



Health Care
Management



The financing function: Raising, pooling and allocating resources

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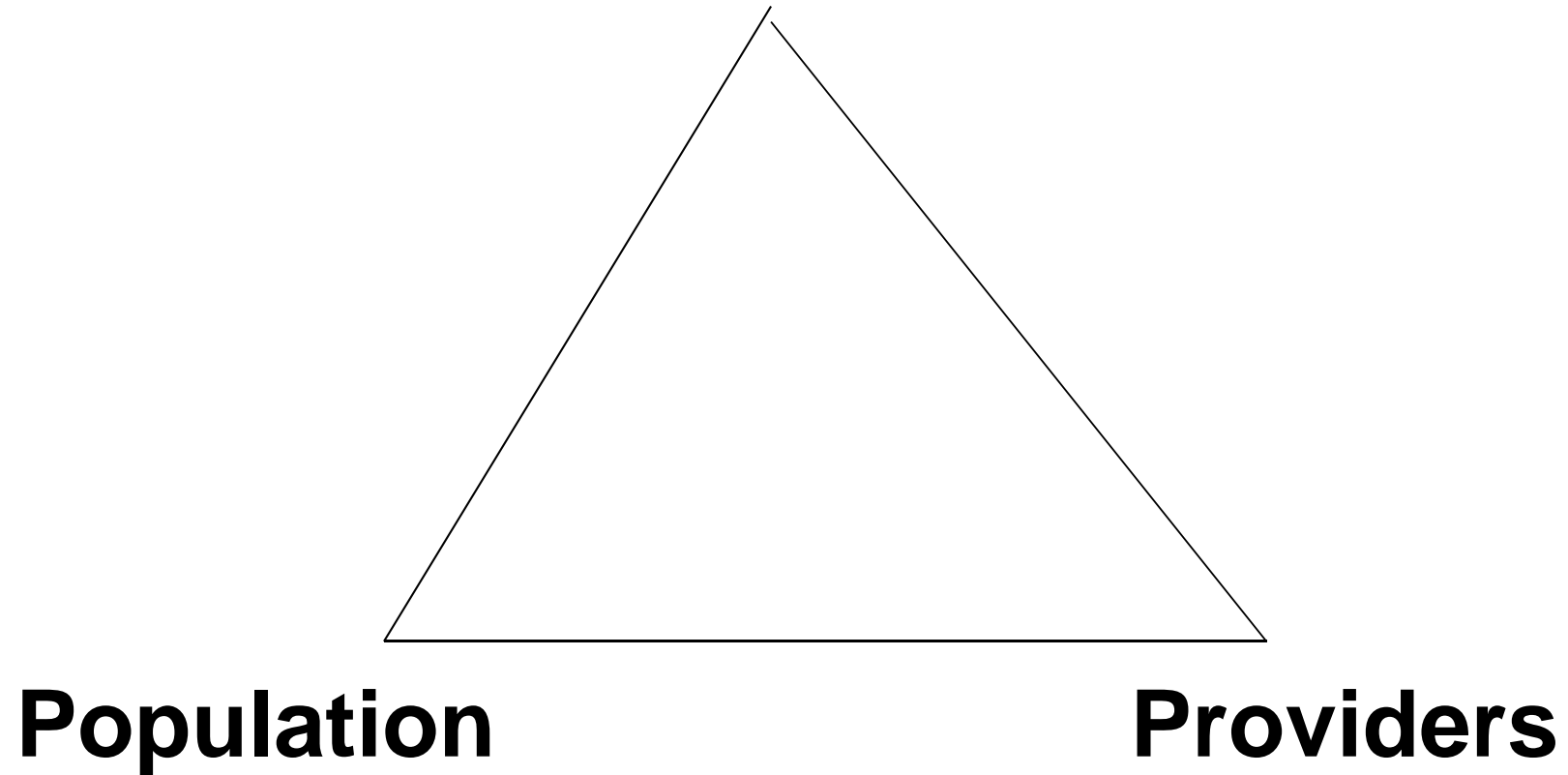
&

