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Technical Report 05

Methods of financing health care

A rational use of financing mechanisms to achieve universal coverage

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Summary

National health policies typically focus on improving the population's health and preventing diseases and health hazards so that their entire population can aspire to a healthy and happy life and thus productively contributing to the prosperous development of the country and its economy.

The achievement of national health objectives is eventually achieved through the selection of an adequate and efficient combination of method of financing, organizational delivery structure for health services and payment approach for health providers. In addition, other structural elements contribute to the achievement of health objectives, such as the regulatory framework and programmes of public education.

The approaches to mobilize resources typically include a mixture of general taxation and contributions to public health systems and private health insurance schemes. The main methods of financing for health care include the national health insurance system, general revenue, private insurance, community-based insurance and out-of-pocket payments. The choice of method will impact on who bears the financial burden, the amount of resources available and who manages the allocation of resources.

This paper focuses on the current International Labour Organisation (ILO) priority in the field of health policies – the achievement of universal health coverage – and discusses various approaches towards this priority, that are designed in a coherent manner for each population group through pluralistic methods of financing and delivery systems while ensuring an efficient use of national resources and sufficient solidarity across population groups.

1. Financing – the backbone to national health objectives

National health policies typically focus on improving the population's health and preventing diseases and health hazards so that their entire population can aspire to a healthy and happy life and thus productively contributing to the prosperous development of the country and its economy.

The objectives of a national health system are usually established as the intention of the state and written in the context of national laws, policy documents and other sources that may not be necessarily confined to a single source and may have been adopted at different points in time.

The scope of objectives of the national health system is eventually limited by the extent to which they are affordable in a national context as health objectives are competing with other government programmes. Scarce national resources need to be optimised and rationalized. Depending on the choice of financing mechanisms and sources, the achievement of national

health objectives will be more or less independent of national budget constraints. Affordability needs to be assessed also in relation to the contributory capacity of individuals, employers and other entities paying taxes to the state and other public programmes, such as social insurance schemes. In the end, politicians must determine priority areas of the national health system at the expense of others. As an example, tradeoffs may be required to assign a given amount of resources between providing high quality health services that will improve the country's average health status and building health clinics in all localities, of a lesser relative level in terms of quality, to provide access to health services to the entire population. Affordability questions must recognize the inflationary pressure over time of health expenditure on government budgets and household incomes.

The achievement of national health objectives is eventually achieved through the selection of an adequate method of financing as well as through the choice of an effective and efficient organizational delivery structure for health services and payment approach for health providers. In addition, other structural elements contribute to the achievement of health objectives, such as the regulatory framework and programmes of public education.

The method of financing consists of the way in which financial resources are mobilized and how they are utilized. It is multi-faceted as it relates to different factors including:

- the approach to mobilize financial resources;
- the institutional and organisation delivery structure;
- the allocation of resources;
- the remuneration and incentive method for health providers; and
- others.

The approaches to mobilize resources typically include a mixture of general taxation and contributions to public health systems and private health insurance schemes. The main methods of financing for health care include the national health insurance system, general revenue, private insurance, community-based insurance and out-of-pocket payments. The choice of method will impact on who bears the financial burden, the amount of resources available and who manages the allocation of resources. For example, the mobilization of resources through general revenue requires that the target group to which resources are allocated and health expenditure incurred be the entire population, in principle. How risks are pooled and who is covered determine in the end who can afford expensive medical services. The selected approach to financing should allow the collective pooling of risk that contributes to meeting the broader objectives of equity, solidarity and affordability. Equity takes place at different levels: equity in financing, equity in access to health care, equal level of health status and equity in terms of risk protection offered.

Depending on the choice of method used to finance health services, the type of organisation for health services through public, private or semi-public providers almost directly follows. The selected institutional arrangements indicate to whom powers are given to manage and to

control the implementation of the health system, including powers to decide on the allocation of funds. The choice of organisation of health services reflects to what extent competition among public and private health providers, ownership of the health system, decentralization and integration of health services are desirable under the national health system.

In addition, the other elements that defined financing include the manner to allocate funds to health providers and rationing. Once resources are mobilized, a criteria for their allocation across categories of health services, prevention programmes and infrastructure development must be decided. The allocation also refers to other considerations such as regional allocations across different types of health providers. The set of allocation criteria must be publicly acceptable.

