# Overview of the Morning

| | |
|---|---|
| 9.30 – 10.30 | **Health Care Financing (I)**<br>**Revenue Collection** |
| 10.45 – 11.45 | **Health Care Financing (II)**<br>**Pooling** |
| 12.00-1.00 | **Health Care Financing (III)**<br>**Purchasing** |

# Objectives of the Morning

- Understand the basic concepts & components of Health Care Financing (HCF)
- Examine the role of user fees and their equity implications
- Understand notion of fiscal space and its implications on revenue generation
- Distinguish between principal ways of funding health services and paying providers

Imperial College London

# Health Care Financing

# Lecture 1: Revenue Collection

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# Health Care Financing

Background

# Key Functions of Health Financing

## 1) Collecting Revenue

- Collecting income in the form of money or its equivalent and can come from a variety of sources

## 2) Pooling collected Funds

- Pooling different forms of revenue to allow governments to support health systems programming

## 3) Purchasing Services

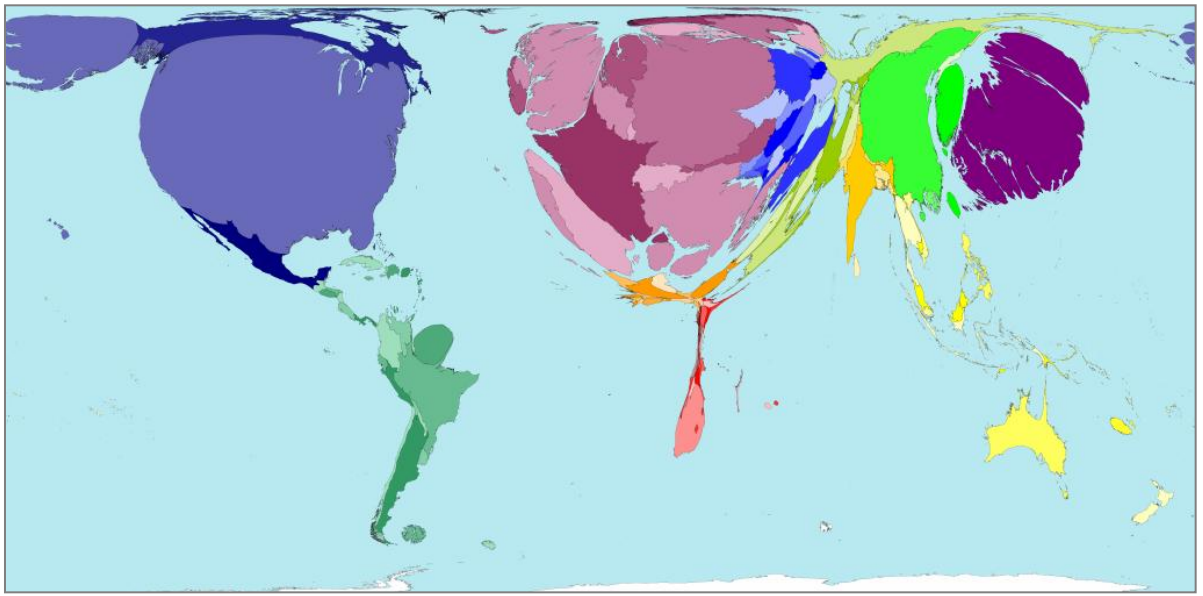
- Payment of service

# 3 Stylized Health Financing Models

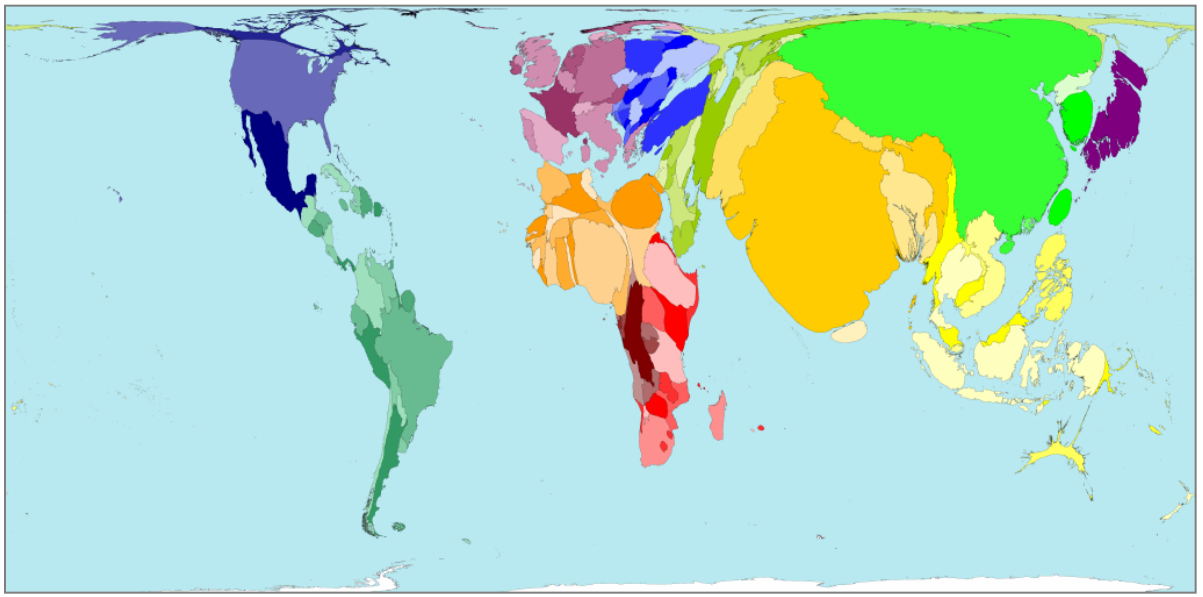
1. **National Health Service**
   - Compulsory, universal coverage (UC), national general revenue finance, and national ownership of health sector inputs
2. **Social Insurance**
   - Compulsory UC under a social security (publicly mandated) system financed by employer and employee contributions to nonprofit insurance funds with public and private ownership of sector inputs
3. **Private Insurance**
   - Employer-based or individual purchase of private health insurance and private ownership of health sector inputs

Gottret & Schieber (2006)

