

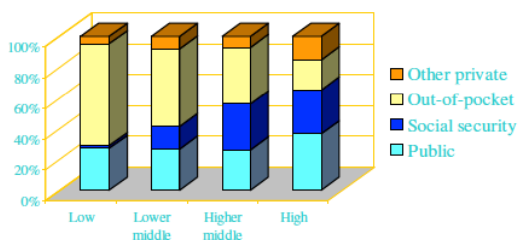
Week 5 lecture Health care financing & funding

Funding concepts (the fund, risk pool, progressive/regressive, pre-payment/retrospective payment)
Typology of funding systems
Descriptive account of the main sources of health system funding
Evaluation of funding systems from an equity perspective

Context: elements of health system analysis

- Goals (eg legislation, equality targets)
- Description and performance assessment
- Financing and funding – how is the money raised and where does it come from
- Administration
- How money moves round the system – grants and reimbursement

Progress towards universal health care depends largely on reducing the contribution of OOP
Out of pocket payments as share of total health financing (data from Gottret and Schieber 2006)



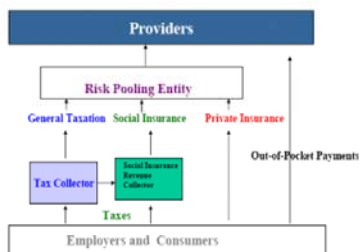
Progressive and regressive systems

In universal systems access to health care is independent of personal resources and there is a **separation of between contributions and utilization**. Such systems have high levels of cross-subsidisation. Financing universal health care out of direct taxation is the most **progressive** financing system, that is, achieves most **redistribution** to the poor (cross-subsidisation). In non-universal systems there is a closer connection between contributions and utilization and less redistribution. Financing from out-of-pocket payments (OOP or user charges) is therefore **regressive**.

Concepts

- **Direct payments and taxation or insurance methods of collecting funds.** Direct payments are generally made by individuals after receiving care. Taxation and insurance are systems of pre-payment intended to build up a fund to pay for care in the event of an individual falling ill.
- **Pooled and unpooled funds.** Pooling refers to the **extent to which the money collected is combined in a fund** that covers groups of individuals. The size of risk pool can vary enormously. Universal funds can geographic populations. Private insurance pools can be limited to relatively small groups of members. Some insurance and most direct payments do not involve pooling.
- **Compulsory, mandatory or voluntary**
- **Prepayment and retrospective payment.** Prepayment, which involves **paying into a fund before health care costs are incurred**, is the standard insurance payment system for pooled insurance. Retrospective payment or **payment upon use** is associated with out of pocket expenditure and with copayments in insurance cover

Figure 1: Financing Mechanisms



Adapted from Moroneo, E. Chon, A. Financing health care in Europe: weighing the options. European Union 275-300 2002

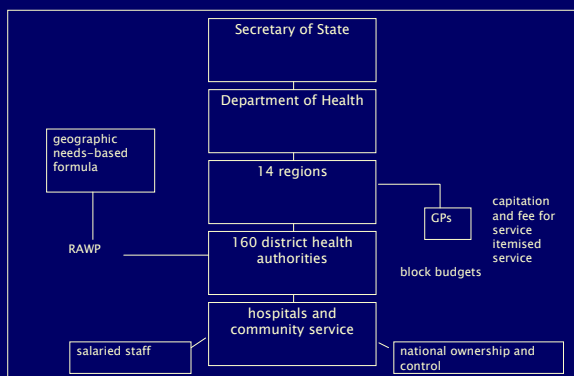
There are four main ways of collecting funds for health care

- Through general taxation of individuals – Beveridge system
- Through individuals becoming involved in compulsory health insurance programmes – Bismarckian system
- Through individuals purchasing private health insurance (including micro-insurance)
- Through non-insurance based systems such as out-of-pocket payments for health, savings accounts and donations.

The Beveridge or tax-based system

In tax based funding 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. Therefore tax revenues pool health risks across a large contributing population mobilising funds from everyone regardless of their health status, income, or occupation.

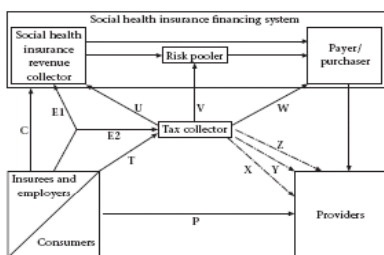
Funding flows and planning: NHS pre 1991



The Bismarckian or social insurance system

- Mandatory social insurance funds raise money from employers and their employees and uses it to pay for health services for members. It tends to be less progressive than tax financing because premiums are often a set proportion of income with caps on contributions above a certain income level
- Social health insurance is compulsory for the majority or for the whole population
- There are several funds, with or without choice and with or without risk pooling (though risk pooling among funds is technically and politically difficult)**
- Contributions made by government (or special funds) on behalf of people not in employment are usually channelled through the sickness funds
- Both employers and employees pay contributions and share responsibility for managing funds

Figure 3.1 Simplified model of the financing functions and monetary flows in countries with social health insurance



Key:
 C = contributions (both income-related and non-income-related);
 E = earmarked health taxes;
 P = private expenditure (cost-sharing for social health insurance services; voluntary health insurance; and out-of-pocket payments for non-social health insurance services);
 T = (general) taxes;
 U = tax-financed contributions, such as for non-employed people;
 V = general subsidies for pooled social health insurance financing;
 W = subsidies for individual sickness funds;
 X = reimbursement of services for people not covered by social health insurance;
 Y = reimbursement for non-social health insurance services (such as public health);
 Z = non-service-related payments (such as for investment) or subsidies.

