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Policy instruments to improve health financing policy

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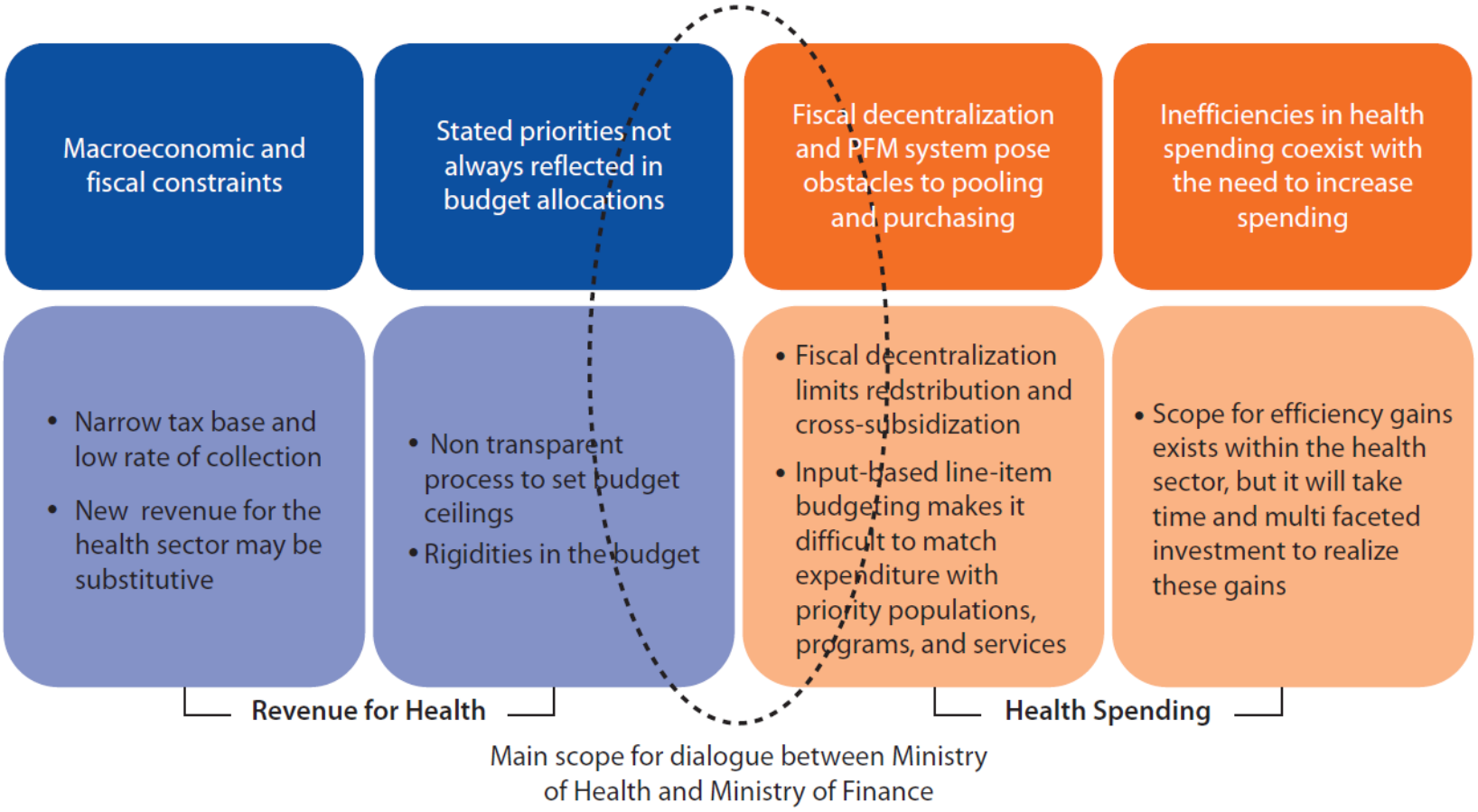
Outline

1. Health financing challenges in low and middle income countries
2. Funding mechanisms and pooling arrangements

Health financing challenges in LMICs

Figure 2.2 Key Challenges in Health Financing in Low- and Middle-Income Countries



Health financing challenges in LMICs

Key questions to understand the macroeconomic and fiscal context

UNDERSTANDING THE MACROECONOMIC AND FISCAL CONTEXT	
Key questions	*Indicators*
How large is the economy; how fast is it growing; and how stable and broad-based is the growth?	GDP per capita (constant prices) Growth rate of GDP per capita Inflation rate Employment rate
How effectively does the government translate economic growth into revenue?	Revenue collection as a percentage of GDP Policies to improve revenue collection
How important is development assistance in overall government revenue?	Net overseas development assistance received as a percentage of GDP Overseas development assistance as a percentage of total government revenue
How much flexibility does the government have to borrow to finance spending priorities?	Gross debt as a percentage of GDP Government deficit as a percentage of GDP

Government spending on health and fiscal space

Fiscal space: Availability of budgetary room for increasing government spending for health without jeopardizing macroeconomic and fiscal stability

$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal context

Public policy priorities

Health financing challenges in LMICs

Key questions to understand the budget process and priority setting

UNDERSTANDING THE BUDGET PROCESS AND PRIORITY-SETTING
Key Questions
How large is the total government budget, and how much of that is discretionary?
How is the budget formed, and how are priorities set?
What share of the budget is made up of international development assistance, and has donor funding been offset by reductions in the government health budget?
Are there areas of the budget that could be targeted for reallocation to health because they are inefficient or exacerbate inequities?
What are the implications of fiscal decentralization for budgetary allocations to the health sector?