European Observatory on Health Systems and Policies



European
Observatory
on Health Systems and Policies

Third-party Payer



Collector of resources **Third-party payer**



**Steward/
regulator**

Population

Providers

Resource pooling & allocation

Collector of → Third-party payer resources

**Raising resources/
funding**

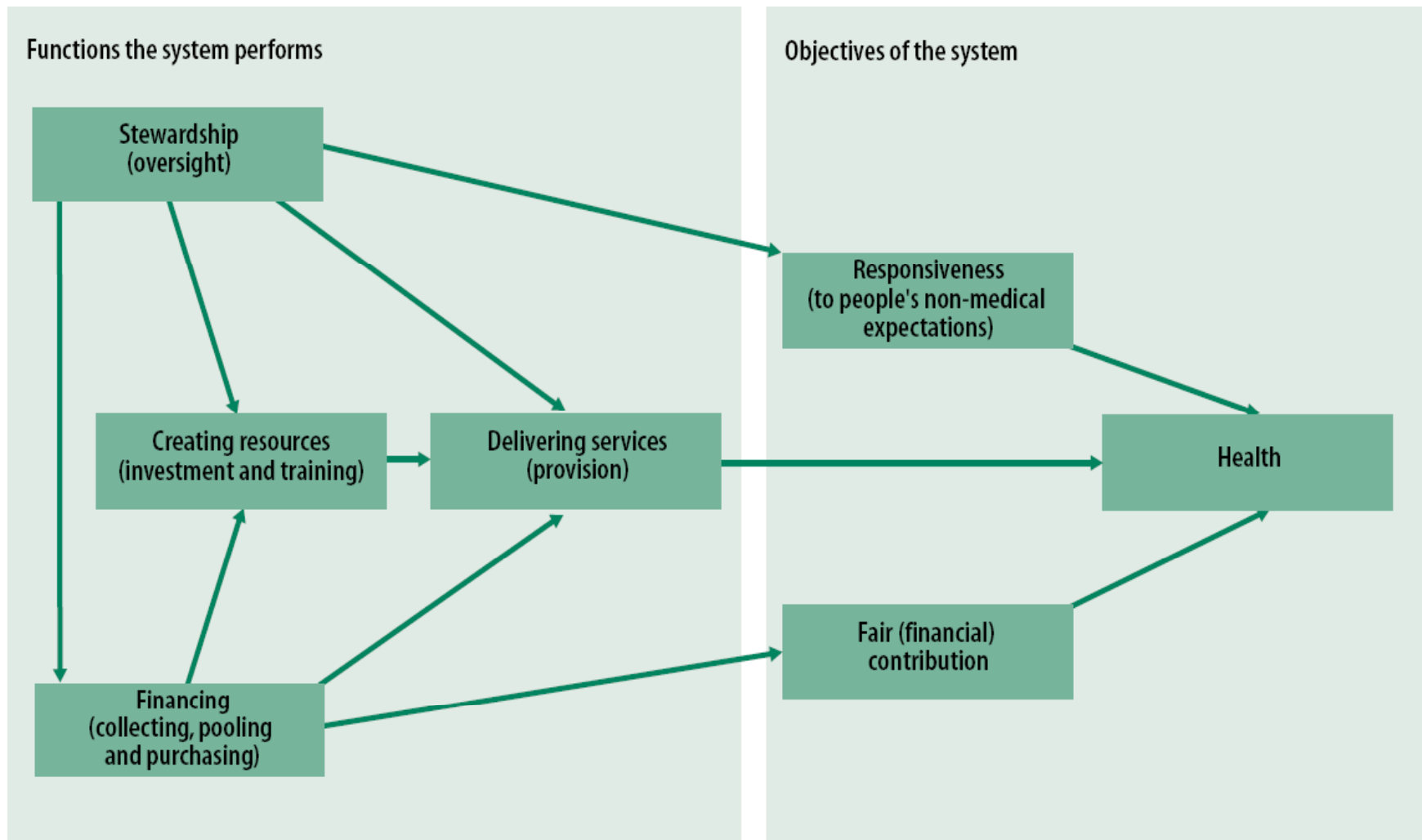
**Steward/
regulator
Regulation**

**Purchasing/
contracting/
financing
providers**

Population Coverage:
Who? What?
How much?

