Evaluating health care financing options: recent international experience

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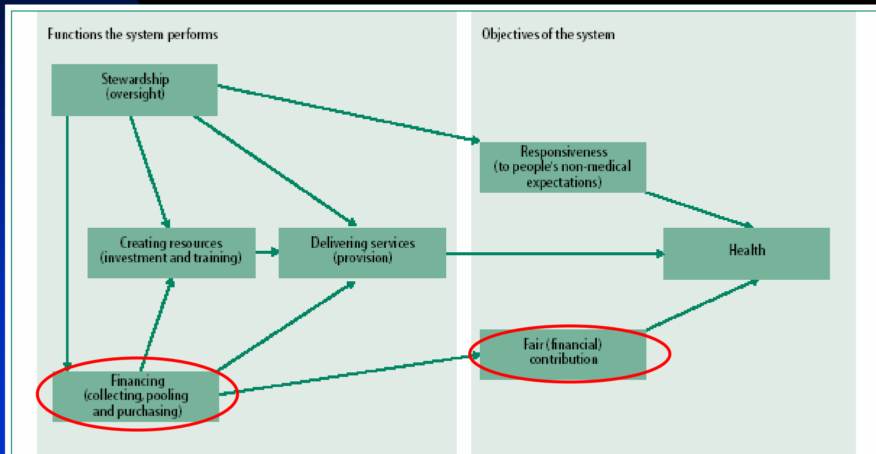
Thoughts from the past

- Historical ‘ideal’ types
- Functional approach of health systems
- From cost containment to efficiency and back again

"Much of what is included in the financing function occurs outside what is usually considered to be the health system, as a process which happens to collect revenues and put them at the system's disposal."



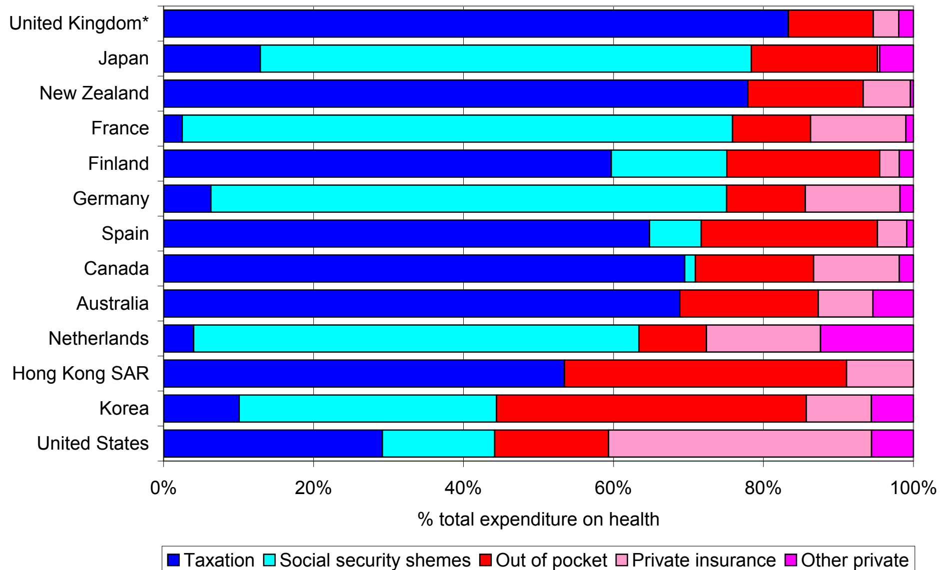
Source: WHO World Health Report 2000

Where we are now?

- Better data from National Health Accounts and Household Surveys
- Some evidence on impact of revenue raising, emerging evidence on pooling and purchasing
- Tension between fiscal objectives and social objectives

Mixed funding

- A little bit of everything, but public funding dominates in most countries
- Finding the ‘right’ mix?
- Not about choosing to replace one funding system with another but altering the mix of revenue sources



