprehensive benefits
- Only dental care has restrictions for those over 19 years of age - for nominal fees that make up only 2% of total public health spending
- Voluntary health insurance is relatively insignificant, involving less than 1% of the population
- Government health spending represents 6.5% of GDP (above the OECD average - 5.7%)

Source: WHO, Tax-Based Financing for Health Systems: Options and Experiences, 2004

Health care financing – 2. Insurance

- **Health insurance** is a very broad idea. There are many different kinds of health care funding arrangements which are referred to as 'health insurance,

Health insurance schemes vary widely:

- Who owns the health insurance organisation: government, not-for-profit, commercial?
- Coverage: voluntary or mandatory (universal)?
- Collection of premiums: employment based or family based?
- Pooling
- Payment for services

Source: WHO, Tax-Based Financing for Health Systems: Options and Experiences, 2004

Health care financing – 2. Insurance

- Differences in insurance model make a difference to the incentives of the insurance organization

- The should be a pressure to control expenditure especcially in case of publicly sponsored health insurance models

- Commercial insurers are under pressure to control their expenditure

Health care financing – 2. Social health insurance schemes

- **Compulsory health insurance** involves a financing arrangement to ensure access to health care for specific population groups through mandatory participation and eligibility based on the payment of health insurance contributions by or on behalf of the individuals concerned
- Health insurance scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment
- Laws on social health insurance define the coverage of persons and the benefit basket to which the insured persons are entitled.

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Social health insurance schemes

- **Health insurance schemes characteristics:**

1. Mode of participation: mandatory, either for all citizens/residents or for a specific population group defined by law/government regulations (e.g. formal sector employees);
2. Benefit entitlement: contributory, based on non-risk-related payments made by or on behalf of the insured person. Family members may or may not be covered on the basis of the contributor's payment. The government may make contributions on behalf of certain defined categories of the population (e.g. pensioners).

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Social health insurance schemes

- **Health insurance schemes characteristics:**

3. Basic method for fund-raising: compulsory non-risk-related health insurance contributions. Insurance contributions may be paid by the government (from the state budget) on behalf of some non-contributing groups of the population, and the government may also provide general subsidies to the scheme
4. Mechanism and extent of pooling funds: national, sub-national, or by scheme. With multiple funds, the extent of pooling will depend on risk-equalisation mechanisms across schemes. By using such mechanisms, it is possible to create pooling across schemes.

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Compulsory private insurance schemes

- **Compulsory private insurance** is a financing arrangement under which all residents are obliged to take out health insurance with a health insurance company or health insurance fund
- The purchase of private coverage is mandatory
- The insurance is established by an insurance contract between the individual and the insurer
- In the Dutch system (from 2006), the government heavily regulates the market for compulsory insurance
  - insurers are obliged to accept anybody for the basic package of services, and the insurance premium is unrelated to individual risks

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Compulsory private insurance schemes

- **Compulsory private insurance characteristics:**

1. Mode of participation: mandatory, either for all citizens/residents, or for a specific group of the population obligated by law/government regulation to purchase a health insurance policy (e.g. formal sector employees)
2. Benefit entitlement: contributory, based upon the purchase of an insurance policy from a selected health insurance company (or other agency involved)

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Compulsory private insurance schemes

- **Compulsory private insurance characteristics:**

3. Basic method for fund-raising: compulsory health insurance premiums, sometimes partially or fully subsidised by the government, including the possible use of tax credits
4. Mechanism and extent of pooling funds: national, sub-national, or by scheme; with multiple funds, the extent of pooling will depend on risk-equalisation mechanisms across schemes. This also depends on the extent of regulation of the premium and the standardisation of benefits across schemes

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Voluntary health insurance schemes

- **Voluntary health insurance** schemes are based upon the purchase of a health insurance policy, which is not made compulsory by government
- Insurance premiums maybe directly or indirectly subsidised by the government
- Voluntary health insurance is taken up and paid for at the discretion of individuals or firms
- Voluntary health insurance may also be purchased by the employer