Private voluntary health insurance

Voluntary health insurance involves individual contributions to private insurance companies for a wide range of cover. Premiums usually depend on an individual's age, sex and health status at entry. This is known as risk rating. Risk rating is usually applied to groups of customers i.e. private risk pools and provides an option for groups who want higher than average cover; it is not an option for population coverage. Individual risk rating is known as indemnity insurance.

Private insurance is normally associated with high transaction costs because risk rating requires detailed information and analysis.

There are two main types of voluntary health insurance in the EU:

- Those that substitute for statutory scheme
- Those that supplement a statutory scheme

Community-based health insurance is a variant of private insurance that has been recommended as a means of mobilising additional resources in the informal sector (that is, the non-state sector)

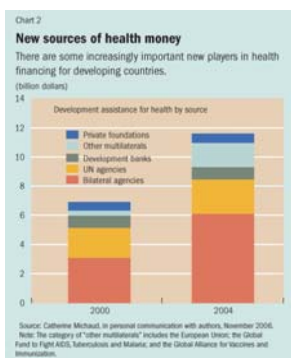
Many countries combine private and social insurance, with private insurance topping up the SHI system. In the USA, the two systems operate side-by-side – Medicare and Medicaid provide coverage for bad risk groups (the elderly and disability pensioners, and the poor). Those who cannot afford private cover and do not qualify for social cover are uninsured. There were c.50 million uninsured in the USA at 2001.

Competitive insurance and adverse selection

- <http://www.youtube.com/watch?v=-mG1-D81Wtg>

Non-insurance based systems

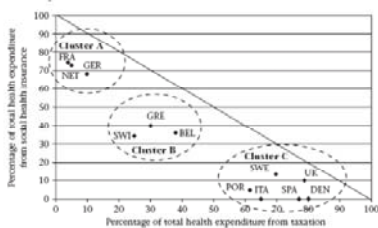
- Medical savings accounts
- User fees or OOP
- Donations



Europe is associated with socialised medicine
 Situation at 2002 (Mossialos)

- most countries rely primarily on taxation or social insurance
- direct payments are relatively high in Greece (40%), Italy (31%), Portugal (37%) and Finland (21%)
- central taxation is the principal source of funding in Spain, Portugal, Ireland and the UK; local taxation in Denmark and Sweden; and general taxation with payroll taxes Italy
- other states rely more heavily on social insurance
- provision of benefits is 'in kind', i.e. the third party payer principle.

Figure 1.8 Percentage of total health expenditure financed by taxation and by social health insurance in selected western European countries in 1998 or latest available year

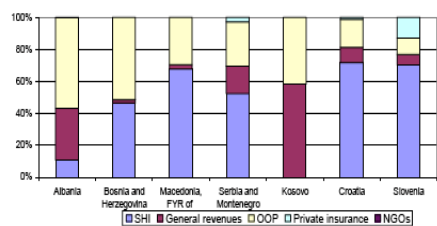


Key: BEL, Belgium; FRA, France; DEN, Denmark; GER, Germany; GRE, Greece; ITA, Italy; NET, Netherlands; POR, Portugal; SPA, Spain; SWI, Sweden; SWI, Switzerland; UK, United Kingdom.
 Source: authors' estimates based on OECD (2000)

SE Europe

The situation is rather different in SE Europe among countries that have only recently acceded to the EU. The figure shows relatively high levels of OOP payments across most of SE Europe.

Figure 1 Sources of health care financing, 2005



Source: WHO NHA database.
 Note: Exact figures are provided in Appendix III; the definition of "private insurance" includes all prepaid, private risk-pooling plans; Kosovo data are for 2004 and the figure does not show the 2.1% of donor funding received in that year.

Funding patterns in low and middle income countries (LMIC)

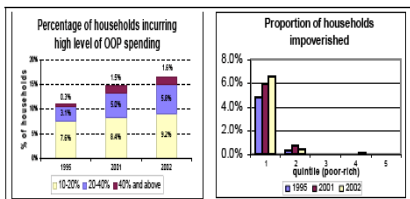
High OOP payments and multiple public and private insurance schemes.

Main mechanisms:

- subsidies to individual within a single risk pool
- subsidies across pools ('risk equalization')
- direct subsidies from the government (either to the individual or the pool)

Strong correlation between high OOP payments and the percentage of families facing catastrophic health expenditure (40% or above of 'non-subsistence income' i.e. income available after basic needs). (Kutzin 2008)

Fig. 3. Measures of catastrophic and impoverishing health payments in Estonia (5)



Equity analysis

- Who bears the risk of health care costs?