The approach used to remunerate health providers and to create incentives for them will have a great impact on the cost, efficiency and quality of health services provided. The two main elements of the payment system include the method of payment and the amount of payment per unit basis. Different payment methods for health providers exist such as fee-for-service, salary paid to health staff, capitation, per-admission cost adjusted in relation to each case, etc. Health providers can be paid following different payment methods that will affect their behaviours differently. Hospitals are also prone to organize and manage their activities and staff in a different manner according to the selected remuneration approach. The choice of method of payment system largely determines whether it is the health provider or the user of health services who bears the financial risk.

When selecting a method of financing and a manner for organising health care, it must be recognized that these play a key role to control health expenditure inflation eventually. This is an important consideration as per capita health expenditure increases steadily and often at a pace exceeding the growth rate of GDP (gross domestic product) per capita. The health financing approach through general revenue is often considered to offer the most efficient manner to control the inflationary pressure of health expenditure as the global budget can be established and used to limit health expenditure although this approach sometimes generates undesirable side-results such as when it induces undesirable behaviours of some health providers. As previously mentioned, this implies that the health budget competes with other priorities of the government for social and economic programmes. A reasonable balance between the demand and supply for health services is the aim.

The choice of method of financing may be governed by the extent to which it is desirable to allow the influence of the government, social partners and other interest groups to play a role in the implementation and on-going business of the national health system. For example, the population of Switzerland recently voted through a referendum against the adoption of the principle of a national health insurance system. This was explained by various factors including the significant reluctance of a large segment of the population to allow the state playing a dominant role in the management of the national health system.

2. Global perspective on health spending and financing mechanisms

Total health expenditure in recent years amounted to 7.7% of gross domestic product in high-income countries, 5.8% in middle-income countries and 4.7% in low-income countries, according to World Bank figures published in 2006. The government public share of total health expenditure represented 70%, 62% and 52% of the total in high-, middle- and low-income countries respectively. It is observed that as a country's economic development evolves over time the more it tends to spend through public health expenditure as the population demand for better social protection increases. In this respect, national health insurance offers one of the most effective ways to extend protection to as many people as possible based on solidarity principles.

According to the World Health Organisation (WHO), public spending in 2003 through national health insurance programmes was particularly dominant among countries members of the Organisation for Economic Co-operation and Development (OECD) and transition economies of Europe as well as in some Western Pacific and North African countries while private health insurance plays a key role in many Latin American countries and in the United States of America. In Europe, government and national health insurance account for 70% of total health expenditure on average while covering nearly 100% of the general population. It is noted that this takes account of the mandatory private health insurance coverage in the Netherlands and Switzerland.

Personal coverage under national health insurance or other forms of coverage varies greatly across countries. In general it is considered to be deficient in most developing countries. The detailed analysis of trends in personal coverage is beyond the scope of the present paper. It can nevertheless be said that it is closely related to the level of per capita health expenditure. Such per capita health expenditure varies significantly between low, middle and high-income countries. Health spending financed from public, private and other sources ranges between USD1,527 in high-, USD176 in middle- and USD25 in low-income countries.

According to the 2004 national health accounts of the WHO, the funding of health expenditure at the global level is characterized as follows:

- governments contributed 33% of global health expenditure;
- social health insurance schemes covered 25% of global health expenditure;
- private health insurance accounts for 20% of global health expenditure; and
- out-of-pocket expenditure and other private expenditure account for 22% of global health expenditure.

The main finding from these statistics relates to the significantly high global share of out-of-pocket payments, namely as it is highest in low-income countries.[1] The International Labour Organisation (ILO) is concerned that the national health systems of too many countries in the low-income category primarily rely on out-of-pocket payments for health expenditure as these considered to leave the burden of health risk and expenditure on individuals whose families are most prone to enter into poverty if a member becomes seriously ill. This leads to conclude there is a lack of public measures to provide systematic health coverage to people, especially in poor countries.

It is observed that the trend is to use various complementary methods of financing for mobilizing financial resources for health care, especially over the period since the 1990's as universal access to health services has gradually been adopted as a development priority in low- and middle-income countries.