Public spending on health

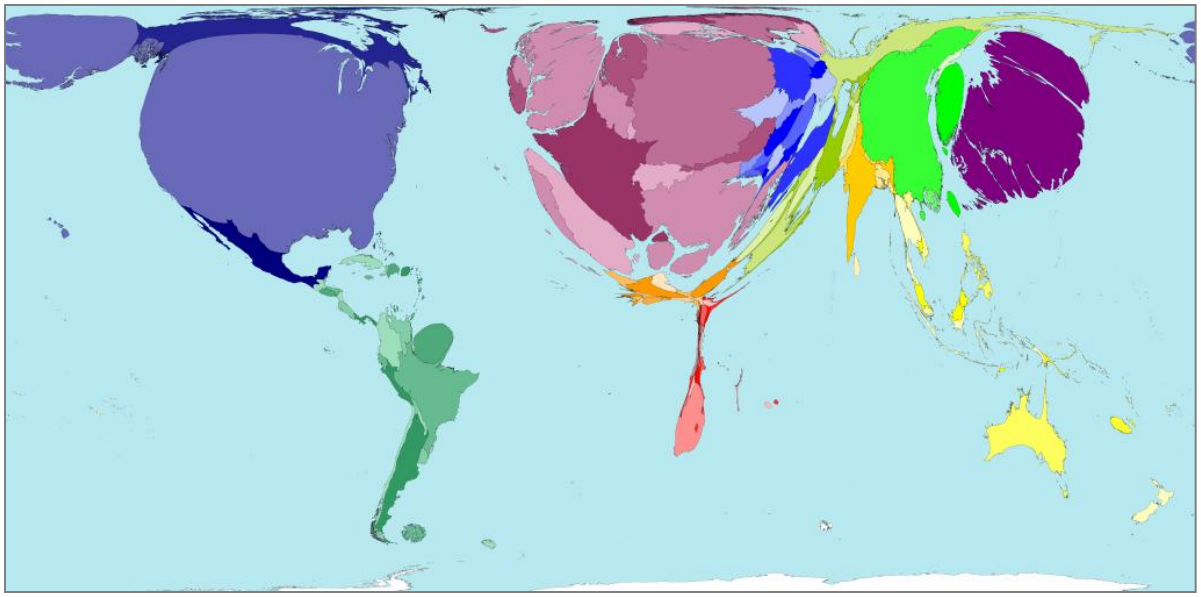


Population



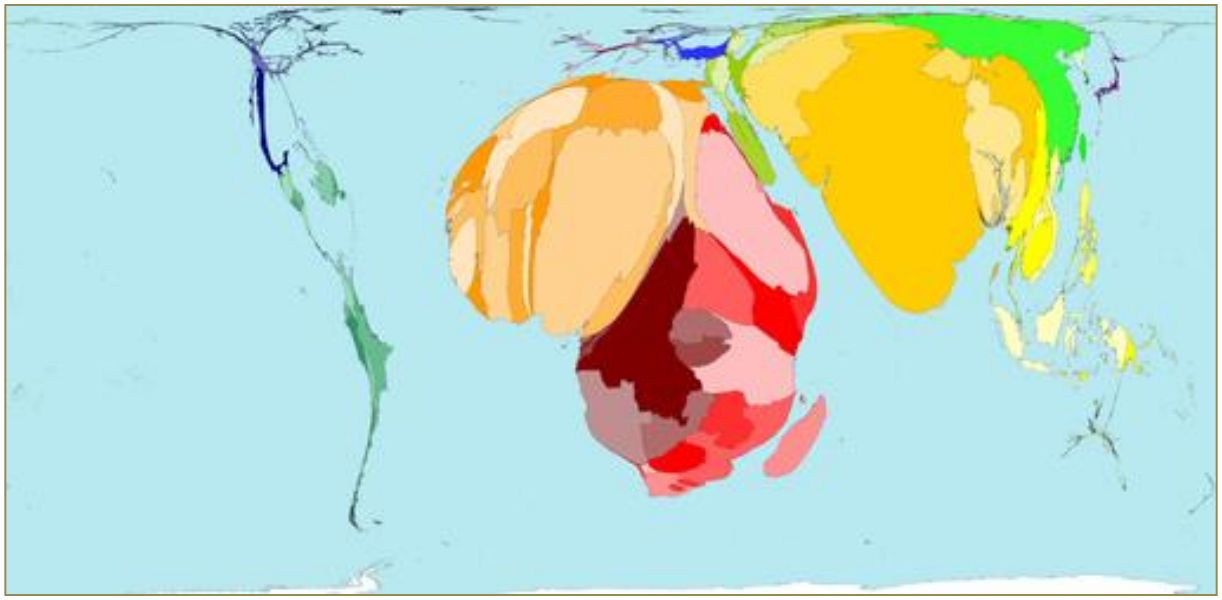
Source: www.world mapper.org

Public spending on health



Source: www.world mapper.org

Mortality 1-4 years



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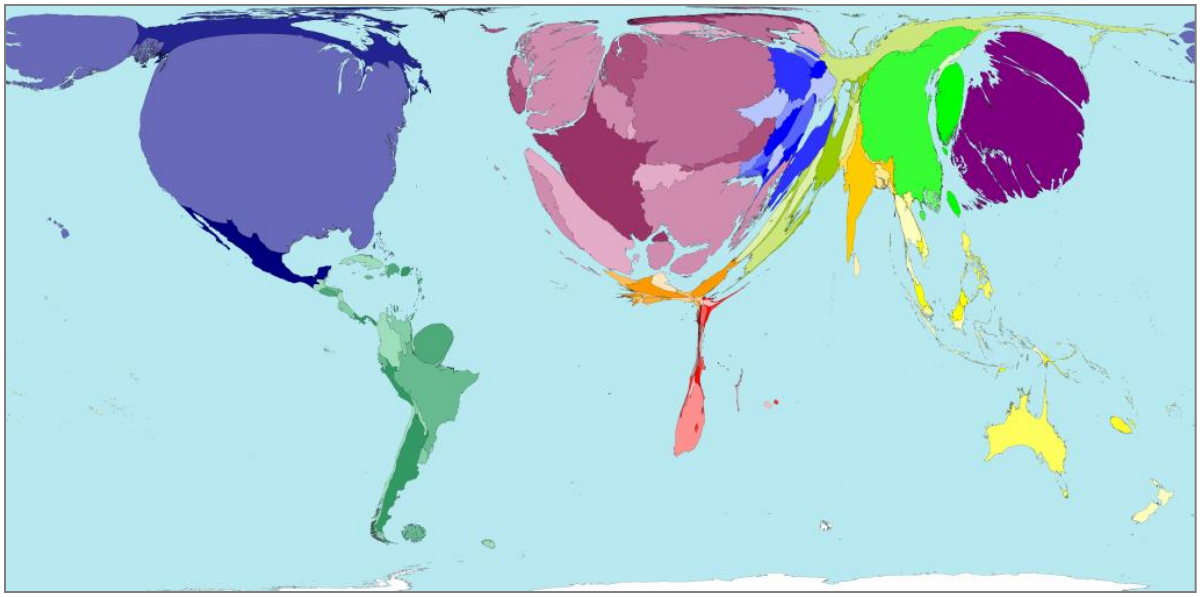
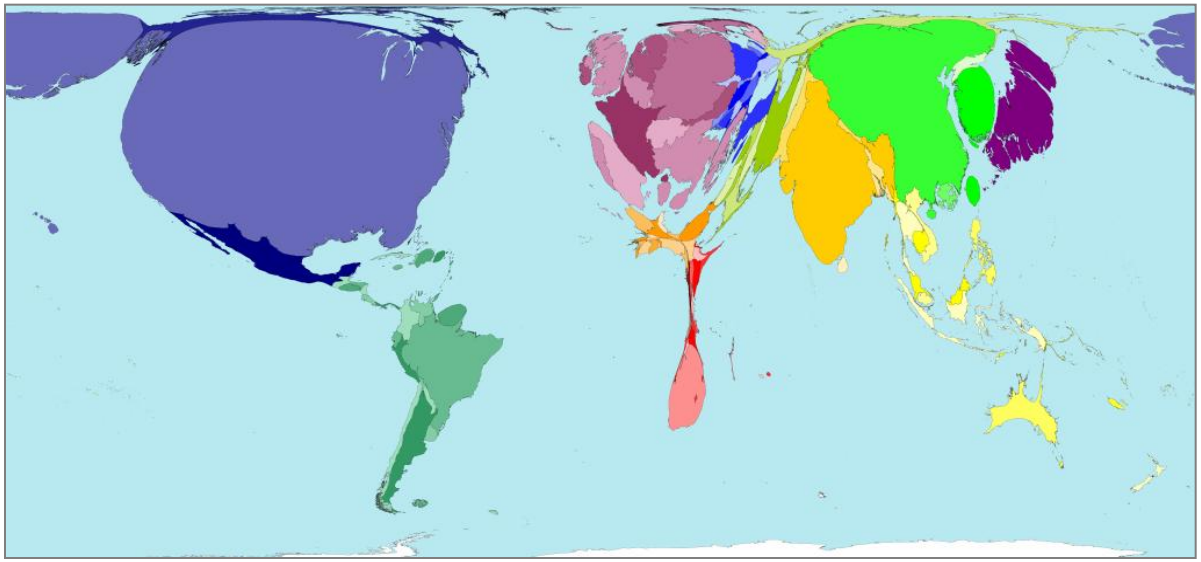
Public spending on health



Private spending on health



Source: www.world mapper.org

# HCF functions have important implications for (i)….

- funds available (now and in the future) and the levels of essential services and financial protection,
- fairness (equity) of the revenue collection mechanisms to finance the system
- economic efficiency of revenue-raising, in not creating distortions or economic losses in the economy,

Gottret & Schieber (2006)

# HCF functions have important implications for (ii)….

- levels of pooling and prepayment
- numbers and types of services purchased and consumed and their effects on health outcomes and costs (allocative efficiency),
- technical efficiency of service production (maximum possible output from a set of resource inputs),