Policy instruments

Path to UHC - Many different paths but three common features:

- Political process to create **public programmes or regulations that expand access, improve equity, and pool financial risks**
- Growth in **financial support for health spending**, which buys more health services for more people
- Increase in the **share of health spending that is pooled rather than paid out-of-pocket** by households. (e.g. taxes or mandatory insurance)

Pooled spending is a necessary (but not sufficient) condition for UHC

Funding mechanisms

Funding sources and contribution mechanisms

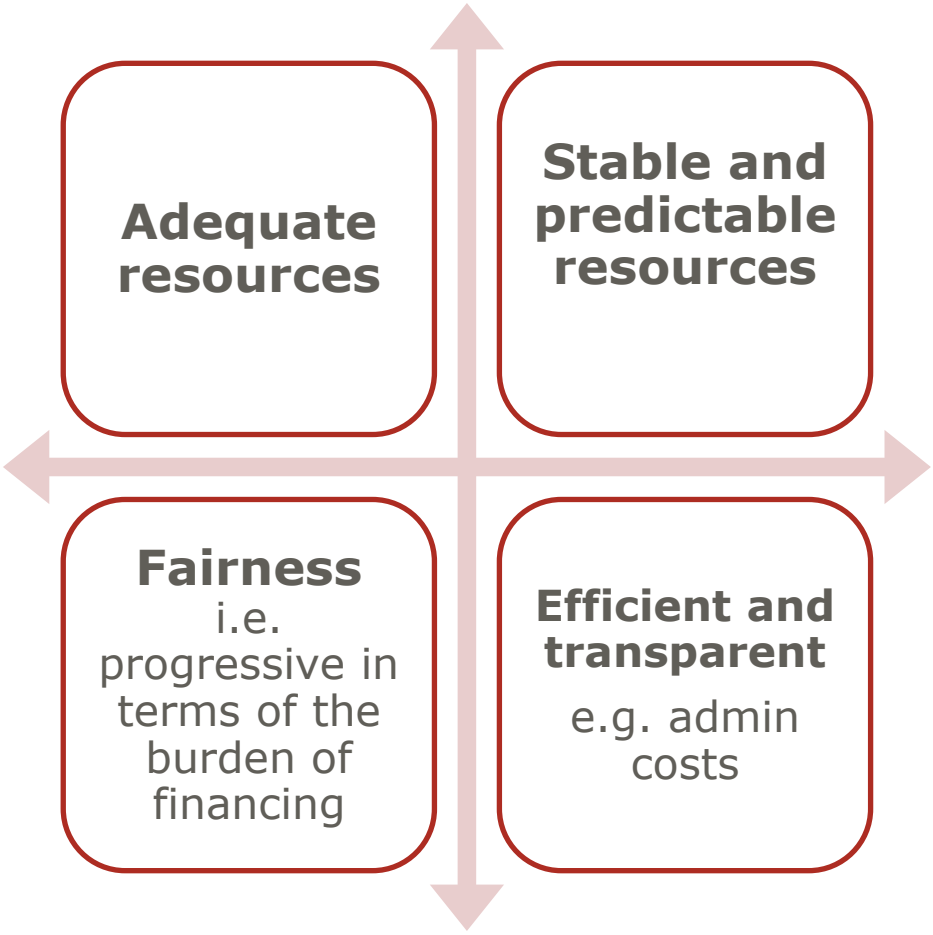
- All funding for health services ultimately comes from households or firms

- All countries adopt a mix of contribution mechanisms

How much is adequate?

- **Money will never be enough!!**
  - In many LICs and MICs still unmet needs and low expenditure
  - Variation and weak correlation between health expenditure and health outcomes
  - In HICs until recently high rates of growth in health expenditure – the crisis may have changed the trend

Raising fund mechanism objectives



The mix of mechanisms is important

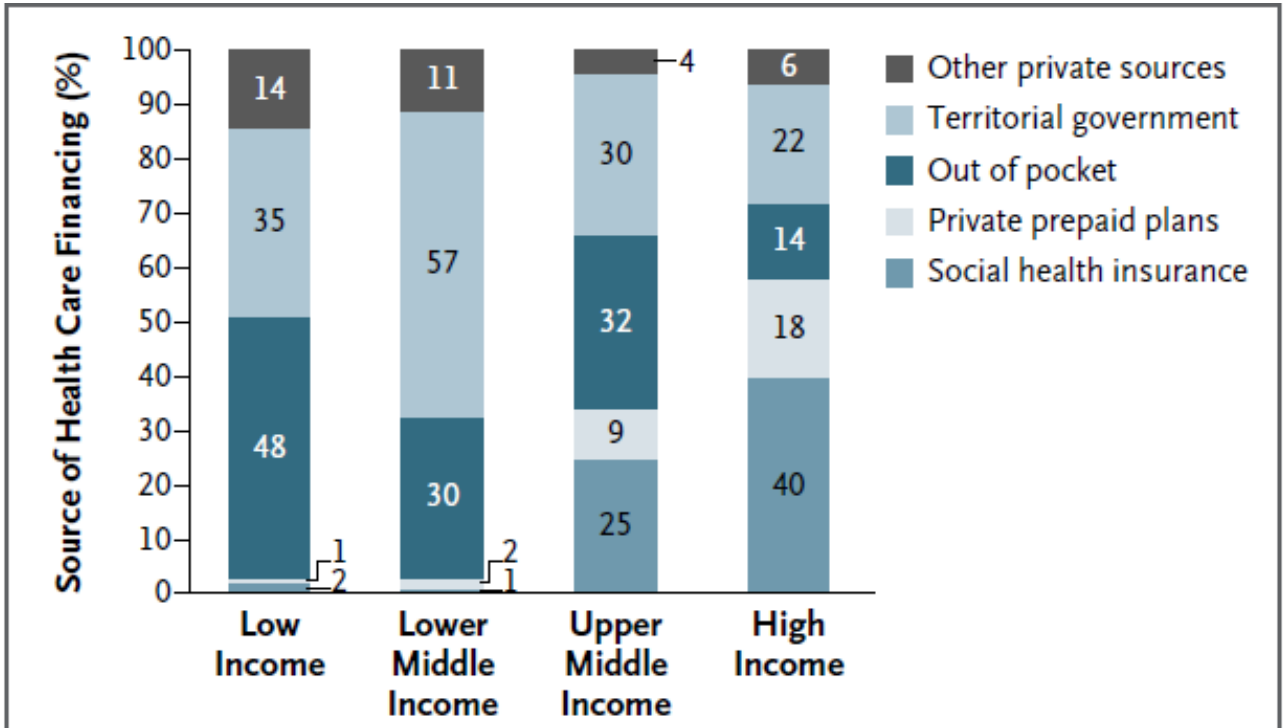
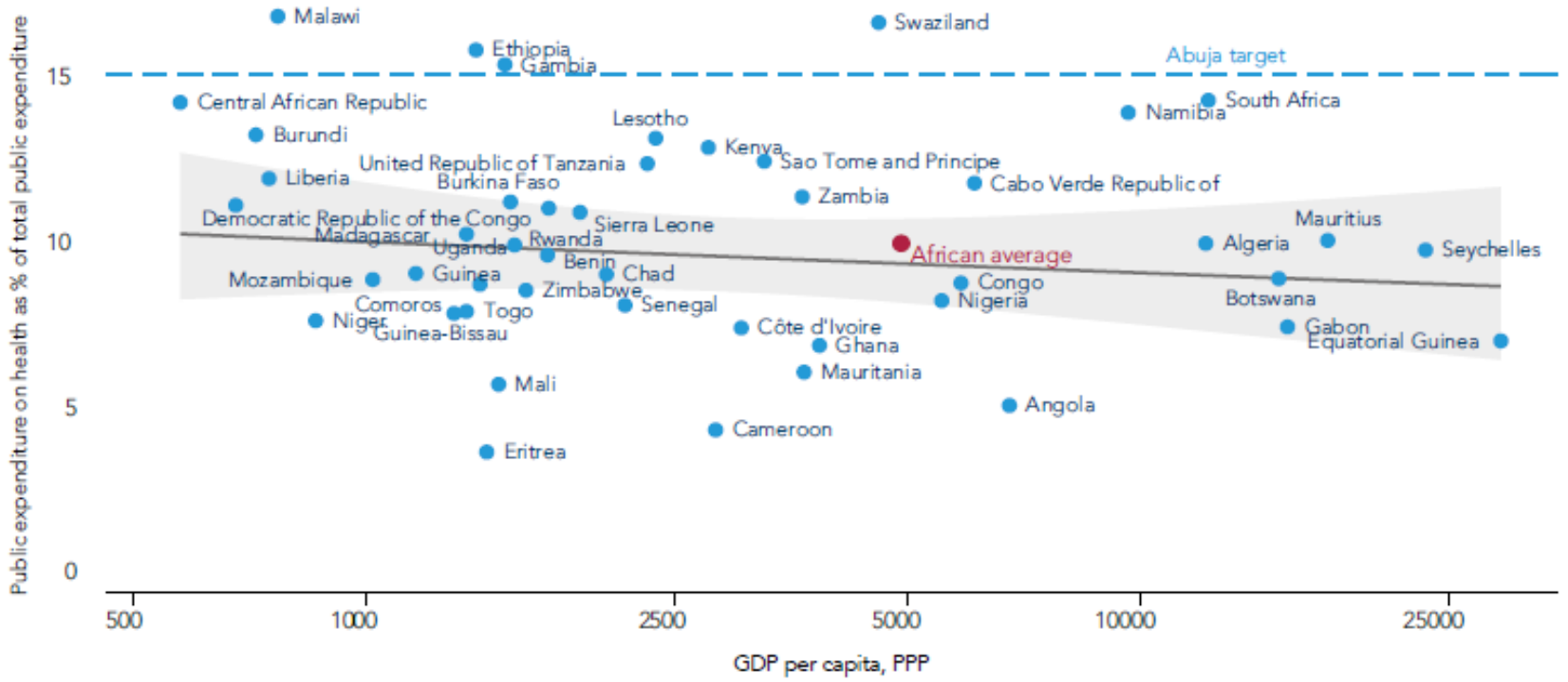