Population ageing worldwide largely influences the projected development of health expenditure. More resources will have to be spent on long-term care and different health services specific to the elderly population. According to OECD data for 2003, the average health expenditure per capita for persons 65 and older in OECD countries is estimated to be about three times higher than that for younger persons. The impact of ageing is estimated by the OECD to increase total health expenditure by about 3% of GDP over the period to year 2050. The expected increase in demand for health services at higher ages and long-term care require that national health systems be adjusted to service this emerging larger number of health services required by the elderly.

3. ILO promotion of universal coverage through rational use of financing mechanisms

In 2001, ILO tripartite members reached a consensus in the course of the General Discussion on Social Security as part of the International Labour Conference of the same year that social security coverage must reach all people. Health coverage is at the centre of the priorities. A difficult challenge is the extension of social security coverage to reach the poor and those engaged in the informal economy through all types of delivery mechanisms. In the case of health risks, this entails access to health services for all. In most countries, health services are provided in principle at a minimum level for all people. However, several barriers prevent the achievement of this noteworthy objective.

The objectives of efficiency and equity of national health systems are heavily influenced by the choice of method of financing to mobilize financial resources, to collectively pool risks, to deliver health care and to remunerate health providers. Most national health systems rely on

[1] Out-of-pocket expenditure ranges between 50 and 80% of total health expenditure in a number of countries of Africa and Asia. For example, the WHO national health accounts of 2006 indicate out-of-pocket expenses were 77% of total health expenditure in Burundi, 82% in Congo, 58% in Bangladesh, and 70% in Cambodia.

more than one method of financing to satisfy the needs of different population groups while some often still remain uncovered by the system.

The ILO gives priority to the achievement of universal health coverage and encourages countries where personal coverage is still deficient to rationalize their resources available for health care through a better use of available health financing mechanisms. In this regard, the ILO attaches particular attention to the active role of the state to adopt legislation that enables universal coverage and elects a funding approach that can satisfactorily ensure resources are made available to provide all health benefits deemed the responsibility of the national health system and that are affordable to all parties concerned. The regulatory role of the state where private health insurance is in place, including community-based insurance and other mutuality-based insurance schemes is key to ensure good governance. These elements serve to establish the rights-based approach to national health systems, namely to include excluded population groups and to adopt methods of financing that covers the health benefits of the whole population while taking due consideration of ability to pay of each population groups.

Where appropriate, the ILO encourages the adoption of action plans towards universal health coverage that are designed in a coherent manner for each population group through pluralistic methods of financing and delivery systems while ensuring an efficient use of national resources an sufficient solidarity across population groups. The national health system of Thailand is considered as a relevant example of a country making a rational use of pluralistic methods of financing. Thailand provides universal coverage through multiple public schemes: automatic coverage is granted to all persons registered with a local health provider (and not otherwise covered by another public programme) which is financed through general revenue, social health insurance is provided to private sector employees through the Social Security Office, the refund of health expenditure is available to public sector employees and their dependants through the Government health scheme.

The combined use of public health services, national health insurance, community-based insurance schemes and mandated private health insurance coverage provide the options for developing an integrated national strategy and framework towards universal coverage.

4. Development of a national health budget

4.1. General considerations

For the purpose of developing an action plan for the extension of universal coverage, the ILO encourages the development and maintenance of a national health budget that reflects all items of spending for benefits, administration and other purposes and all items of revenue from taxes, contributions and private insurance premiums. A national health budget that provides a sufficient level of disaggregation of data should highlight the extent of affordability and coverage so to assist policy makers when adopting adjustments to the national health system.

The national health budget assesses the financial status and development of the national health system and its different organizational/institutional components. When developing a national health budget, the compilation of time series of all expenditure and revenue items according to the various institutions and organizations providing health benefits is used to develop a structure that easily reflects the context of the country. Each expenditure item is analysed to understand patterns of use, how unit cost evolved over time, infrastructure development, administration cost, etc. The analysis should highlight the reference population statistics and external factors to which the use of certain benefits and the unit cost are linked. This serves to develop elasticity factors for the purpose of projections into the future. Projections of the national health budget are normally made for the short- to medium term and should be made in parallel to demographic projections that indicate the extent of personal coverage.