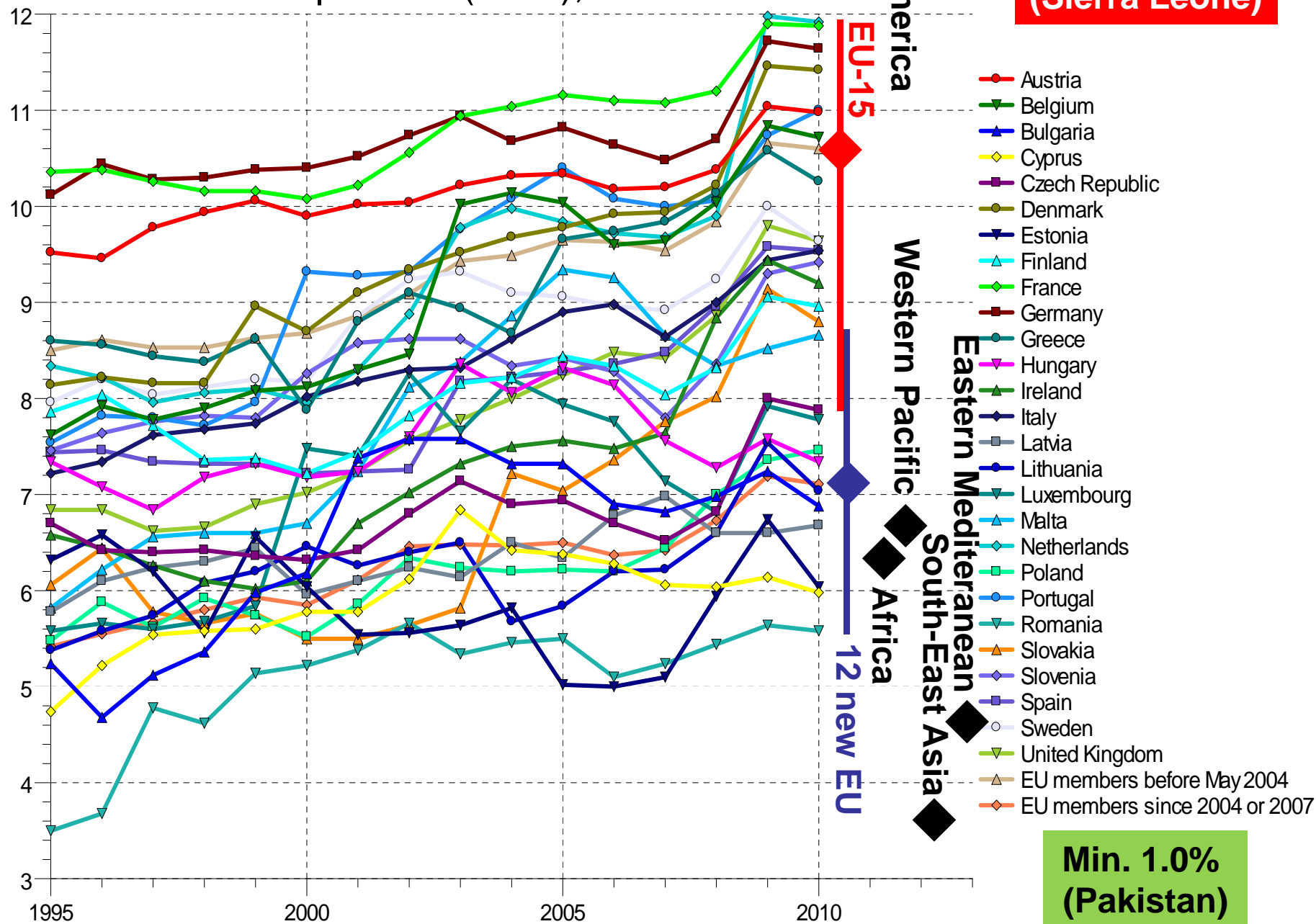
**Delivery/
provision of services** **Providers**

Functions



WHO World Health Report 2000

Total health expenditure as % of gross domestic product (GDP), WHO estimates



Why is the Health Expenditure/GDP ratio of interest?

- A measure of the *opportunity cost* of health spending.
- A means of international comparison.

