Health Care Financing; Objectives, Functions, and Options

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Tehran, Iran
Introduction; Health spending

- Spending on health has been increasing worldwide including in EMR

- Advances in medical technology, higher population and providers’ expectations, income growth, health system development are some determinants

- Increased inequalities in health spending between and within countries
Investing in health has a high rate of economic return

Share of World GDP allocated to health has increased from 3% in 1948 to 9.8% in 2008 ($5.8 trillion)

- Health is considered a form of “human capital”
  - Affect individual productivity
  - Affects overall economic growth

- Health industry is relatively large and as a service sector employs large share of labor force
Financial barriers continues to be a major obstacle to access health care

Barriers to access health care:

– Cultural barriers

– Political barriers

– Financial barriers
  • Fiscal space
  • Households’ capacity to pay out-of-pocket
Health policies should target reducing out-of-pocket expenditures

Out-of-pocket health expenditure

Risk of financial catastrophe

- Push some households into poverty
- Reduce expenditures on other basic needs
- It is a barrier; may cause households to forgo seeking health care and suffer illness
Risk of financial catastrophe and impoverishment drops substantially with OOPs less than 20%
There are large inequities in health spending in EMR.
HEALTH SYSTEM CONCEPTUAL FRAMEWORK

SYSTEM BUILDING BLOCKS

- Governance
- Health workforce
- Financing
- Health technology

Information Support

GOALS OF HEALTH SYSTEM

- Responsiveness
- Coverage
- Provider performance
- Quality & Safety
- Efficiency
- Financial protection

Service Delivery

Equity

Social Determinants of Health
Healthcare Financing

- Collection
- Pooling
- Purchasing

Financial Protection
Objectives

Collection

raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner to provide individuals with both a *basic package of essential services* and *financial protection against* unpredictable catastrophic financial losses caused by illness and injury

Pooling

manage these revenues to *equitably* and *efficiently* pool health risks allowing for subsidies from healthy to unhealthy, rich to poor, and productive workers to dependents

Purchasing

assure the purchase of health services is strategic and both *allocatively* and *technically efficient* (for whom to buy, what services to buy, from who to buy, and how to pay)
Moving towards Universal Coverage

- Breadth (Population covered)
- Depth & Quality (services covered)
- % Cost covered

Current Pooled fund
Moving towards Universal Coverage

- **Breadth (Population covered)**
  - Extend to non-covered
  - Reduce out-of-pocket payment

- **Depth & Quality (services covered)**
  - Include other services
  - % Cost covered

- **Current Pooled fund**
Complete Universal Coverage is not possible or optimal

Total Health Expenditure

Pooled Funds

Breadth (population covered)

% Cost covered

Depth & Quality (services covered)
Universal Coverage to be understood as; covering all, for most services, at reasonable cost.
HEALTH Financing SYSTEM MODELS

- **DIRECT PAYMENT (out-of-pocket) at point of service** (e.g., prevailing system in most low-income countries)

- **NATIONAL / REGIONAL Government Single Payer System** (e.g., Australia, GCC countries, Finland, Italy, Greece, Sweden, ...)

- **SOCIAL HEALTH INSURANCE – Bismarckian System** (e.g., Germany, Japan, France, Korea, Turkey)

- **PRIVATE INSURANCE Model** (e.g., US)

- **MIXED SYSTEM**

- **MICRO INSURANCE**
Funding by itself may not guarantee social health protection for all

Per Capita Total Health Expenditure; Iran 1995-2007

Catastrophic Health Expenditure and impoverishment; Iran 1995-2007
There is a high degree of correlation between Out-of-pocket and Government spending.

[■ - per capital out-of-pocket payment, ♦- per capita government expenditure]

2000-Constant Prices in Local Currency, 1995-2008
Comparison of Mean and Spread of Per capita Income in Developed and Developing Countries

\[ \sigma_{\text{Developed}} > \sigma_{\text{Developing}} \]
Health Profile and Health Financing system

Healthy

Healthy with Risk Factors

SHI

Acute Illness

Chronic/Disable

Risk Factors

Healthy
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Moving towards Universal Coverage

- % Cost covered
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Current Pooled fund
Financial catastrophe is a problem in low and middle income countries of EMR

Financial catastrophe

Impoverished

I.R. Iran - 2007
Jordan - 2006
Morocco - 2001
Palestine - 2004
Tunisia - 2005
Transmission Mechanism between Health and Income; a two way interplay-micro view

Health

1- Buys more health services
2- Improves life style
3- reduces job related risks
4- Buys more education

Income

1-Improves productivity
2-Reduces medical spending
3-Increases labor supply (quantity & intensity)
4-Reduces time preference
5-Increases saving
6-Reduces fertility
NHS Systems

Financed through general revenues, covering whole population, care provided through public providers or contracting

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<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>– Pools risks for whole population</td>
<td>– Unstable or limited funding due to nuances of annual budget process</td>
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<td>– Relies on many different revenue sources</td>
<td>– Often disproportionately benefits the rich</td>
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<td>– Single centralized governance system has the potential for</td>
<td>– Potentially inefficient due to lack of incentives and effective</td>
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<td>administrative efficiency and cost control</td>
<td>public sector management</td>
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Social Health Insurance

Mandated for specific groups, financed through payroll taxes, semi-autonomous administration, care provided through own and/or contracting

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<td>• Additional health revenue source</td>
<td>• Poor are often excluded unless subsidized by government</td>
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<td>• As a ‘benefit’ tax, there may be more ‘willingness to pay’</td>
<td>• Potential negative impact on employment</td>
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<td>• Removes financing from annual general government appropriations process</td>
<td>• Administrative cost can be high</td>
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<tr>
<td>• Generally provides covered population with access to a broad package of services</td>
<td>• Can lead to cost escalation unless effective contracting mechanisms are in place</td>
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<td>• Can effectively redistribute between high and low risk and high and low income groups in covered population</td>
<td>• Poor coverage for preventive services</td>
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<td>• Often needs to be subsidized from general revenues</td>
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Private Health Insurance

Financed through private voluntary contributions to for- and non-profit insurance organizations, care reimbursed in private and public facilities

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<td>• As a prepayment and risk pooling mechanism is generally preferable to out of pocket expenditure</td>
<td>• Associated with high administrative costs and profit (up to 40%)</td>
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<td>• May increase financial protection and access to health services for those able to pay</td>
<td>• It is generally inequitable</td>
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<td>• When an “strategic purchasing” function is present it may also encourage better quality and cost-efficiency of health care providers</td>
<td>• Applicability in LICs and MICs requires well developed financial markets and strong regulatory capacity</td>
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<td>• Has the potential to divert resources and support from mandated health financing mechanisms</td>
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Financing & Provision of health care; Who pays? Who provides?

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<th>Public</th>
<th>Private</th>
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<td>Public Financing &amp; Private Provision</td>
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<td></td>
<td>• Solidarity in financing</td>
<td>• Competition and Choice in provision</td>
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