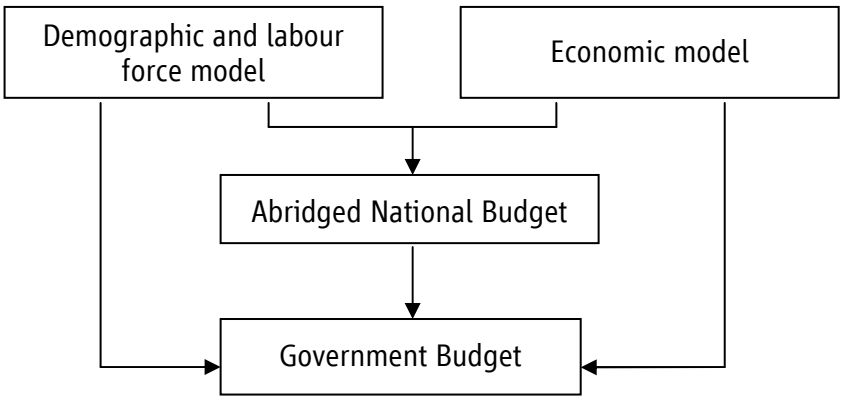
The International Labour Office (ILO) has a generic health budget model that can be used as a starting point to develop a national health budget.

4.2. Thailand national health budget model – an illustration

The national health budget model for Thailand was developed through a close collaboration between the International Health Policy Programme of Thailand and the ILO Social Security Department in 2004. It is provided as an illustration.

The basic structure of the model is mapped out in the following Figure 1. The basic modeling approach follows the ILO general concept of social budgeting.[2] The budgetary analysis was limited to the health sector and its impact on the government budget.

Figure 1. ***Structure of a national health budget model for Thailand, 2004***



Source: ILO, 2004.

[2] W. Scholz et al. (2000): *Social budgeting*, ILO, Geneva.

The model provides classical and pragmatic "if–then" projections as it depends on exogenous demographic and economic assumptions and then simulates their impact on health expenditure and revenues and the government budget.

The national health budget model consists of four deterministic modules projected on the basis of a set of exogenous assumptions:

The first module is a demographic projection module for the general population and the labour force on the basis of assumptions on future developments of fertility, mortality, migration and labour force participation rates.

The second module is an economic projection module that derives employment and wages based on exogenous assumptions such as GDP growth rates, labour productivity and the wage share at GDP.

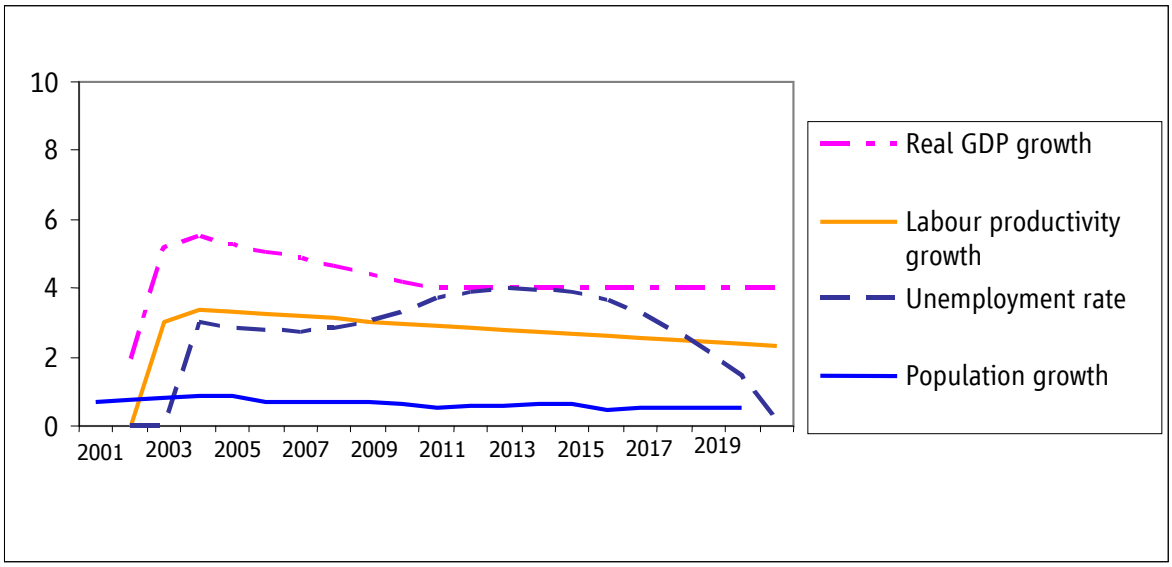
The third module is the main one consisting of the health budget module where projections of health expenditure are performed. Its structure follows the four major health care schemes: universal coverage scheme financed by the government (UC), the health insurance scheme for private employees administered by the Social Security Office (SSO), the civil servant medical benefit scheme (CSMBS) and privately funded health care. It reflects the main methods of financing to mobilize financial resources through general taxation, contributions on earnings, out-of-pocket payments and other private outlays. The key results are overall national health expenditure and the financial requirement for the stage general revenue towards the universal coverage scheme.