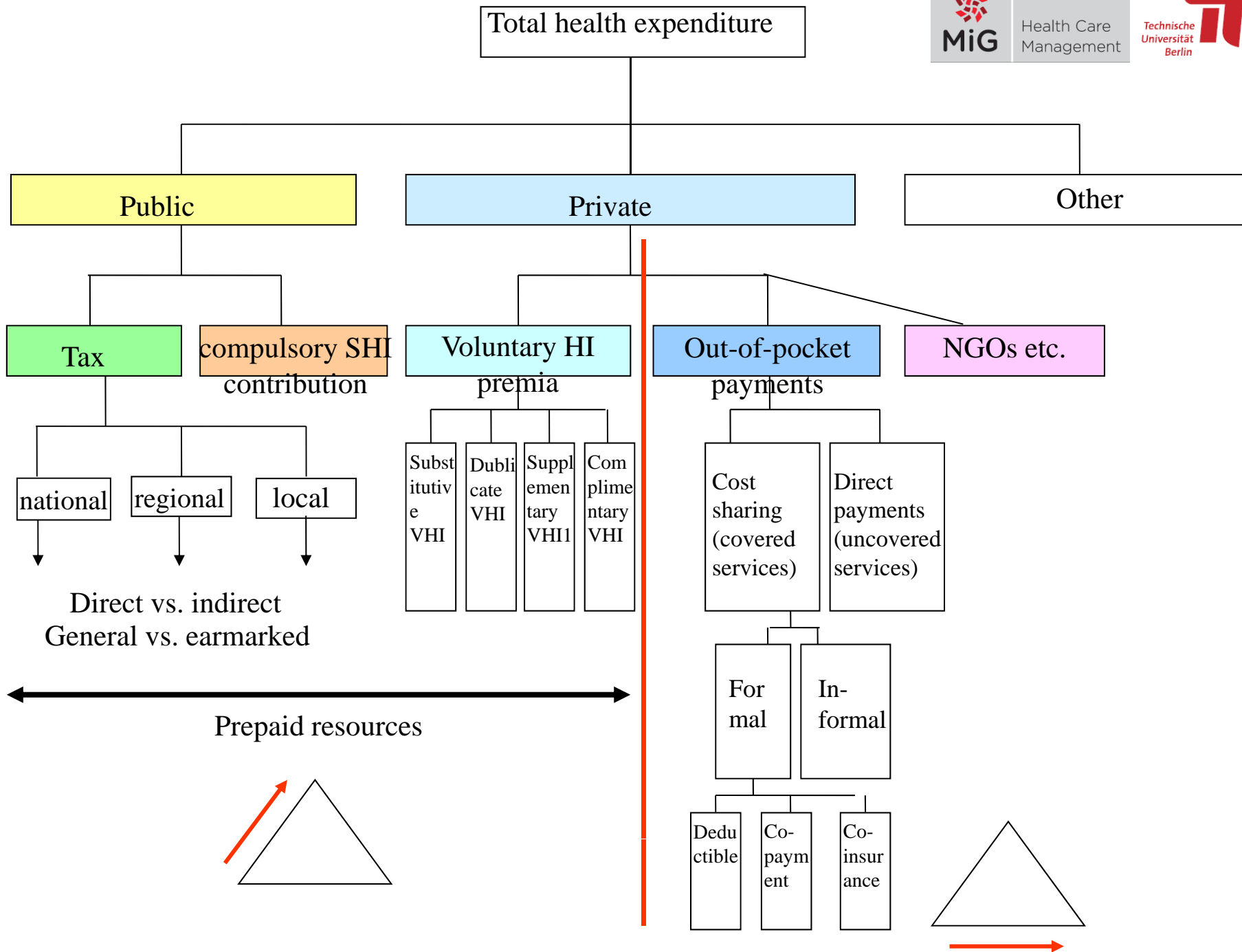
But:

There is no unambiguous optimum level. It is a matter of political preferences.

Basically, there are just four main ways
to fund health care:

- Out-of-pocket payments by users
- Voluntary (private) insurance payments = premiums
- Social insurance payments = contributions or community-rated premiums
- Tax payments

(and the fifth: external support)