- financial and physical access to services

Gottret & Schieber

# Revenue Collection

Where do we find the money to pay for health care?

# Revenue Collection

Government's collect revenues through:

- **General Taxation**
- VAT
- Sin taxes (tobacco and alcohol)
- **External income through donations**
- **Grants form bilateral and multilateral agencies**
- **From individuals who pay for health services in public and private facilities**

# General Taxation

# Role of Government Expenditure

- How much are government collecting in general tax revenue?
- How much of this general tax revenue is spent on healthcare?
- How does government spending on health care compare to private spending (OPP and prepayments)?

# Where does the UK Gov't get it's money? Tax Revenue

| | Revenue (£bn) | % Tax Revenue |
|---|---|---|
| Income Tax | 156.7 | 28.7 |
| National Insurance | 97.7 | 17.9 |
| VAT | 82.6 | 15.1 |
| Corportation Tax | 44.9 | 8.2 |
| Council Tax | 24.6 | 4.5 |
| Tobacco duties | 8.2 | 1.5 |
| Alcohol Duties | 8.5 | 1.6 |
| Betting & Gambling Duties | 1.5 | 0.3 |



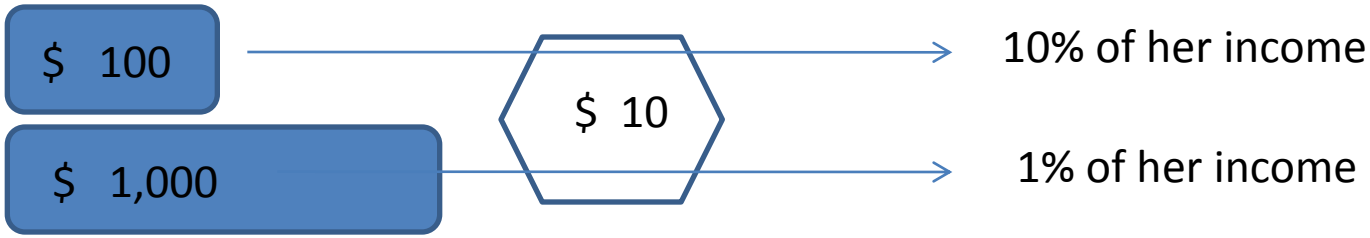
Source: HM Treasury Pre-Budget Report 2008