The last module consists of the government budget model which expresses public health expenditure and the general revenue resource requirement in the context of the government budget and its future projections. The central result variable is the government annual budget deficit.

The national health budget model is produced in its abridged form and allows to trace the effects of changes in the health delivery and financing system to overall national health expenditure and the government's budgetary balance, i.e. to one global health system performance indicator and a public finance performance indicator. Two model scenarios were developed. The first status-quo scenario reflects the legal status quo. The second scenario for the UC uses identical demographic and economic assumptions and differs only in the health budget module which simulates the introduction of the UC Fund and the implementation of the two major cost reducing measures in the perspective of NHSO (extension of SSO coverage and CSMBS contributions) after 2005.

The model is based on a set of demographic and economic assumptions summarized in Figure 2.

Figure 2. ***Economic assumptions for the projections of the national health budget model for Thailand, 2002-2020 (percentage)***



Source: ILO projections.

Projections of the government budget are based on the assumption that GDP nominal growth will be the main driver for all income and revenue items of the central government accounts that are not explicitly linked to wages, such as revenues from income taxation, and are not imported from the abridged health budget module. Further assumptions are documented in the model itself and beyond the scope of the present paper.

The central results of the projections are summarized in the Figures 3 and 4. Overall health care expenditure, measured as a percentage of GDP, is projected to rise by about 0.3 percentage-points of GDP over the next half decade starting from an initial level of 3.5% of GDP. This is largely an effect of two factors: the assumed substantial real GDP growth rates over the next decade and the fact that the cost development of the major share of public health expenditure is contained through the use of the capitation mechanism which is exercising an overall cost-containment effect on the health financing system as a whole. Total national expenditure is expected to slowly increase back to the original level till 2020 as the GDP growth rates decline.

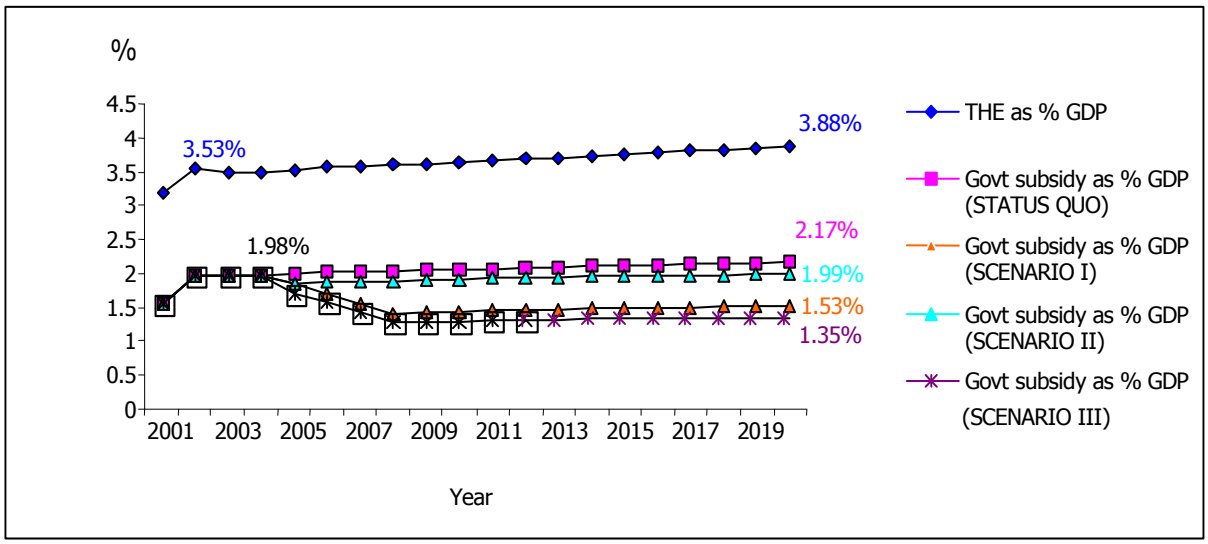
For the status quo scenario according to which the present system is assumed to continue prevailing, the general revenue share in the financing of total health expenditure stagnates throughout the period at a level of 1.98 to 2.17% of GDP.