Resource pooling & allocation

Collector of resources → **Third-party payer**

**Income-dependent contributions
& sickness funds =
Social Health Insurance system**

Steward/Managing

**Raising
resources/
funding**

**Taxes &
governments/ health authorities
= tax-funded system (NHS)**

Population

Delivery/Providers

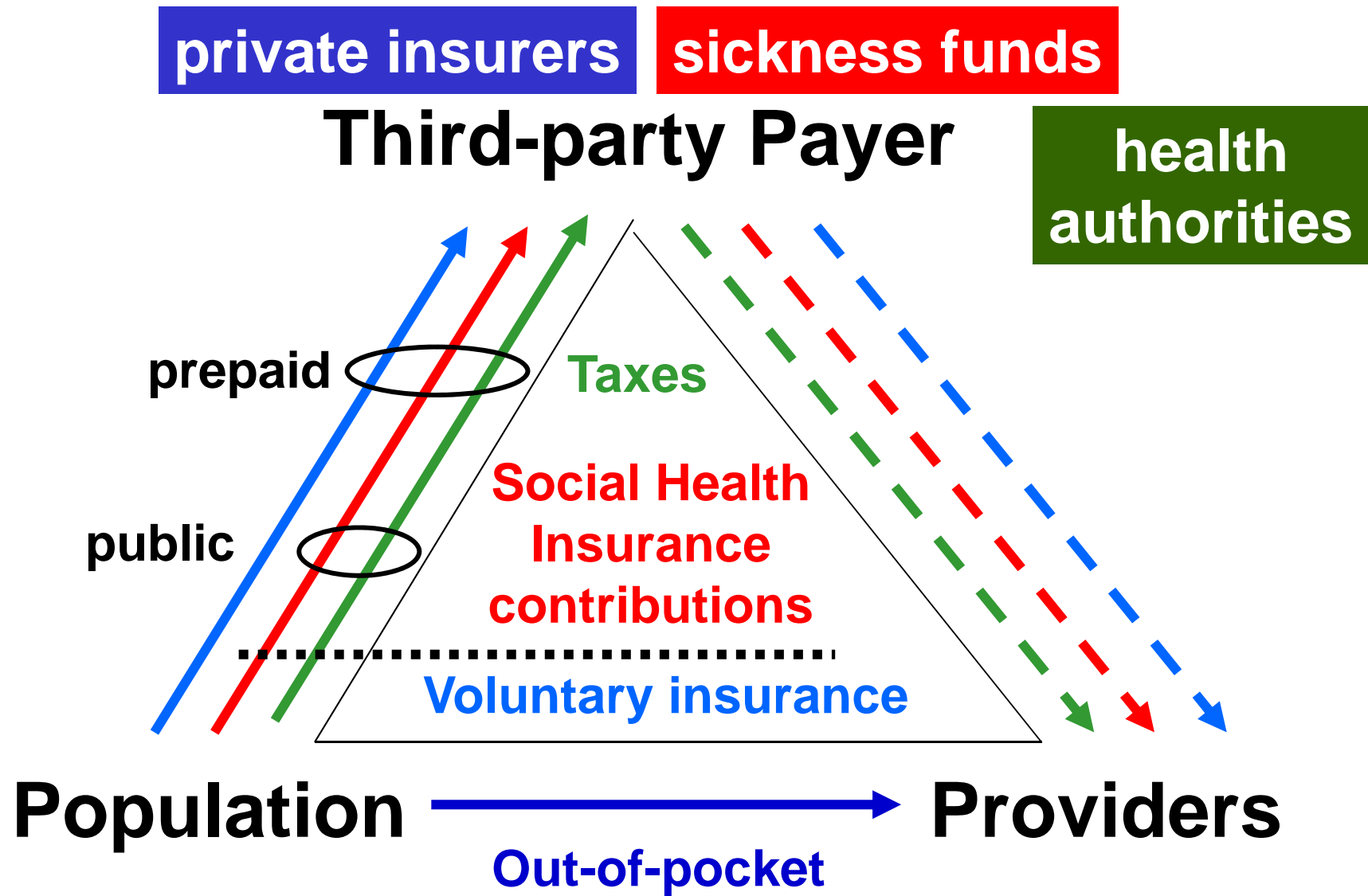
Coverage

**Risk-related premia
& private insurers =
Voluntary Health Insurance system**

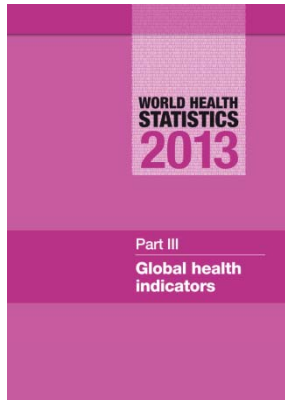
Who? What

How much

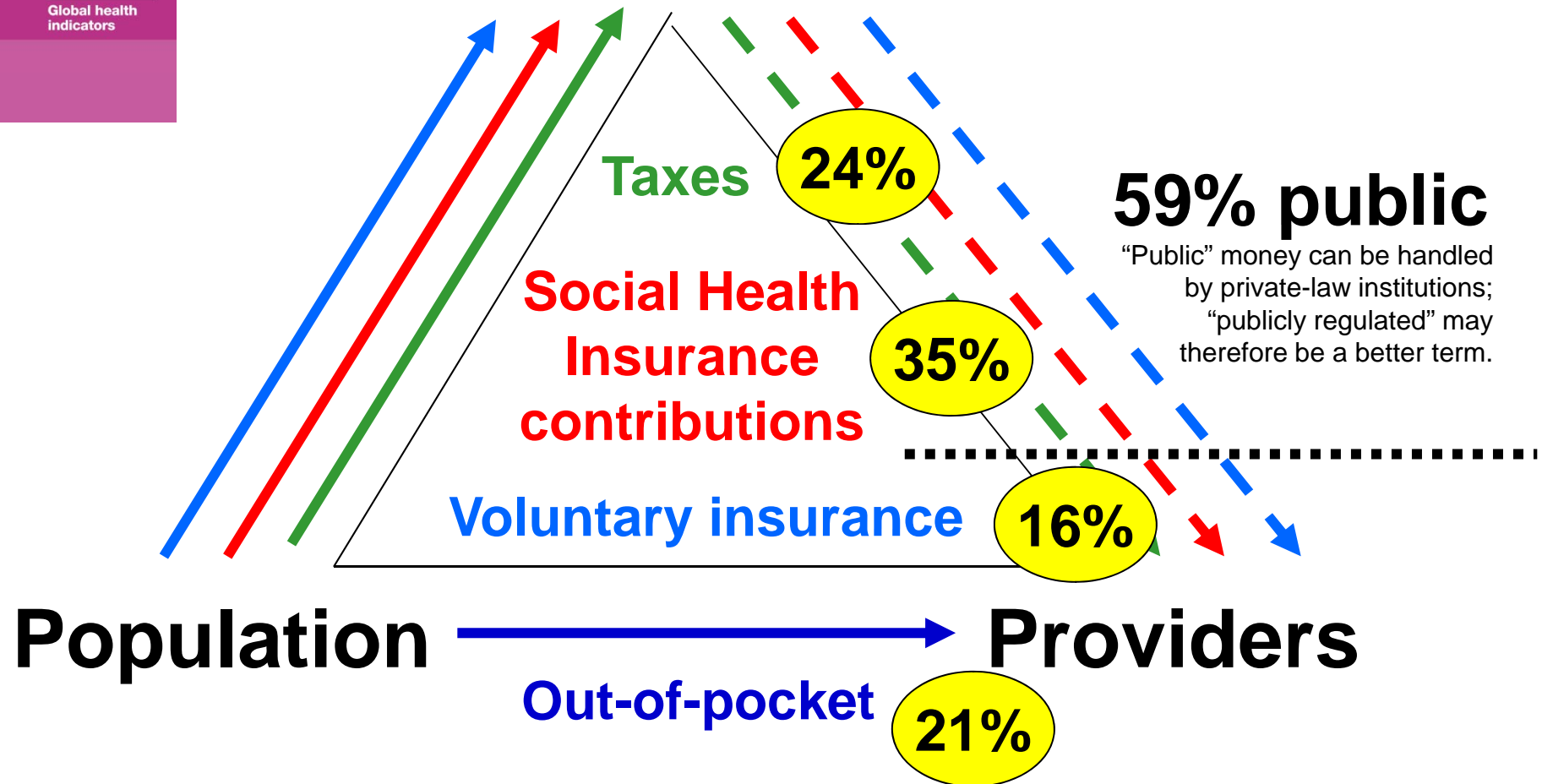
System typology



Finding the “right” funding mix ...