# Horizontal Equity

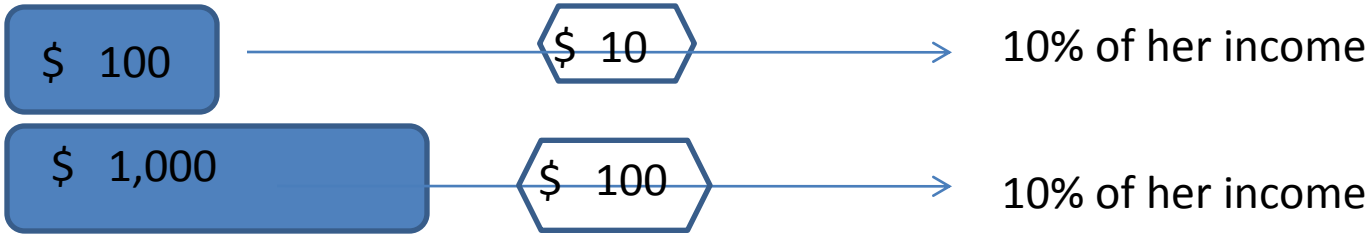
- Equal opportunities in access for equal (health) needs
- Inequity when obstacles to access for some

# Vertical Equity

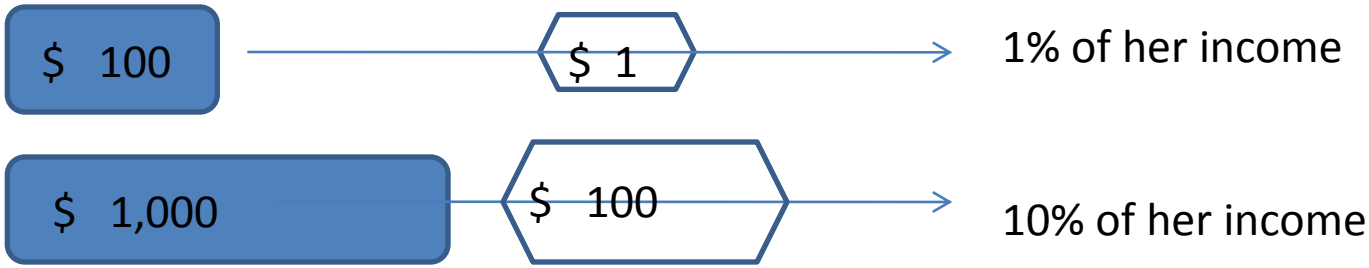
- Regressive financing




- Equitable financing

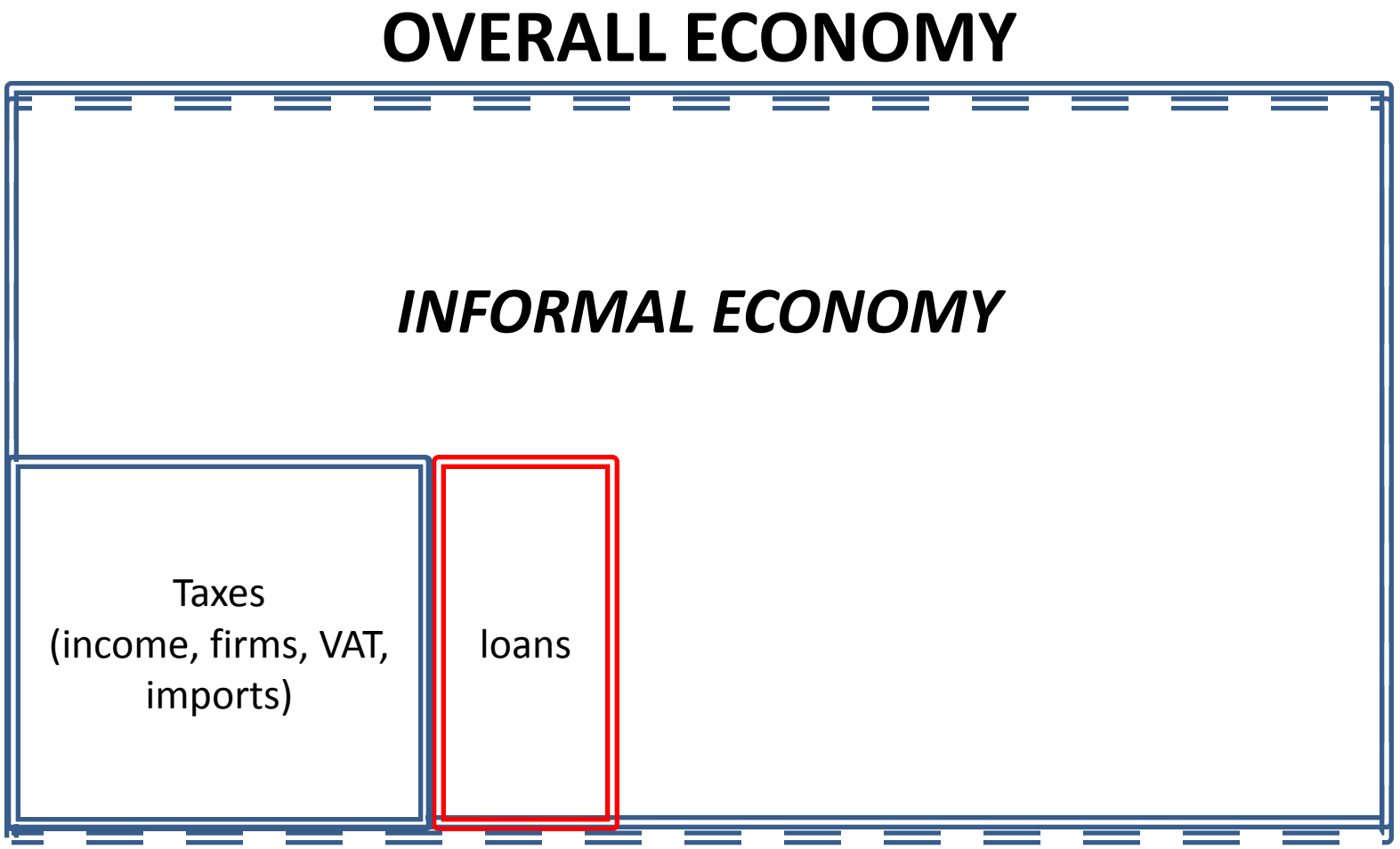



- Progressive financing




Slide courtesy of Dr Mylene Lagarde