Figure 1. Sources of Health Care Financing According to Country Income.
Data are from the World Health Organization.[10]

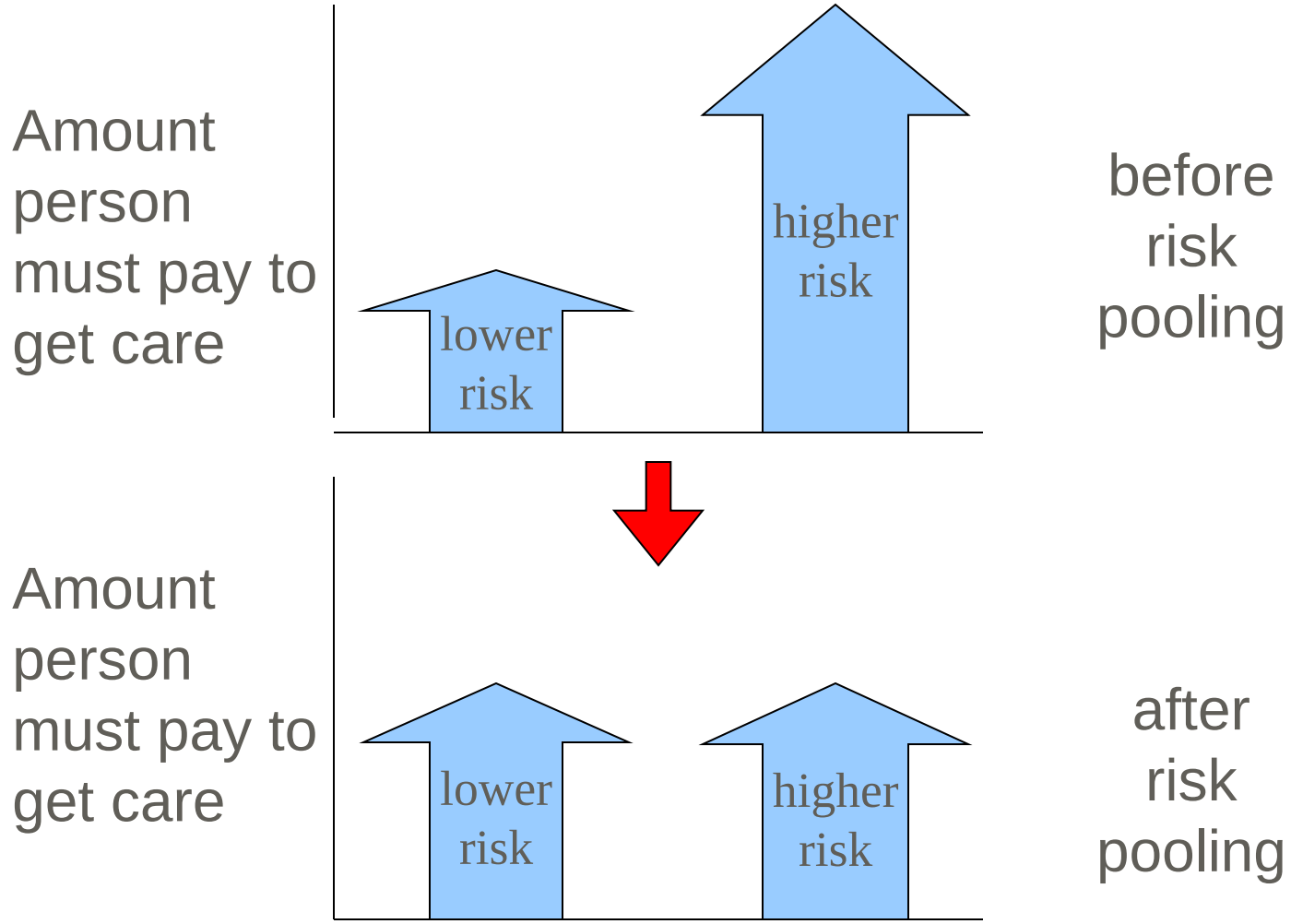
Variation in how countries prioritise health