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Voluntary health insurance schemes

- **Voluntary health insurance characteristics:**

1. Mode of participation: voluntary, at the discretion of an individual or a firm
2. Benefit entitlement: contributory: based upon the purchase of the voluntary health insurance policy (usually on the basis of a contract)
3. Basic method for fund-raising: usually non-income-related premiums (often directly or indirectly risk-related); may be directly or indirectly subsidised by the government(e.g. through tax credits)
4. Mechanism and extent of pooling funds: individual scheme level

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Public health insurance

- **Universal health coverage** (UHC)
  - In recent decades, achieving UHC has been a major health policy focus globally
  - UHC entitles all people to access healthcare services through publicly organised risk pooling
  - Safeguard against the risk of catastrophic healthcare expenditures

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Public health insurance

- UHC is a problem for low- and middle-income countries – they face particular challenges in achieving UHC due to particularly limited public resources for health care, inefficient allocation, over-reliance on out-of-pocket payments, and often large population size
- In this countries as a result, access to health care and the burden of financial cost tends to be worse for the poor, often resulting in forgone care
- Private insurance is mostly unaffordable for the poor
  - Introducing and increasing the coverage of **publicly organised and financed health insurance** is widely seen as the most promising way of achieving UHC

Source: OECD/World Health Organization/Eurostat (2011), "Classification of Health Care Financing Schemes (ICHA-HF)", in A System of Health Accounts: 2011 Edition, OECD Publishing, Paris.

Health care financing – 2. Public health insurance

- Study (Erlangga, D., Suhrcke, M., Ali, S., & Bloor, K.; 2019) has found stronger and more consistent evidence of positive effects of health insurance on health care utilisation, but less clear evidence on financial protection
- Classification of health insurance is complicated due to the many characteristics defining its structure:
  - The mode of participation (compulsory or voluntary)
  - The benefit entitlement
  - The level of membership (individual or household)
  - The methods for raising funds (taxes, flat premium, or income-based premium)
  - The mechanism and extent of risk pooling

Source: Erlangga, D., Suhrcke, M., Ali, S., & Bloor, K. (2019). The impact of public health insurance on health care utilisation, financial protection and health status in low- and middle-income countries: A systematic review. *PloS one*, *14*(8), e0219731. doi:10.1371/journal.pone.0219731

Health care financing – 2. Public health insurance

Public health insurance:

- solidarity
- consistent transparency in the management of public funds
- availability of quality care for all
- monitoring, evaluation and publication of quality and health care cost indicators
- clear definition of competences (state, regions, insurance companies) economic equilibrium

Health care financing – 2. Public health insurance

- This system based on compulsory public health insurance, known as the Bismarck system, is typical of developed European countries such as Germany, Belgium, the Netherlands, France, Switzerland, Hungary, Poland, Czech republic.
- Typical features of this system include fundraising from employees' wages, employers and the state
- The existence of a system of hospitals providing healthcare that can take various forms of ownership and funding, and outpatient health services provided by private doctors who are paid for through contracts with health insurance companies.

Health care financing – 2. Public health insurance

Public health insurance in the Czech republic

- Since the 1990s there has been a system of public health insurance as a model of health care financing
- This system is a very complex system in which the income part is represented by the payers of premiums, who pay the premiums for public health insurance. Furthermore, the system includes health insurance companies that provide this public health insurance
- These perform the function of payers and purchasers of health care for their insured persons and the risk is balanced between individual insurance companies with regard to the structure of their insured persons
- Furthermore, there are health care providers in various legal forms who receive reimbursement from health insurance companies for the provision of health services

Health care financing – 2. Public health insurance

Public health insurance in Germany

- In Germany, compulsory health insurance exists, but this obligation, depending on the level of income, only applies to approximately three quarters of the population when persons above a certain income limit are not subject to the compulsory insurance law
- In Germany the health care system is financed on the principle of social solidarity
- Health insurance premiums are paid as a percentage of income, half of which is paid by the employer and half by the employee