# Limitations of tax-based systems in LMIC



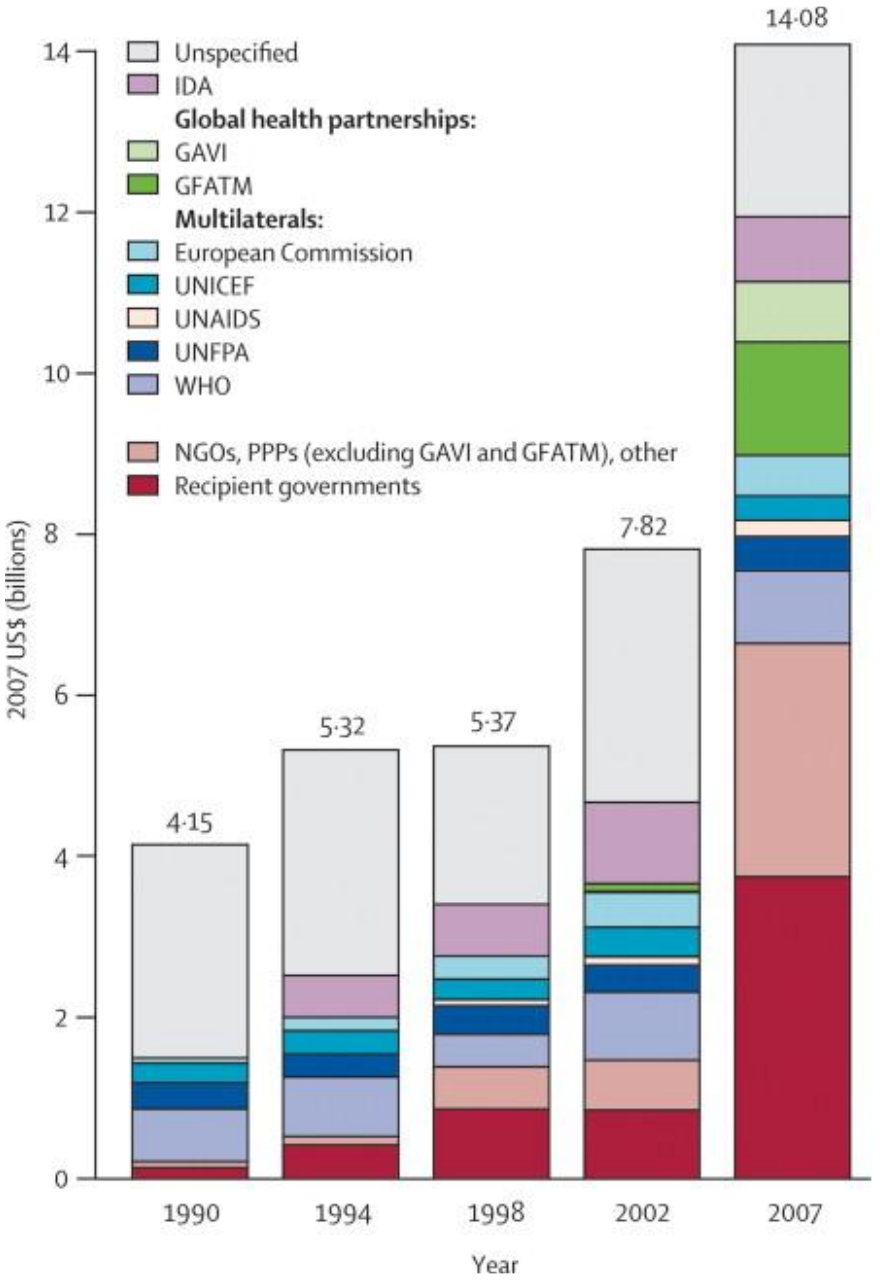
# Limitations of tax-based financing

- Faced with increasing needs
  - High burden of disease
  - Insufficient health systems/infrastructure
  - Escalating costs of health services

- Need to increase limited resources
  - Limited budget allocated to health
  - Limited national budget
  - Limited ‘fiscal space’