Figure 2: Government health prioritization and GDP per capita, 2014



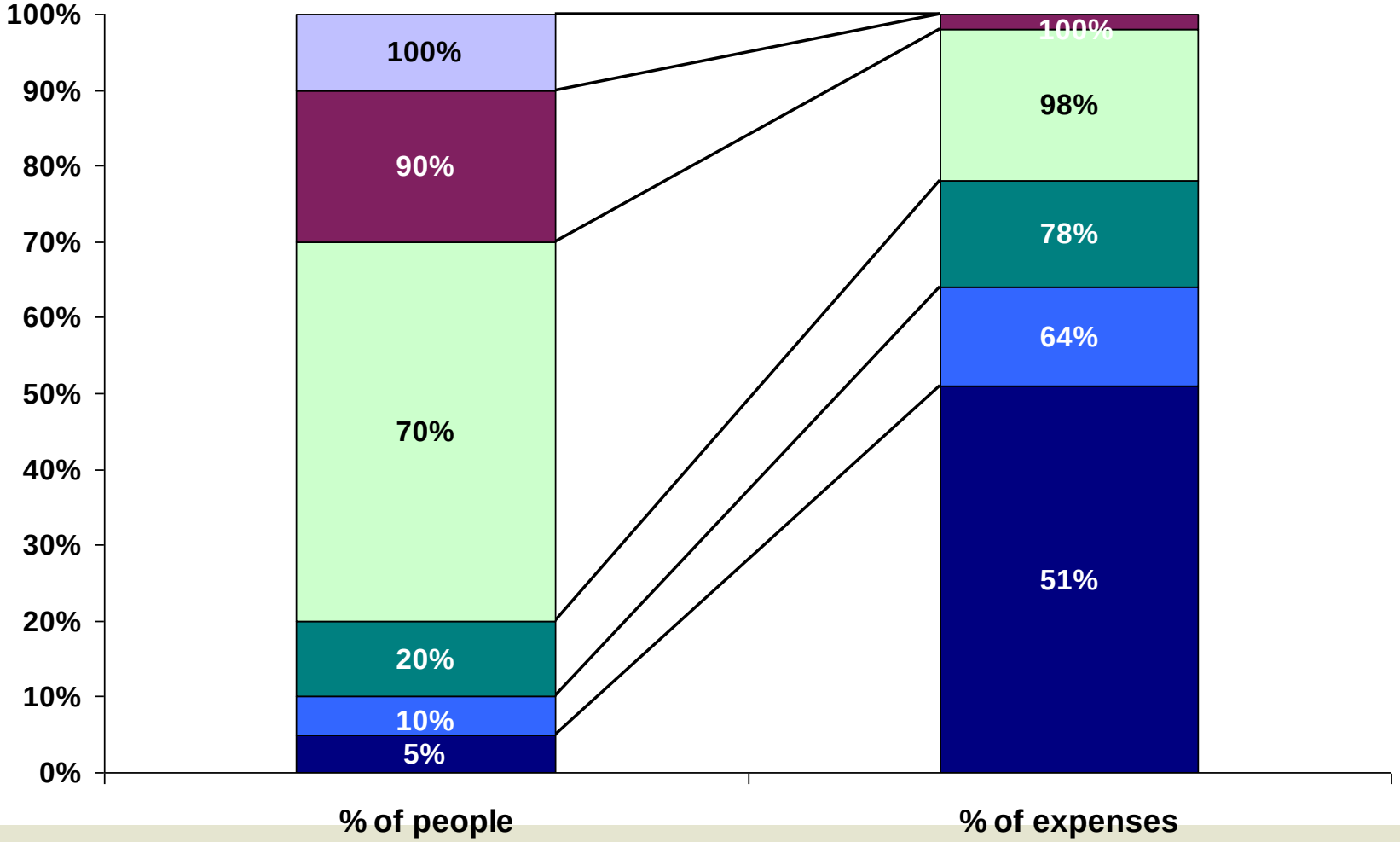
Source: Global Health Expenditure Database, WHO, 2016

Why risk pooling?