Health care financing – 2. Public health insurance

Public health insurance in Austria

- The financing of Austrian health care is also based on the public health insurance system
- This insurance covers approximately 99% of the population
- There is also a co-insurance scheme whereby other family members are co-insured together with a gainful member of the household

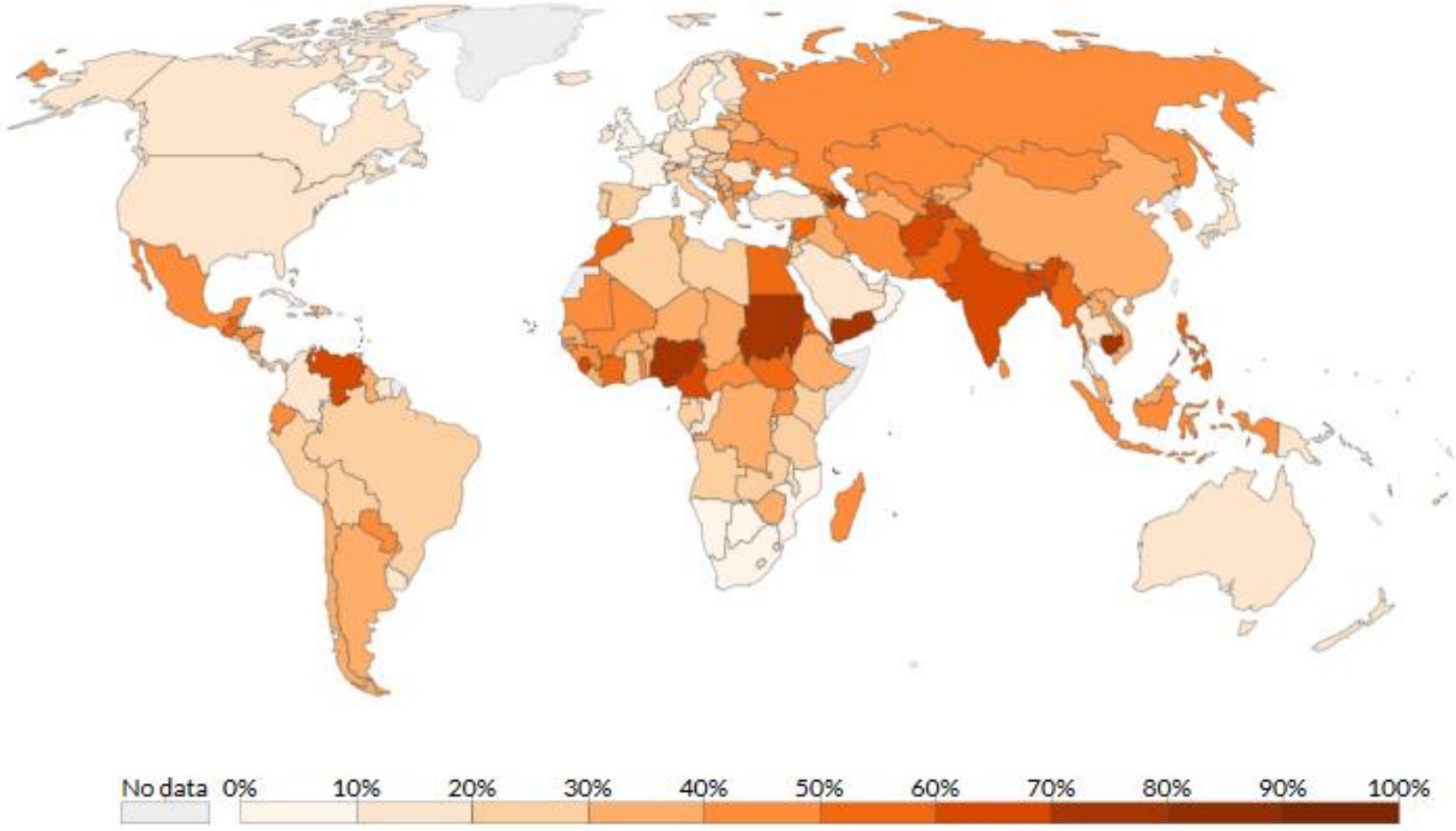
Health care financing – 3. User pays (out of pocket, no reimbursement)