# External donations and grants form bilateral and multilateral agencies

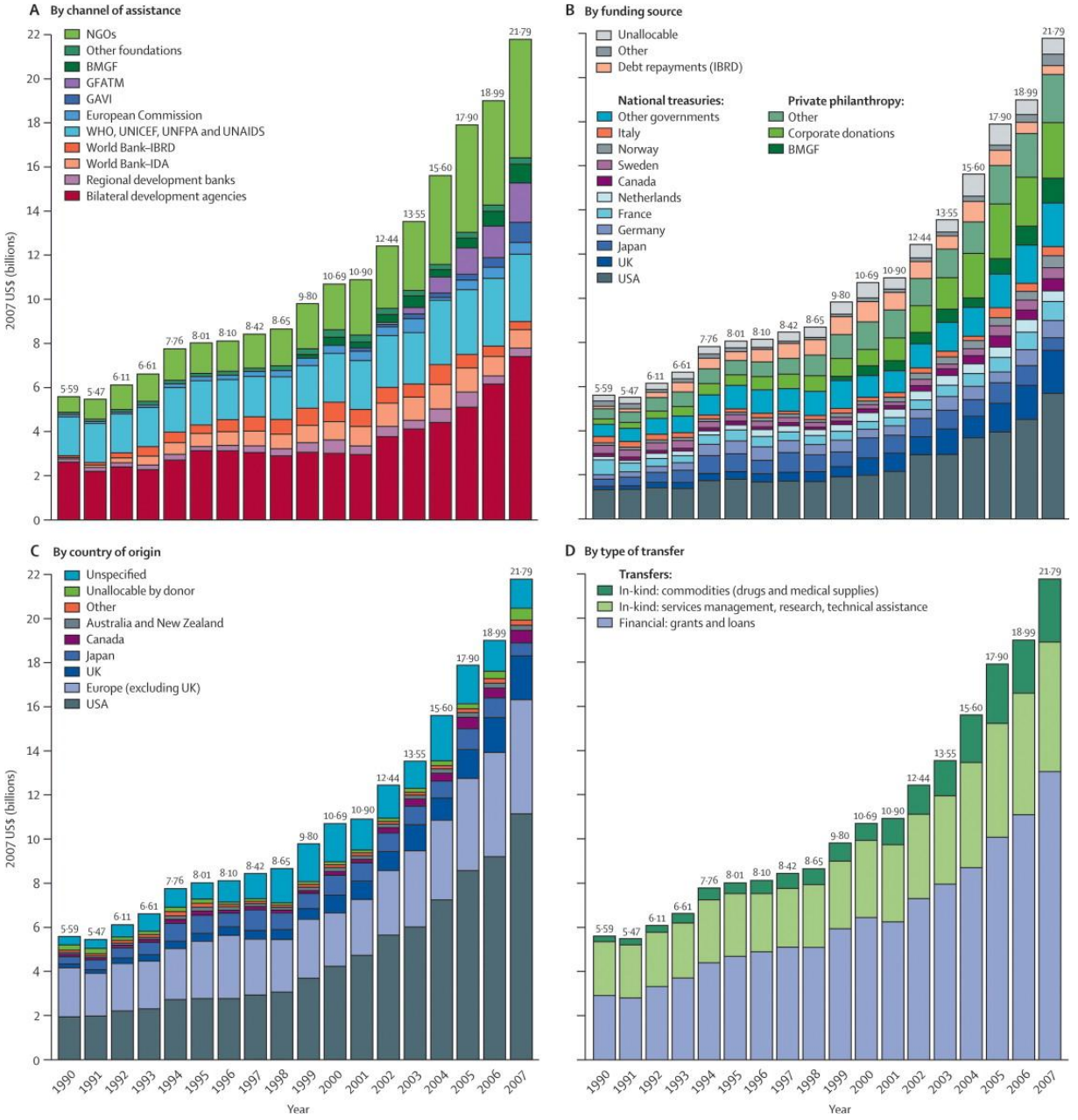
# Funding Flows




The Lancet 2009; 373:2113-2124

Ravishankar et al (2009)

# Funding Flows




The Lancet 2009; 373:2113-2124

Ravishankar et al (2009)

Individuals who pay for health services in public and private facilities

- User fees
  - ‘Official fees charged by public health care providers’
  - ‘Unofficial user fees’

- Insurance based – different forms of copayment

# Discuss……

What are the pros and cons of user fees in low and middle income countries?

# User fees and equity

- Horizontal inequity
  - Only those who can afford it benefit from health services
  - The better off benefit from better health care (private sector)

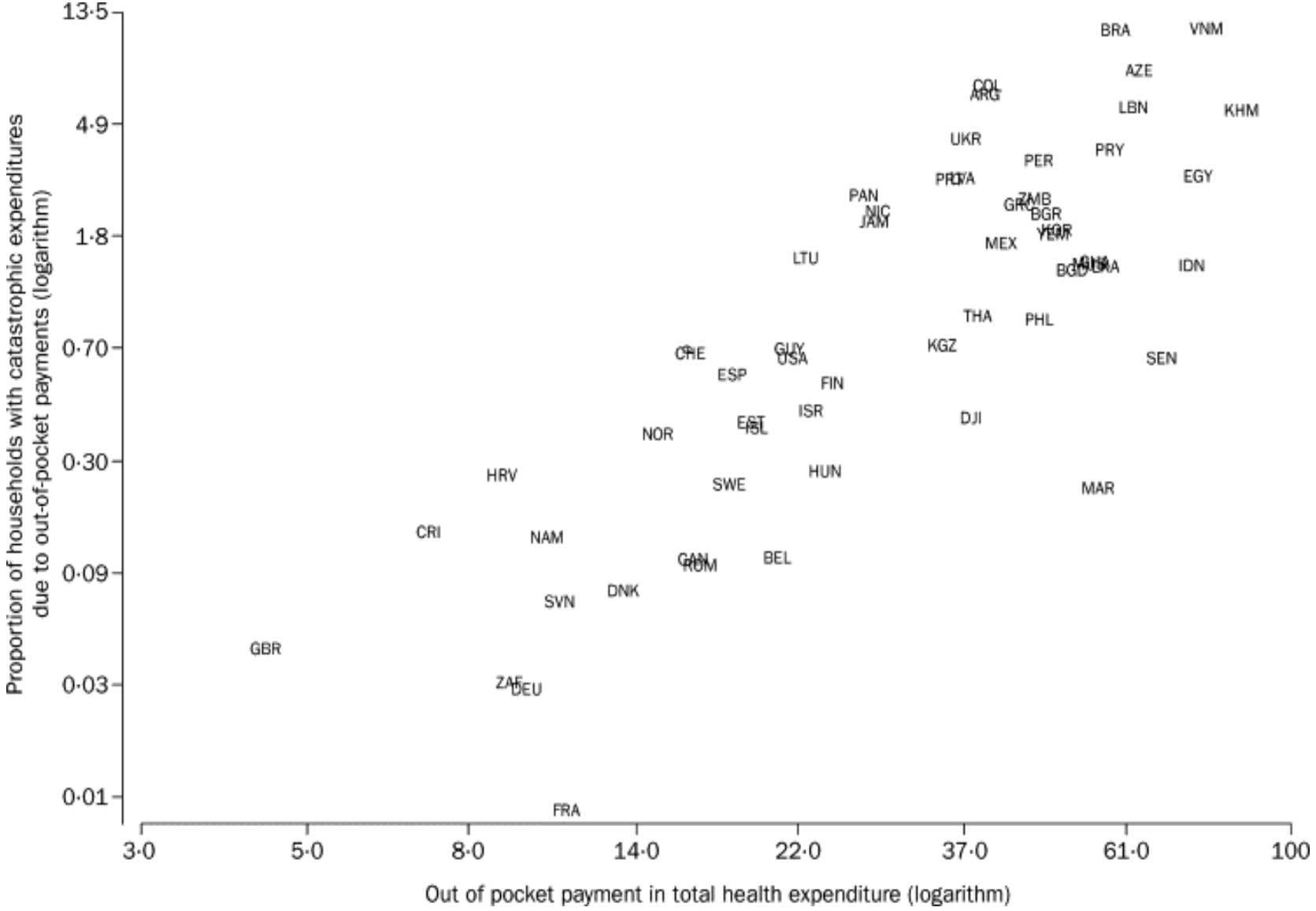
- Vertical inequity
  - Flat fees
  - Catastrophic health expenditures for the poorest
  - Coping strategies  may make the household fall into poverty (vicious circle..)