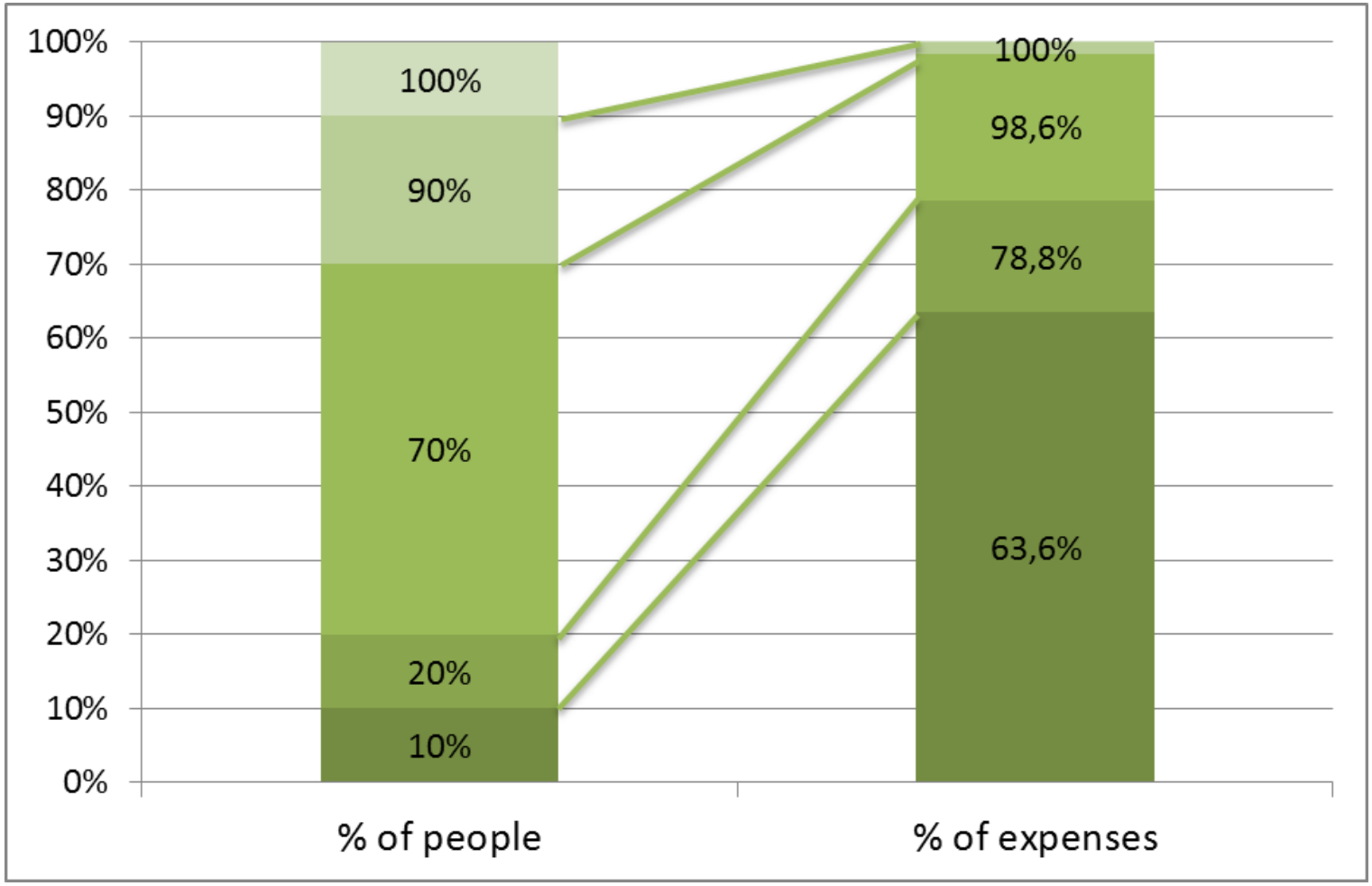
Source: Baeza et al. 2001

Concentration of total health expenditures, France 2001



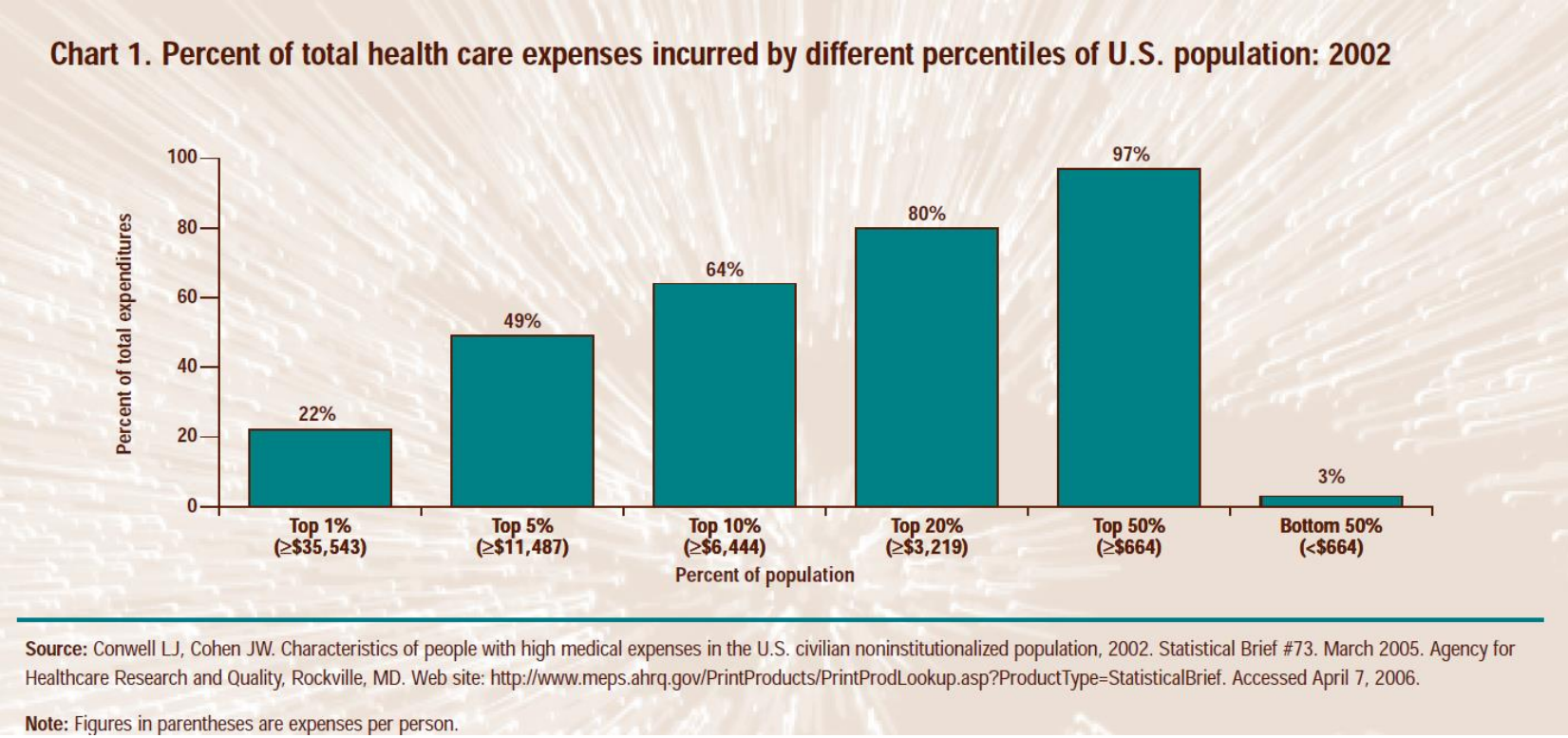
Source : CNAMTS/EPAS

Concentration of total health expenditures, Germany (2011)