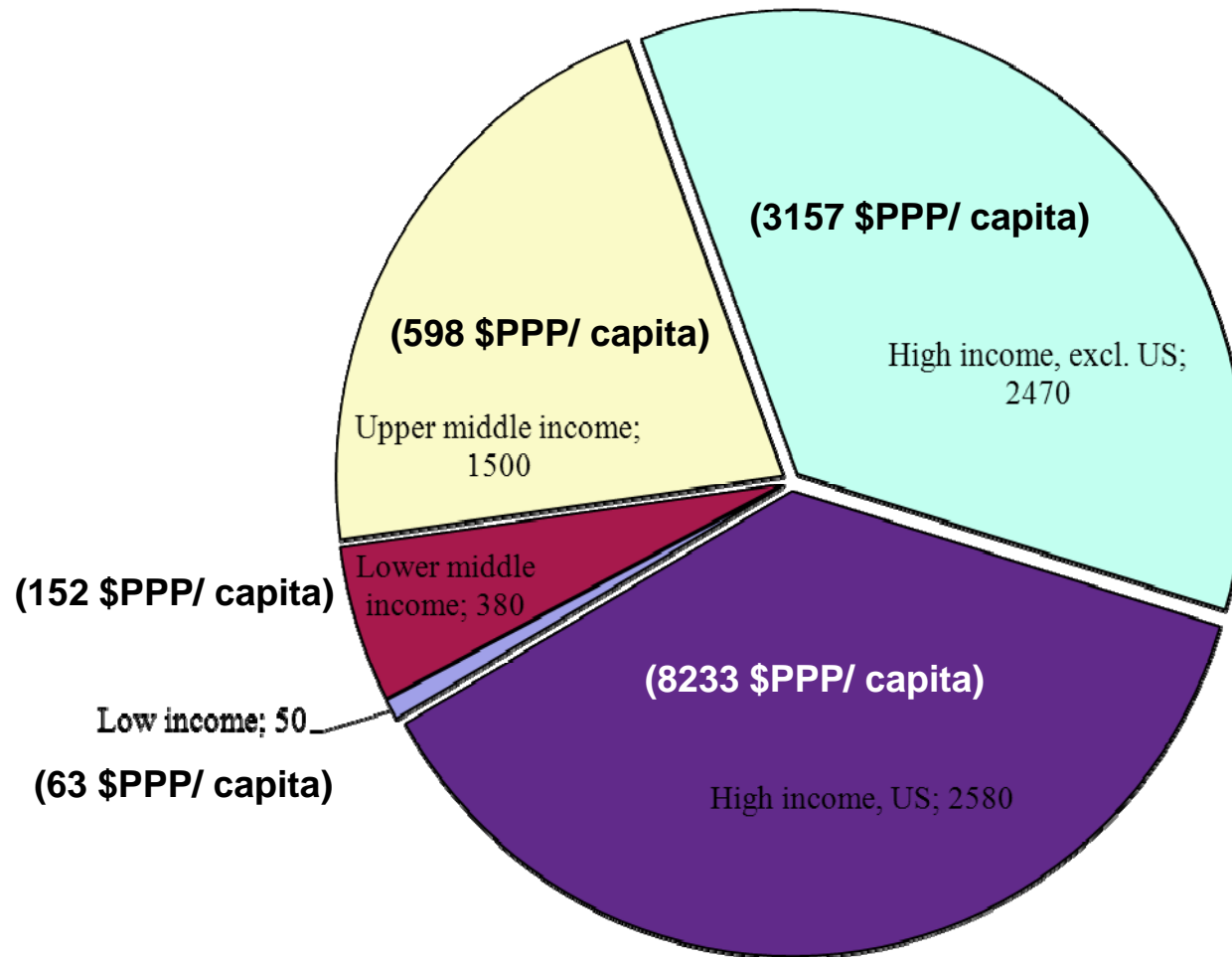
Third-party Payer



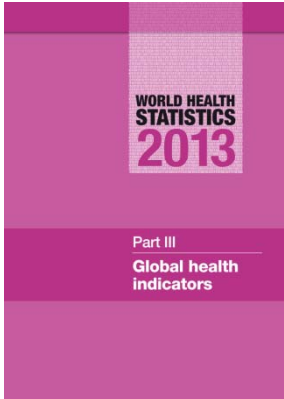
World-wide 2010 (large US market!)

1000 \$PPP =
9.2% of GDP

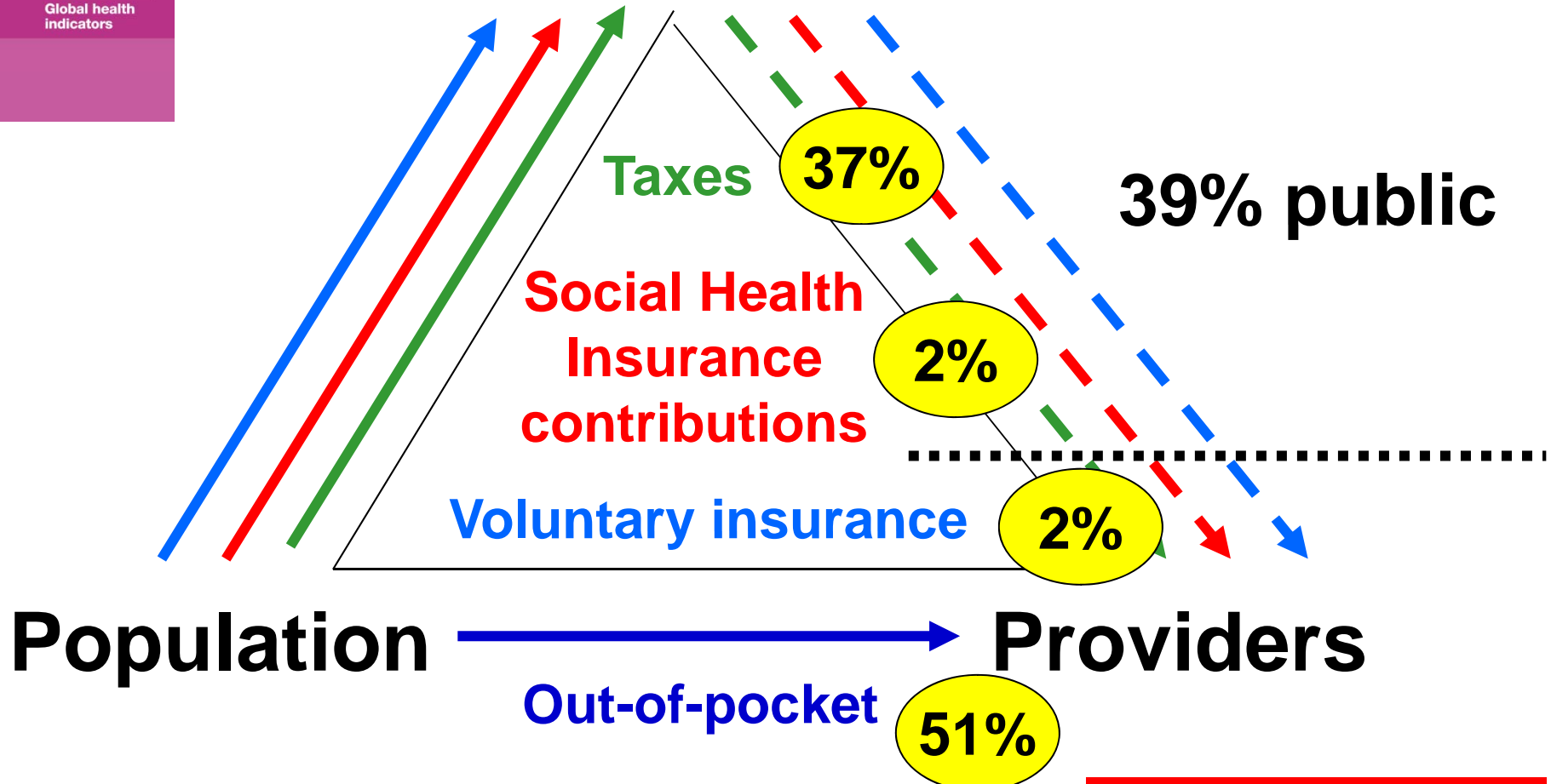
Total expenditure on health in billion PPP Int\$