# Household catastrophic health expenditure: a multicountry analysis

- Data from hhds surveys in 59 countries
- Catastrophic if a hhds financial contributions to the health system >40% of income remaining after subsistence needs met.
- Proportion of hhds facing catastrophic payments from OOP health expenses varied widely between countries
- Three key preconditions for catastrophic payments were identified: (i) the availability of health services requiring payment,(ii) low capacity to pay, and (iii) the lack of prepayment or health insurance.

Xu et al (2003)

# Household catastrophic health expenditure: a multicountry analysis




Proportion of households with catastrophic expenditures vs share of out-of-pocket payment in total health expenditures. Log-log plot is used because the relation not linear. Xu et al (2003)

# The failure of exemption schemes

- Failure of targeting
- Failure in management
- Failure in funding

# DIFFICULTY TO IDENTIFY THE "INDIGENTS"

**Eligibility criteria for waivers in selected MOH health care facilities (Kenya)**

| Attributes relating to the patient | Facility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Occupation | X | X | X | X | X | X | X | X | X |
| Mode of dressing/hairstyles | X | X | | X | X | X | X | X | X |
| Mode of transport to hospital | | | | X | X | X | | | |
| Recommendation by local administration | | X | | X | X | | X | | X |
| Direct observation | | | X | | X | X | X | X | X |
| Number of dependents/family size | | X | | X | | | | | |
| Nature and type of relatives | | X | X | | | | | | |
| Number and type of accompanying family members | X | | X | X | X | | X | X | |
| Length of stay after discharge" | | | X | | X | X | X | | |
| Recommendation by social worker | | X | | | | X | | X | |

Bitran and Giedion (2003)

# Exemptions not enforced

**% of exempted patients paying full user fees (Ghana)**

| REGION | Indigents | Pregnant Women | Child welfare clinic | Curative care, children <5y | Health care for patients >70y | TB | Other exempted diseases |
|---|---|---|---|---|---|---|---|
| Ashanti | - | 100 | 100 | 100 | 60 | 67 | 100 |
| Brong | - | 50 | 38 | 100 | 63 | 0 | 40 |
| Central | - | 50 | 100 | 75 | 13 | 33 | |
| Eastern | 0 | 82 | 100 | 50 | 73 | 0 | 100 |
| Greater Accra | 25 | 93 | 100 | 94 | 63 | 43 | 100 |
| Northern | 33 | 18 | 0 | 24 | 8 | - | 43 |
| Upper East | 50 | 24 | 0 | 56 | 44 | 0 | 0 |
| Upper West | 50 | 42 | 0 | 31 | 9 | 33 | 20 |
| Volta | 0 | 56 | | 100 | 31 | 0 | 50 |
| Western | 100 | 40 | 60 | 100 | 50 | 33 | |
| **TOTAL** | **40** | **56** | **51** | **71** | **41** | **28** | **36** |

3

Garshong (2001)

?

How many regions are there, where in all categories of exempted patients, some patients' rights to be exempted were respected?

Slide courtesy of Dr Mylene Lagarde

# Efficiency and sustainability of user fees?

| Country | % | Country | % |
|---|---|---|---|
| **Botswana** | 1.3 – 2.8 | **Zimbabwe** | 3.5 |
| **Ghana** | 7.9<br>11.8 – 12.1<br>7.8 | **Cote d'Ivoire** | 3.1 – 7 |
| **Guinea-Bissau** | 0.5 | **Mali** | 1.2 – 7 |
| **Kenya** | 2.1 | **Senegal** | 4.4 – 7 |
| **Lesotho** | 5.8<br>9 | **China** | 24<br>36 |
| **Mozambique** | 8<br><1 | **Swaziland** | 2.2<br>4.6 |
| **Yemen** | 3.3 | **Salvador** | 4 |
| **Papua New Guinea** | 3 | | |

Creese and Kutzin (1995)