Fiscal vs. social objectives

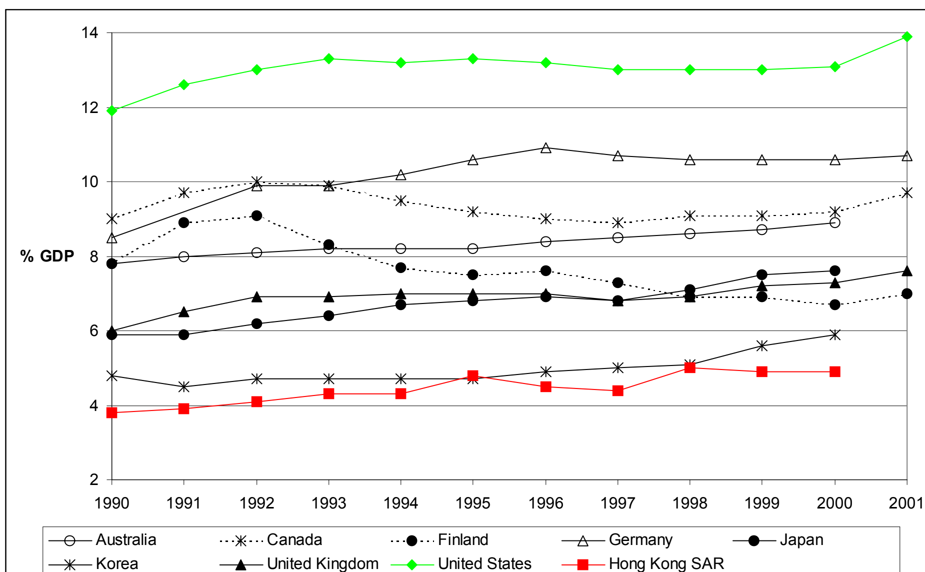
- Fairness of financing
- Redistribution and poverty alleviation
- Encourage economic investment and activity
- Low non wage labour costs
- Trade-offs will have to be made – do we know how much each is valued?

Impact of revenue raising

- Cost containment
- Administrative efficiency
- Progressivity of financing
- Equity of access
- Coverage
- Responsiveness

"Single payer public financing creates an institutional environment encouraging the supply of ingenuity to contain costs; costs are higher in multi source funding systems where ingenuity is diverted into shifting costs onto someone else"
Robert G Evans (2003)

Expenditure on health % GDP



Administrative efficiency

	Private insurers (% income)	Public (% total public)
Canada	13.2	1.3
USA	11.7	2.1
UK	15	3.5
France	10-15 (mutual) 15-25 (commercial)	4-8
Germany	10.2	5.09
Netherlands	12.7	4.4

Source: Mossialos and Thomson (2002); Woolhandler et al (2003); OECD Health Data 2003

Equity of financing

- Direct taxes – progressive in all
- Indirect taxes – regressive except in Spain
- Social health insurance – regressive in Germany, Netherlands and Spain, progressive in France
- Private health insurance – regressive in US and Switzerland

Source: Wagstaff, van Doorslaer et al (1992, 1999)

Equity of access

	AUS	Can	NZ	UK	US
Doctor visit	14% (4%)	9% (6%)	24% (6%)	4% (2%)	36% (21%)
Test or follow-up	17% (3%)	9% (5%)	18% (7%)	4% (3%)	36% (22%)
Prescription	21% (3%)	22% (15%)	20% (9%)	7% (0)	39% (21%)
Medical bills	17% (9%)	14% (11%)	20% (13%)	4% (2%)	35% (24%)

Source:K Davis et al 2004

Coverage

- Based on legal residence / citizenship in:
  - UK, Finland, Norway, Denmark, Sweden and since 2000 France (*Couverture Maladie Universelle*)
- Based on contribution and employment in:
  - Austria, Belgium (self employed)
- Based on contribution and income in:
  - Germany (<€3375 per month 2002)
  - Netherlands (< € 30,700 per year 2002)
- Based on ability to pay:
  - USA (45 million adults age 19-64 or one in four uninsured)

Responsiveness

- Choice of insurer
  - For individually purchased VHI except where age rated premium and non transferable claims record (Germany and Netherlands substitutive)
  - Limited choice for group purchased VHI
  - Germany, Netherlands, Switzerland, Israel and Belgium choice of sickness fund
  - State insurer in tax funded systems (national and local) except Medicare plans, and Swiss subsidised
- Choice of provider (unrelated)

Funding policies

- Increase contribution rate (tax or SHI)
- Widen revenue base
- Introduce or increase copayments, coinsurance rates or deductibles
- Use tax subsidies to encourage purchase of private health insurance
- Reduce benefits or coverage

Recent developments

- Increased taxation or insurance contribution rates – UK, Austria, Switzerland (failed)
- Increasing size of risk pool – China (urban insurance), Korea
- Expansion of coverage – France
- Reduction/ expansion in benefits - Singapore Eldershield, Japan, USA Medicare
- Incentives for private spending – Australia

What This Means

- Important impacts of revenue raising
- Sustainability arguments are often disguising cost shifting
- Need to assess carefully 'real' objectives and impacts

The future

- Where next for health financing research and policy?
- Better data enable analysis linking functions to outcomes
- Further analysis of purchasing and pooling functions
- Clarity of policy objectives and relative values
- Dialogue with Ministries of Finance and Labour/ Trade