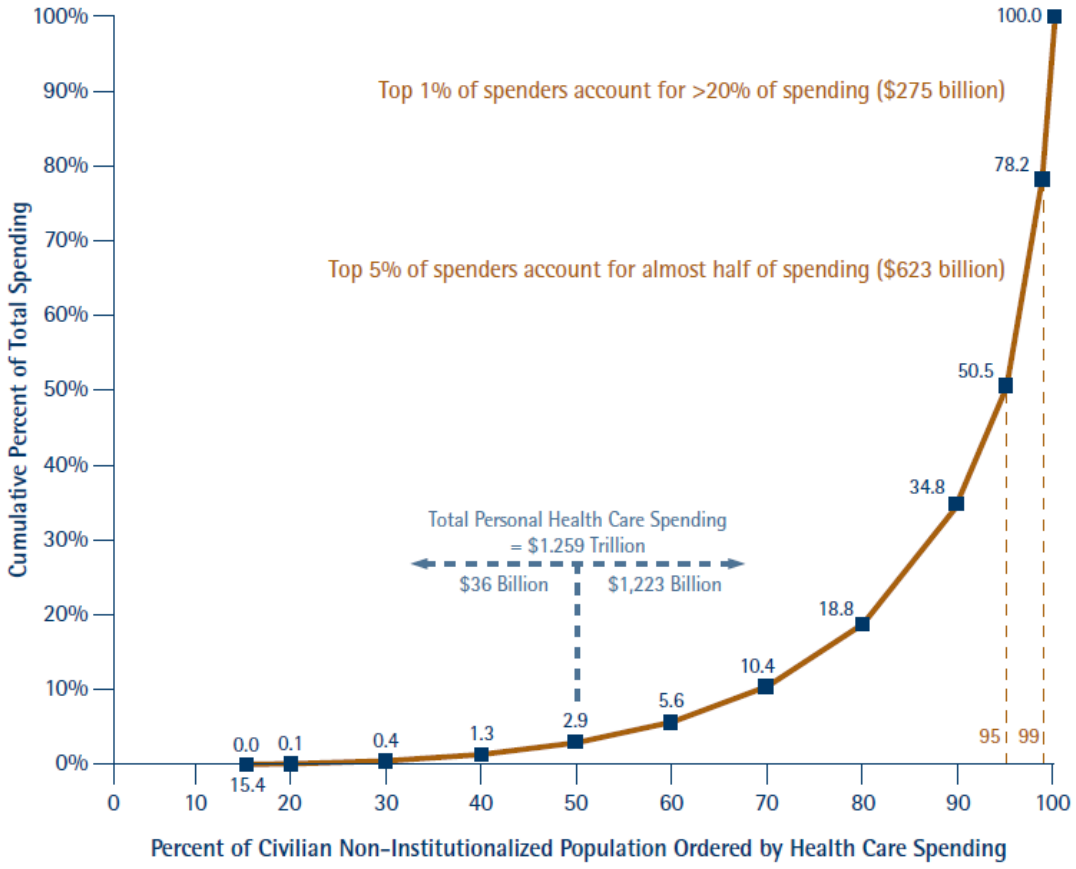
Source: Buchner/Göpffarth (2014): Risikostrukturausgleich als ‚technischer' Kern der Solidarischen Wettbewerbsordnung, in: Cassel/Jacobs/Vauth/Zerth (eds): Solidarische Wettbewerbsordnung, Heidelberg, in print

Concentration of total health expenditures, USA



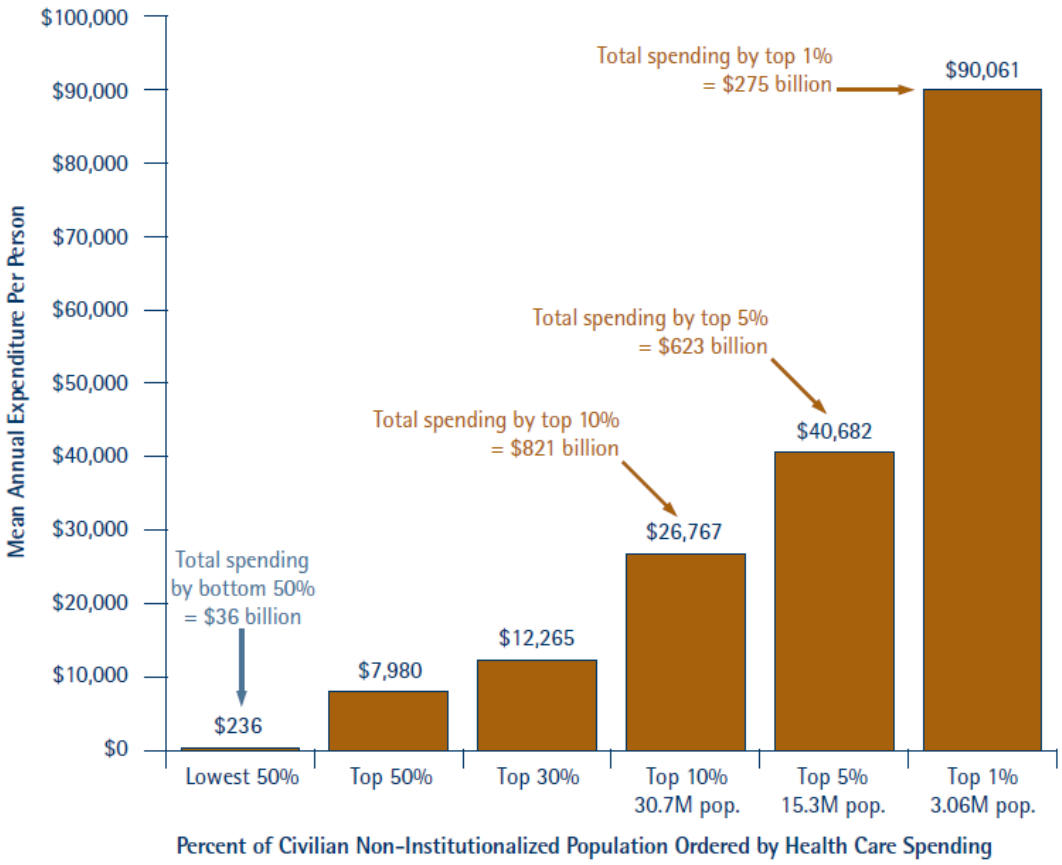
Concentration of total health expenditures, USA

FIGURE 1. CUMULATIVE DISTRIBUTION OF PERSONAL HEALTH CARE SPENDING, 2009



Concentration of total health expenditures, USA

FIGURE 2. MEAN PER-CAPITA SPENDING BY SPENDING GROUP, 2009



Pooling arrangements and UHC

- If the policy objective is to move towards UHC – e.g. promoting financial risk protection and equity in service use relative to need

- **Health financing should be redistributive**

- **Which characteristics?**
- Size: large or small?
- Risk mix: similar or diverse?
- Participation: compulsory or voluntary?