Slide courtesy of Dr Mylene Lagarde

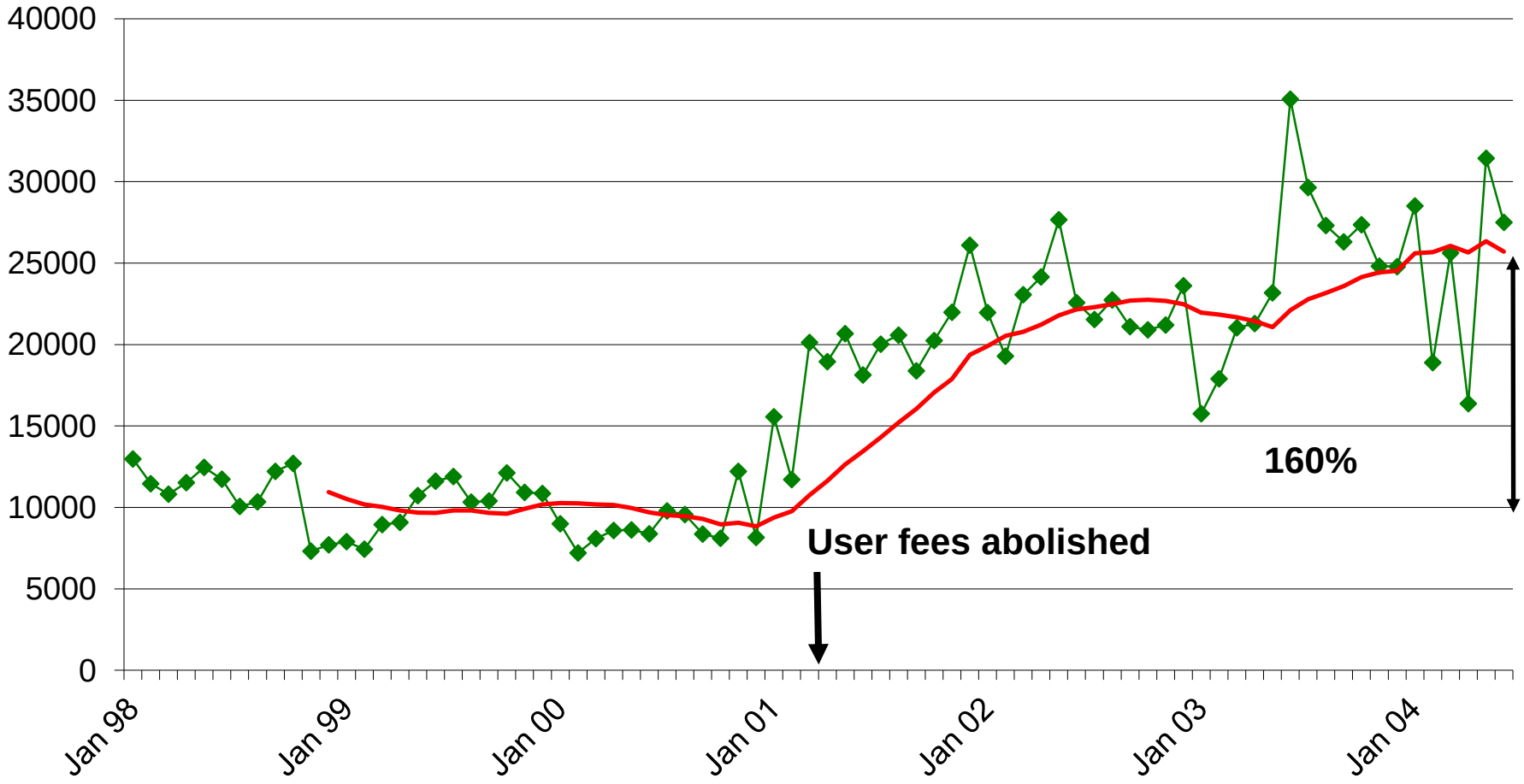
# Moving away from user fees

- Growing consensus against user fees
  - Huge body of evidence on inequity and impact on access to services
  - US government, Dfid, SCUK
  - WB: “no blanket policy”

- Consequences on policies in LMIC
  - Abolition of user fees
  - Introduction of risk-sharing mechanisms

# Impact of user fee removal on utilisation

Slide courtesy of Dr Mylene Lagarde




**Evolution of Total Monthly Outpatient Attendances in Kisoro District (Uganda) from 1998 to 2004**

# ABOLISHING USER FEES – All good news?

- Who benefits most?
  - Still other costs (indirect, transport)
  - Still exclusion of some groups

- Adverse consequences (Zambia, SA, Uganda)
  - Demotivated personnel $\Rightarrow$ informal charging
  - Shortages of drugs $\Rightarrow$ buying in the private sector

# Discuss…..

1) What are the main sources of revenue in your country?

2) What do you think are the equity & efficiency implications of the revenue generation modality used in your country?

# Fiscal Space

- The availability of budgetary room that allows a government to provide resources for a desired purpose **without any prejudice to the *sustainability* of a government's financial position**

# What are the obvious *sources* of fiscal space?

**Domestic**

- A higher tax burden
- Cutting expenditure
- Reducing debt (via budgetary surpluses or debt relief)
- Enhance the effectiveness of government spending
- Promote a high-growth mix of expenditure

**External**

- Borrowing
- External Grants

Heller (2005 & 2006)

# Discuss……

What are the hazards of a government being too reliant on foreign aid as a source of fiscal space?

# Crowding Out?

| | International health aid % of GDP | | | Government health funding % of GDP | | |
|---|---|---|---|---|---|---|
| | 2002 | 2006 | Change | 2002 | 2006 | Change |
| Benin | 1·1% | 1·0% | –0·1% | 1·1% | 1·5% | 0·4% |
| Burkina Faso*† | 0·7% | 2·1% | 1·4% | 1·6% | 1·7% | 0·1% |
| Ethiopia*‡ | 0·5% | 1·7% | 1·2% | 2·4% | 1·0% | –1·4% |
| Ghana | 1·0% | 1·2% | 0·2% | 2·2% | 1·3% | –0·9% |
| Kenya | 0·7% | 0·7% | 0·0% | 1·7% | 2·0% | 0·3% |
| Madagascar | 1·2% | 1·6% | 0·4% | 2·0% | 1·0% | –1·0% |
| Malawi*‡ | 4·4% | 7·7% | 3·3% | 4·4% | 4·1% | –0·3% |
| Mali | 0·8% | 1·0% | 0·2% | 1·5% | 1·9% | 0·4% |
| Mozambique*‡ | 1·8% | 3·0% | 1·2% | 2·3% | 1·4% | –0·9% |
| Niger*† | 0·8% | 1·9% | 1·1% | 1·4% | 1·4% | 0·0% |
| Rwanda*† | 1·4% | 5·7% | 4·3% | 1·8% | 2·8% | 1·0% |
| Senegal | 0·8% | 0·7% | –0·1% | 1·3% | 3·2% | 1·9% |
| Uganda*‡ | 1·6% | 2·2% | 0·6% | 3·2% | 2·2% | –1·0% |
| United Republic of Tanzania*† | 0·4% | 2·8% | 2·4% | 1·5% | 2·1% | 0·6% |
| Zambia*‡ | 1·7% | 2·4% | 0·7% | 3·0% | 2·2% | –0·8% |

Lu et al (2010)

# Summary

- Tension between ideals and reality revenue collection mechanisms
  - Tax-based health systems are (usually) more equitable.. but how to raise enough resources with small/poor economy?
  - User fees are inequitable .. but useful 'oil' to (some) make things work?
  - External funds can have huge benefits but can also in certain circumstances distort funding flows and priorities

"*Revenue collection in developing countries is the art of the possible, not the optimal*"

- No simple solution
  - Even in high-income countries

- Most systems have multiple funding sources
  - Increasing the available resources
  - Compensating the weaknesses of one mechanism with another

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