The first scenario simulates the impact of the suggested revenue increases and cost reductions for the government and the introduction of a special UC fund that would generate earmarked income for the UC scheme form taxes on alcohol and cigarettes.

The second scenario was produced based on the assumption that the social health insurance scheme for private sector employees under the SSO would expand its coverage to non-working spouses and dependants such that its coverage of nearly 8 million persons would increase by another 6 million persons approximately in 2005. This implies that such non-working spouses and dependants who are presently covered under the UC scheme of the government would no longer need to be covered by the UC and this would reduce the burden on the government budget. It is assumed that if the SSO would expand its coverage in such a manner without increasing the level of the contribution rate in the initial period – an assumption made in view of the observed high surplus funds available under the health branch of the SSO – and assuming the state would not introduce additional taxes, this would have the effect of reducing the government spending on health care, namely by reducing its allocation to the UC scheme, from 2.17% initially to 1.99% of GDP by 2020.

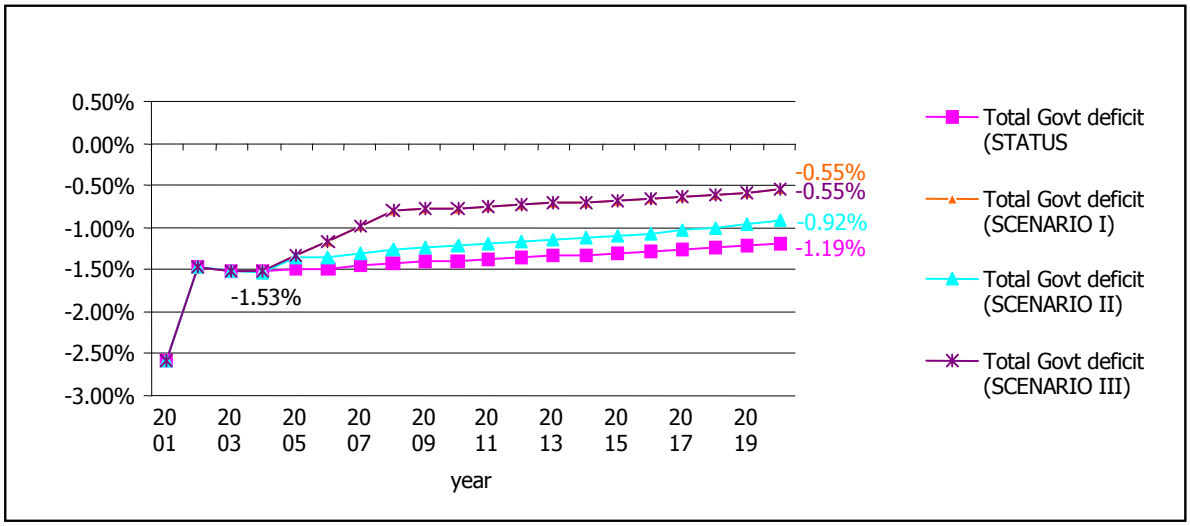
The first and second scenarii were combined together into a third scenario whereby the SSO would expand its coverage to spouses and dependants and the government would introduce additional taxes. This resulted in a decrease of the government expenditure on health from 2.17% initially to 1.35% of GDP by the end of projection period in 2020.