- Direct payments made by individuals to health care providers at the time of service use
- No prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments
- Unregulated direct charges often constitute a major access barrier to needed health care and contribute to high out-of-pocket payments generating problems of financial protection
- Charging people for their medical care means that those with the greatest need, and those with the lowest income, will feel the brunt
- Moreover, patients may forgo necessary care - in contrast to other forms of financing such as taxes and premiums, which cannot be avoided by forgoing health care

Source: WHO, Out-of-pocket payments, user fees and catastrophic expenditure, 2021

Health care financing – 3. User pays (out of pocket, no reimbursement)

Out-of-pocket expenditure on healthcare by country (as percent of total healthcare expenditure) in 2014



Health care financing – 3. User pays (out of pocket, no reimbursement)

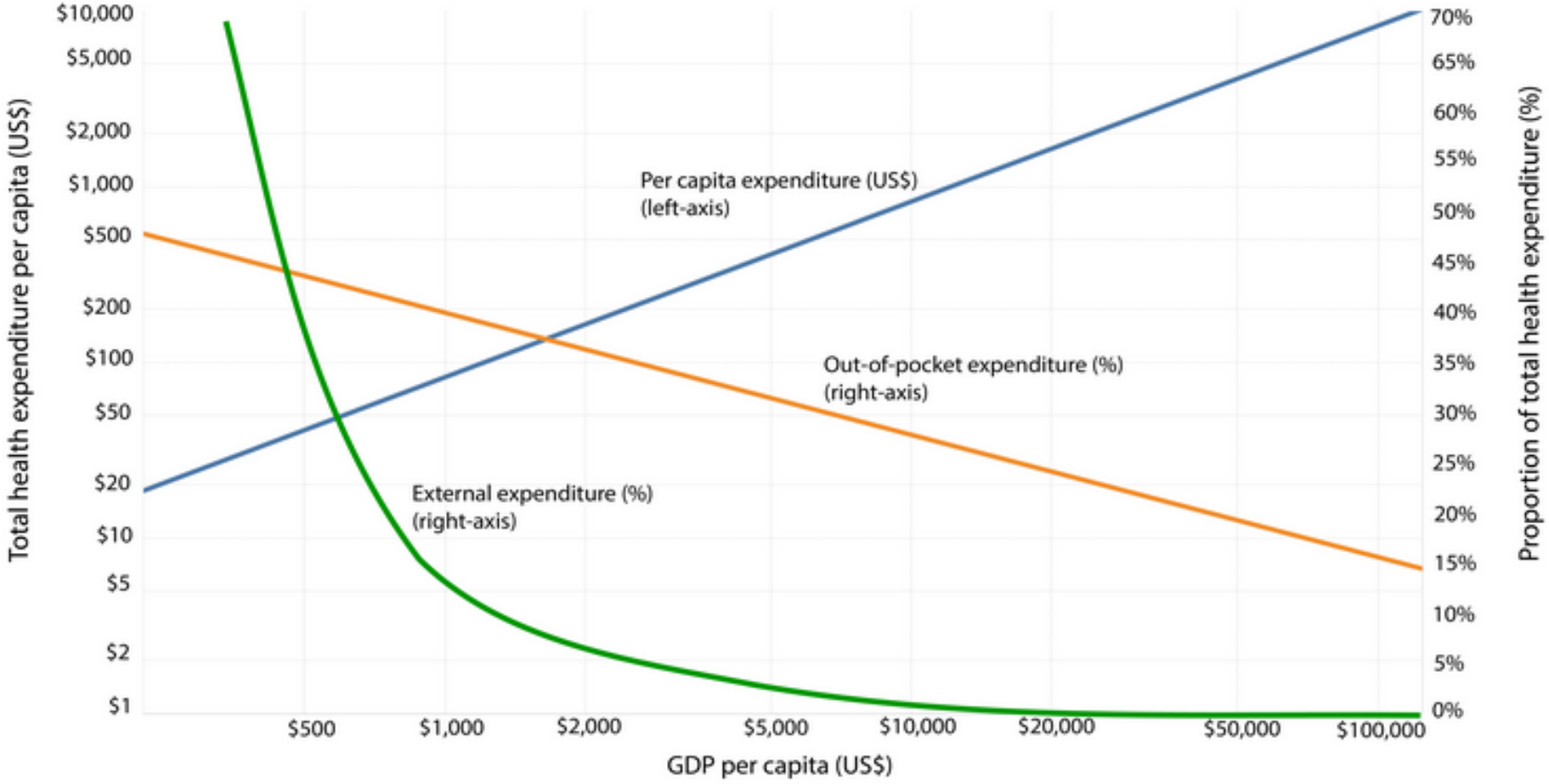
- The visualization presents out-of-pocket expenditure on healthcare by country
- In high-income countries these outlays tend to account for only a small fraction of expenditure on healthcare
- In low-income countries, they account for the majority of funding
- Many countries have followed a clear path in the direction of reducing this type of expenditures (particularly in the developing world)
- Overall, we see that these outlays tend to account for a smaller fraction of overall health spending in higher-income countries versus low-income nations