Pooling arrangements and UHC

	Taxation	Social insurance	Voluntarly insurance	OOP
Size of pool	+++	++	+	-
Risk mix	+++	+++	+	-
Participation	+++	+++	-	-

Pros and cons of contribution mechanisms

- **Taxation**
  - Some progressive, others regressive
  - Funds allocated through Government budgets
  - Macroeconomic and fiscal constraints
  - Competition from other sectors
  - Potential to allocate efficiently and equitably

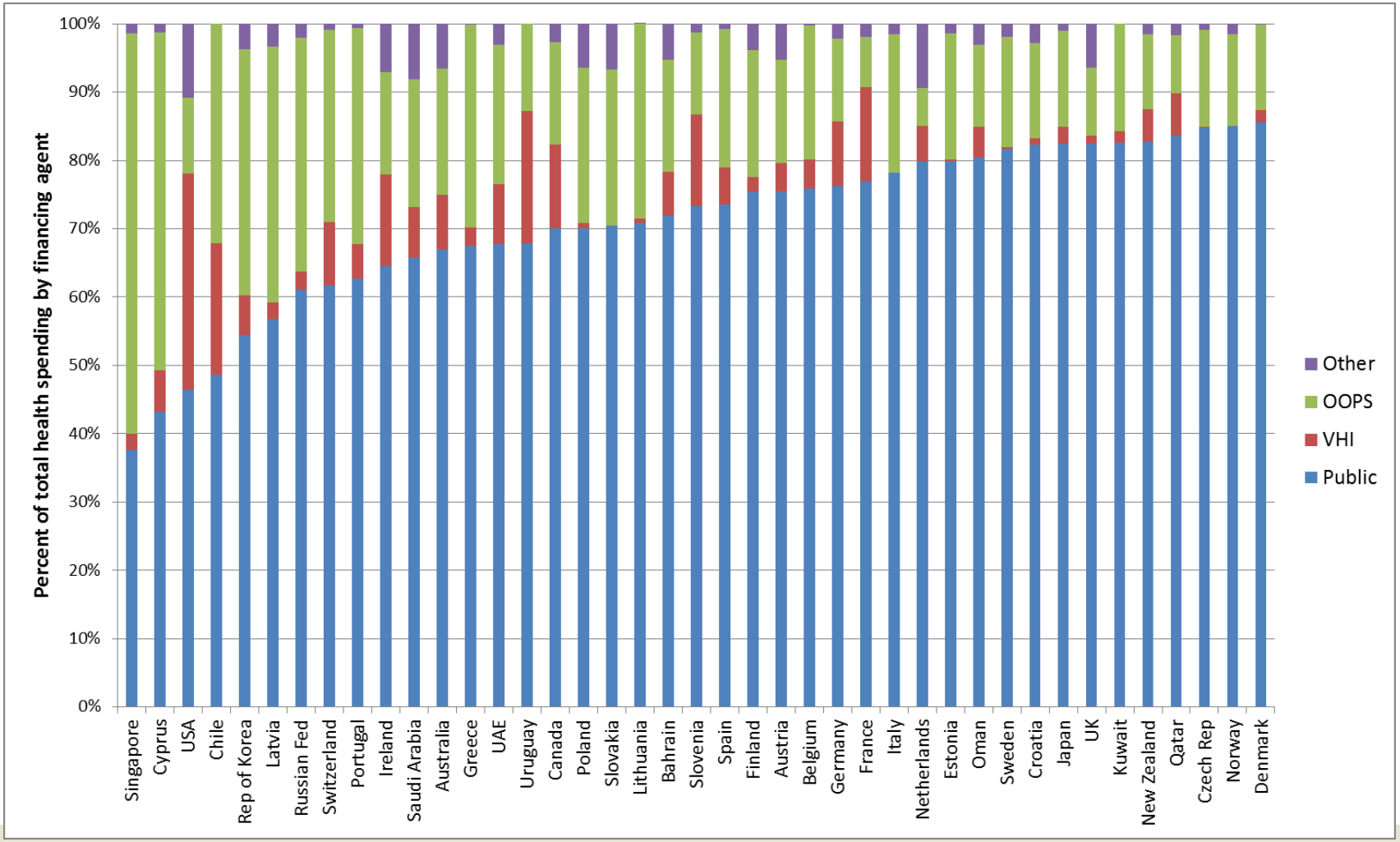
Pros and cons of contribution mechanisms

- **Social Health Insurance**
  - Works for the formal sector
  - Some scope for cross-subsidisation
  - No major success yet in LICs, better in MICs
  - Risk of two tier health system may become an obstacle to extending coverage
  - Not easy targeting subsidies to the poor
  - Not easy to set premiums affordable for the poor and raising enough funds and collect contributions

Pros and cons of contribution mechanisms

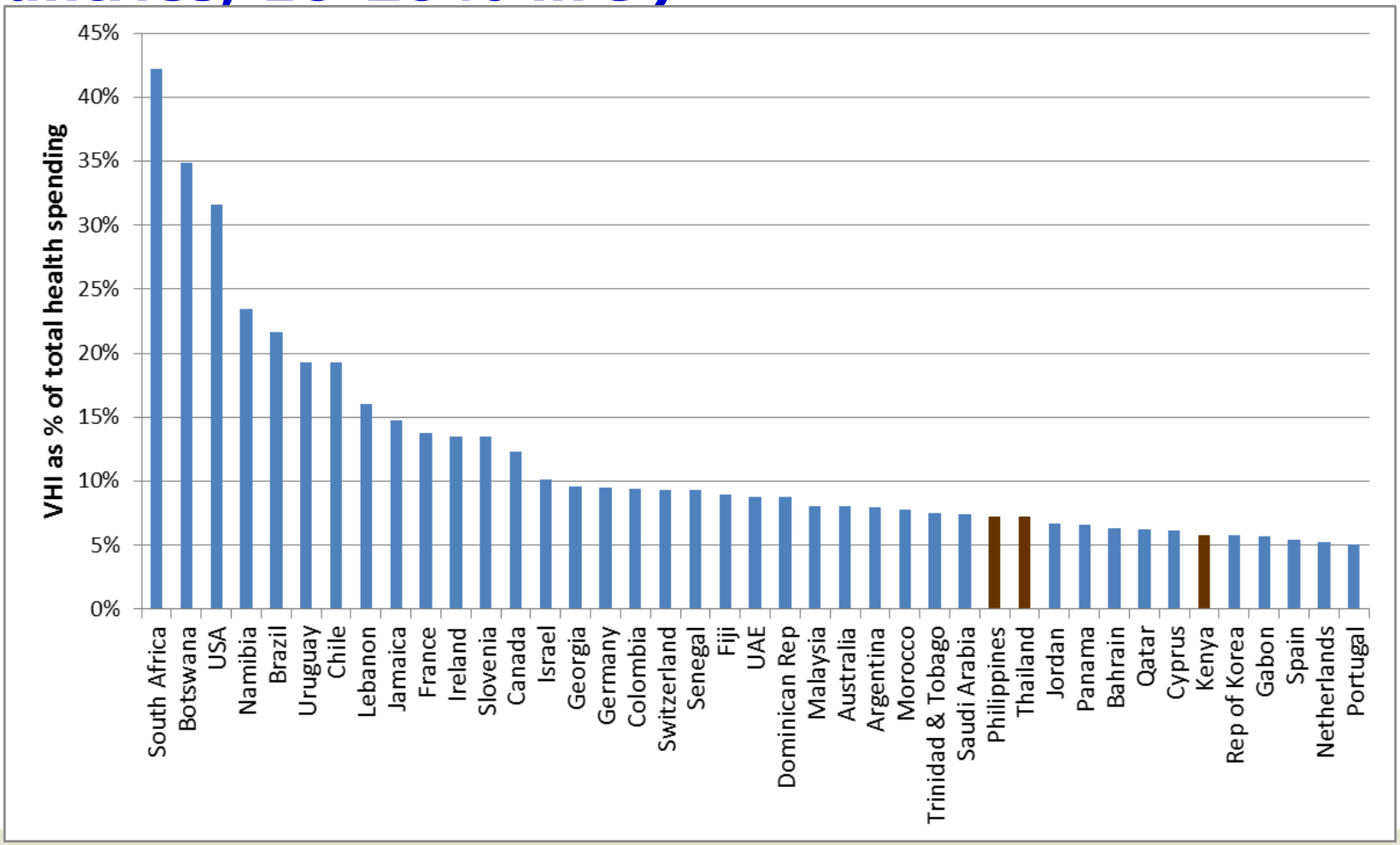
- **Voluntary Health Insurance**
  - Adverse selection – the healthy wealthy leave
  - Little scope for cross subsidisation
  - Community health insurance has the same disadvantages
  - Poor performance in SSA – low coverage, high drop out, inequitable, often subsidised