Figure 3. ***Projection total health expenditure Total Health Expenditure (THE) under the national health budget model for Thailand, 2001-2020 (% of GDP)***



Source: ILO projections, 2004.

Figure 4. ***Projection results under the national health budget model for Thailand, Government deficit, 2001-2020 (% of GDP)***



Source: ILO projections, 2004.

5. Review of a pluralistic approach to health financing

Based on the results of the national health budget, areas of improvement to optimize the use and allocation of health resources can be identified. This can be achieved through the adoption or extension of one or more methods of mobilizing resources that will achieve universal coverage ultimately such as:

- introducing universal health care services financed from general revenue;
- improving the effective coverage of existing social insurance schemes and extending their legal coverage definition to the extent possible;
- encouraging micro-insurance schemes, where appropriate; and
- mandating private health insurance, where appropriate.

The advantages and disadvantages of each of these alternatives need to be discussed carefully as presented in Table 1. The following questions should be addressed in the analysis to arrive at an optimal package:

- What is the contributory capacity of the population and its sub-groups?
- What is the capacity of a method to mobilize financial resources?
- Is the method efficient in targeting public funds to the poor?
- What strategy will allow shifting financial resources and powers from the supply to the demand side in order to improve equity, efficiency and quality of health services?
- What is the level of accountability and the quality of budgeting under a method?

Considerations affecting the choice of financing mechanisms for particular sub-groups of the population refer to the number, structure and performance of existing schemes, the political and cultural context, the size of tax base, the size of informal economy, the disease burden, the availability of infrastructure, the capacity to collect taxes, contributions or premiums, managerial capacity, possibilities to enforce legislation and regulation and related impacts on equity.

Table 1. ***Advantages and disadvantages of the main methods of financing health care***

Tax-based health coverage		Social health insurance (including micro-insurance and community-based schemes)		Private health insurance	
Pro	**Con**	**Pro**	**Con**	**Pro**	**Con**
Risk pooling across 100% of population. Fully redistributes between high and low risk and high and low income groups in the covered population. Potential for administrative efficiency and cost control.	Risk of unstable funding and often under-funding due to competing public expenditure. May be Inefficient due to lack of competitive incentives for health providers and potential ineffective public supervision.	Generates stable revenues. Often strong support from population. Provides access to a broad package of services Involvement of social partners. Redistributes between high and low risk and high and low income groups in the covered population.	Poor are excluded unless subsidized by government. Payroll contributions can reduce competitiveness and lead to higher unemployment. Complex to manage. Governance and accountability can be problematic. Can lead to cost escalation unless effective contracting mechanisms are in place. Community based schemes may be financially vulnerable if not supported by national subsidies.	Preferable to out of pocket expenditure. Increases financial protection and access to health services for those able to pay. Encourages better quality and cost-efficiency of health care. providers	High administrative costs. Ineffective in reducing cost pressures on public health financing systems. Inequitable without subsidized premiums or regulated insurance content and price. Requires administrative and financial infrastructure and capacity.

In broad terms, taxes are considered to be an efficient and equitable source of revenue for the health sector. Taxes can be considered as resources leading to the most effective manner for national risk pooling across the whole population and redistributing between high and low risks and high and low income groups. The civil services have the potential to perform administratively efficient and control costs.

However, their potential to contribute to health care financing depends largely on national macroeconomic performance and competing demands from other sectors, the quality of governance, the size of the tax base and human and institutional capacity of the government

to collect taxes and supervise the system. In practice, government schemes often tend to be under funded which might lead to a shortage of goods and services and to under-the-table payments and lack efficient governance.

The success of *social health insurance schemes* depends on the generation of stable resources, the often strong support of the population, the provision of a broad package of services, the involvement of social partners and the redistribution between risk and income groups. However, administratively schemes are complex and governance and accountability can be problematic. Further, from a macro-economic point of view payroll contributions can reduce competitiveness and lead to higher unemployment.