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Health care financing – 3. User pays (out of pocket, no reimbursement)

- external funding refers to economic resources from non-resident units channeled towards healthcare (whether explicitly labelled so, or not), through the government or private sector

Global trends of total health care expenditure in 2017



Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Source: WHO, 2017

Health care financing – 3. User pays (out of pocket, no reimbursement)

- Overall, as countries get richer, per capita expenditure on healthcare tends to increase
- As per capita income increases, the share of both out-of-pocket outlays and external donor funding decreases
- As the contribution of these sources decline, typically the share from public funding increases
- Out-of-pocket and external funding contributions decline at different rates
- External donor funding decreases at a lower income level than out-of-pocket outlays, and shows a significantly steeper decline

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Health care financing – 3. User pays (out of pocket, no reimbursement)

- Out-of-pocket spending is also low in countries where healthcare is largely financed through private funds in the form of private voluntary insurance
- In countries where healthcare is principally financed through public funds, out-of-pocket spending is typically low
- External donor funding is often the dominant source of healthcare spending for the poorest, but is quickly replaced by other sources as those on very low incomes move towards low- and lower-middle incomes

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Health care financing – 4. Donor funding

- The need for sufficient and reliable funding to support health policy and systems research in low- and middle-income countries has been widely recognized
- External funding refers to economic resources from non-resident units channeled towards healthcare
- Most resources to support such activities come from traditional development assistance for health donors
- There was a very high level of concentration among donors with most of the aid for HPSR coming from just a handful of donors

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Health care financing – 4. Donor funding

- The top 10 donors (United States, Global Fund, BMGF, IBRD, IDA, Canada, United Kingdom, Norway, Australia and France) accounted for 93% of total commitments to health policy and systems research (HPSR) projects from 2000 to 2014
- Countries in sub-Saharan Africa received the largest share of aid for HPSR, or roughly half of all HPSR in later years
- Funding for this region doubled between 2008 and 2009
- Latin American countries also demonstrated dramatic increases in funding in 2010, which corresponded to the global economic crisis

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

Health care financing – 4. Donor funding

- Aggregate figures show shifts in funding from bilateral to multilateral donors and across recipient country regions
- Donor funding for healthcare tends to decline sharply as countries get richer
- As per capita income increases, the share of external donor funding decreases
- External donor funding is often the dominant source of healthcare spending for the poorest, but is quickly replaced by other sources as those on very low incomes move towards low- and lower-middle incomes

Source: Esteban Ortiz-Ospina and Max Roser (2017) - "Financing Healthcare". *Published online at OurWorldInData.org.*

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