Nearly all rich countries do NOT rely on VHI to play a major role



Source: WHO estimates for 2012, high-income countries with population > 600,000

VHI represented more than 5% of health spending in only 41 countries over 20% in only 5 countries, 10-20% in 9)



Source: WHO estimates for 2012, countries with population > 600,000

Community-based health insurance

- Umbrella term for the various types of community financing arrangements
- CBHI schemes tend to be small (adverse selection)
- Evidence of moderate strength that such schemes improve cost-recovery
- Weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced

CBHI in West Africa: low enrollment, small pools, insignificant funding impact

	Burkina Faso	Benin	Mali	Togo
Number of CBHIs	188	200	168	25
Number of beneficiaries	256,000	140,000	510,000	16,000
% population covered with CBHI	1.5%	1.5 %	3.1%	0.3%
Ave. beneficiaries per CBHI	1,362	700	3,036	640
% Total Health Expenditure	0.3%	0.25%	0.4%	0.04%

Source of slide: Alexis Bigeard, WHO West Africa Intercountry Support Team

Why many LMICs are interested in CBHI?

- It reduces pressure to Finance Ministries?
- ????
- Any Idea?

Two conditions for universal coverage (Fuchs)

- **Subsidization** - some will be too poor or too sick to be able to afford voluntary coverage
- **Compulsion** - some who can afford it are unwilling to buy it

One without the other won't work

- subsidies alone not sufficient because rich/healthy will not join
- compulsion without subsidies impose heavy burden on the poor and sick

The problem of fragmented pooling

- Fragmentation of pooling limits the potential ability to cross-subsidize

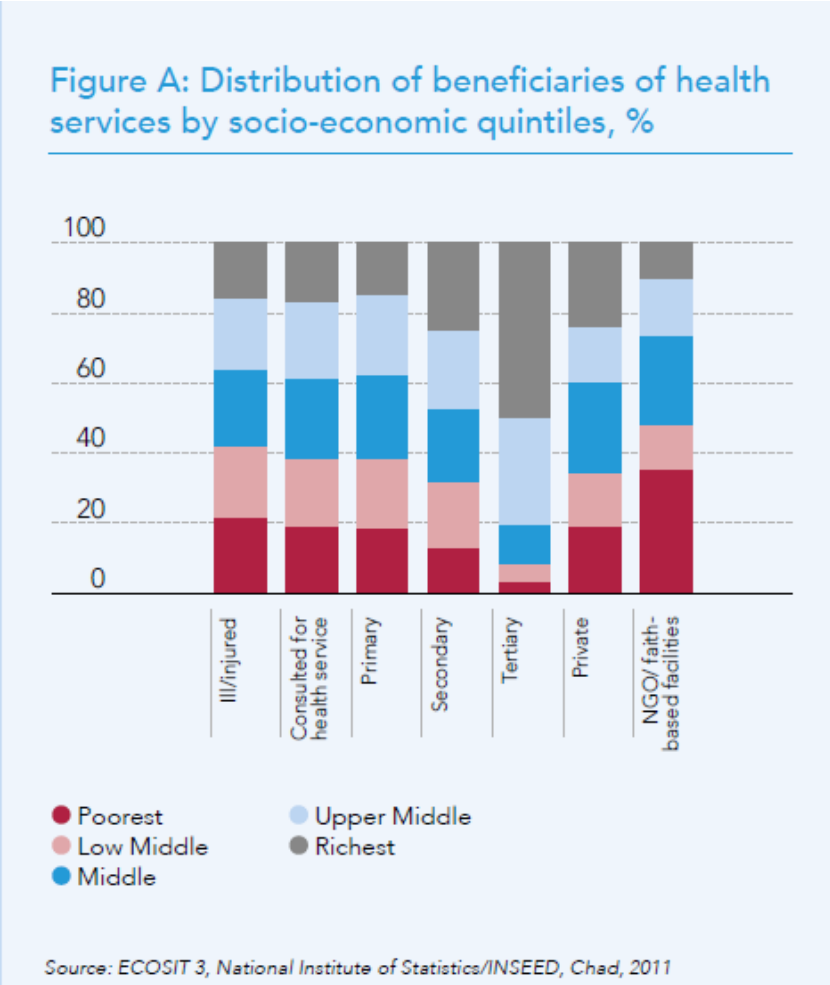
- Can only cross-subsidize within pools, not between pools (unless there is central re-distribution mechanism)

- Fragmentation often a consequence of history: the way that health coverage developed over a long period of time

Many forms of fragmented pooling

- Territorially distinct but small insurance funds
- Decentralized local government health agencies with overlapping population coverage
- Overlapping but uncoordinated population or service mandates between different funding agencies, e.g. MOH, local governments and health insurance funds
- Competing health insurance funds
- Vertical programs, often reinforced by external funds

Resource allocation



Resource allocation