Further, if coverage is not universal, social health insurance might have an impact on equity in countries with important informal economies. It should be emphasized that health care for the work force is not free and that enterprises and the economy have to bear a respective share of the financial burden. In case of social health insurance schemes funding should consist of shared financial resources from both employers and employees. Specific benefits such as maternity benefits specific rules might apply, e.g. full coverage through public funds in order to avoid disadvantages for specific groups protected.

Specific schemes such as private community health insurance schemes can be efficient to collect non-salary-related contributions and reduce costs for the poorest at the point of delivery. However, they often experience problems of coverage and therefore achieving sufficient pooling, difficulties to organize membership across different ethnic groups, management capacity and inadequacy of resources.

A current trend in low-income countries includes increasing the role of mutual health organizations and social health insurance when mainstreaming pro-poor policies in social health protection and addressing issues of high user fees. Also voluntary and community-based schemes are gaining support in many low-income countries. Their success and sustainability depends highly on the attractiveness of benefit packages and quality of services. Increased interest in these schemes is related to coverage of workers in the informal economy and their families. Key issues for sustainability, e.g. with regard to the capacity to pay and adverse selection are currently addressed in creating financial and administrative linkages among schemes at various levels based on different ownerships. Current country examples point to the fact that schemes can work successfully, e.g. in India the Yeshasvini scheme covering some two million workers and their families. In other countries, however, for the time being coverage remains often limited.

Private for-profit health insurance schemes are also found in many developed and developing countries ranging from OECD to developing countries such as Peru and the Philippines. If not subsidized they cover the wealthier part of population based on risk-related premiums. The exclusive character and the high administrative costs are often critized, whereas the better quality of services are appreciated.

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The pros and cons of the various financing mechanisms can be overcome by improving and linking the different approaches. In the context of the development of a coverage plan, an evaluation should be undertaken that identifies mechanisms suiting best with regard to raising sufficient and sustainable revenues in an equitable manner for the provision of adequate benefit packages and financial protection to the whole population.

Given the country-specific nature of the evaluation, there is no general rule on an optimal composition of the portfolio of national health financing subsystems that a country should build up. However, it is suggested that a set of guiding principles be applied during the system building, including equity and solidarity in financing with a view to capacity to pay and equity in access to all health services. This includes risk pooling and sharing contributions payments in social health insurance between employees and employers, inclusiveness of all citizens without discrimination of gender, ethnicity, religion etc.

A health financing policy checklist is provided in the following box.

Check list: Key policies on health care financing

- Mobilizing sufficient resources for achievement of policy objectives
- Equity and solidarity in financing through burden sharing by income level
- Setting up risk equalization and solidarity funds where appropriate
- Maximising risk pooling and reducing fragmentation
- In insurance schemes government subsidies for the poor and informal sector workers and their families (either direct or for contributions/ premiums)
- Minimizing out-of-pocket payments
- User charges referring to the capacity to pay
- Financial sustainability
- Using a mix of health financing mechanisms to accelerate achievement of universal coverage and balance equity, efficiency, and quality of care.
- Efficient and effective use of resources

Usually, extending social health protection requires increasing funds, particularly in public spending on health. However, in many middle and high-income countries revenue collection based on public funds and payroll taxes often encounter perceived limits. The spending on health is perceived as unproductive cost that hampers economic development. In many low-income countries fiscal space and domestic revenues are considered too limited to ensure access to health services for the majority of the population.

Further, mobilizing additional government resources usually requires functioning formal economy whereas in many low-income countries large informal economies exist. Increasing fiscal space is key for increased sustainability of social health protection. It often involves changes in governments' policies and – for countries relying on international aid – more sustainable support from donors. Most successful methods to increase fiscal space through government policies include:

- more efficient use of public expenditure;
- strengthened efficiency in public institutions and service delivery;
- budgetary reallocations;
- increased efforts to collect taxes and contributions; and
- introduce new sources of funding for the national health budget.

These approaches require strong political commitment, priority setting towards extending social health protection and addressing issues of transparency and accountability. In this context, it is crucial that a democratic management is established and based on tripartite governance. This also refers to a participatory approach of management of schemes and governance based on social and national dialogue between policy makers, social partners, civil society groups, public and private insurers, health care providers, and others.