Global expenditure on health 2010: around \$ 7 trillion (7,000,000,000,000)

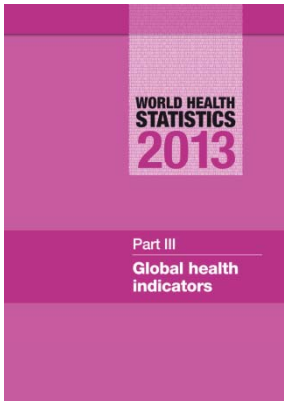


Third-party Payer

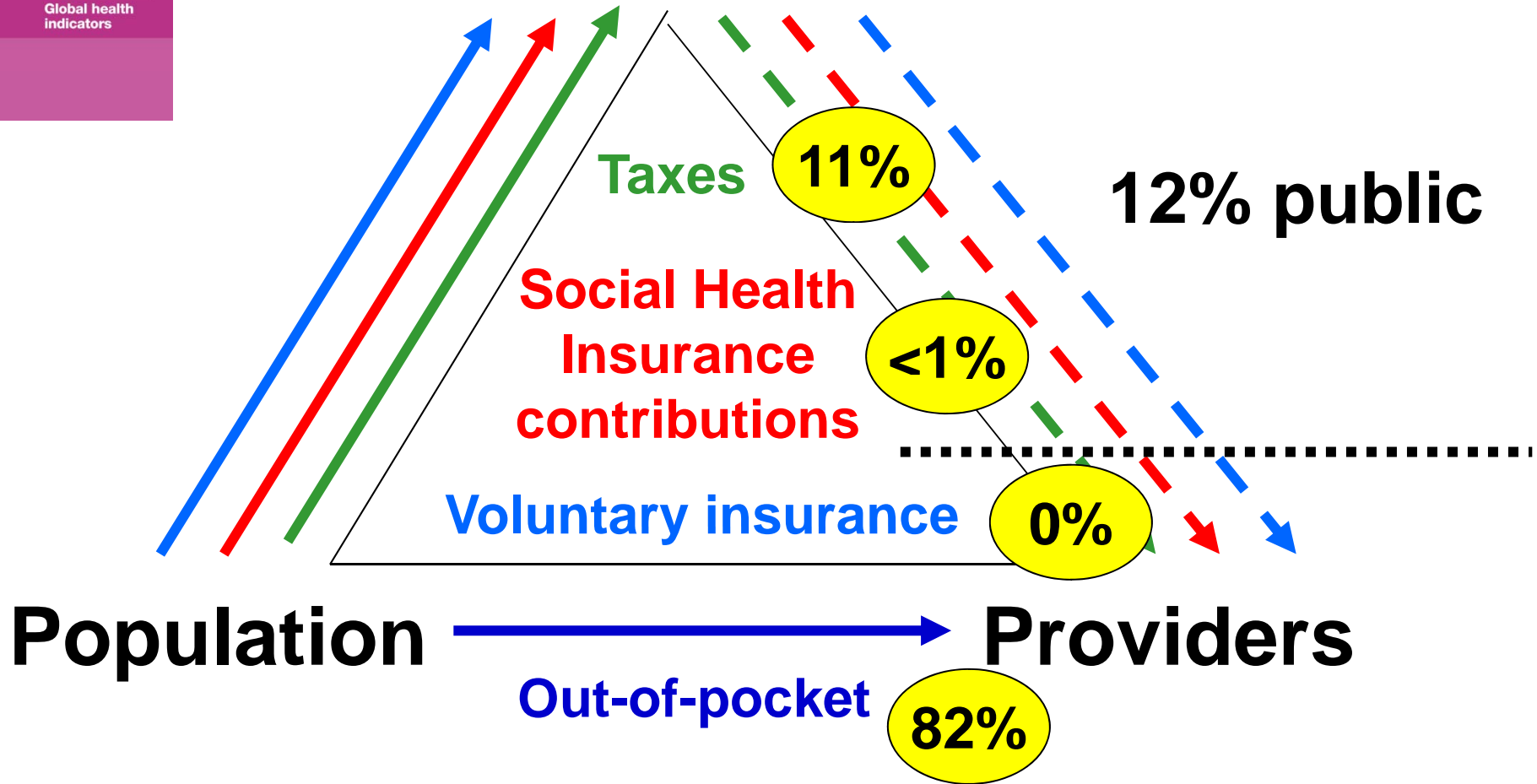


Low-income countries 2008

60 \$PPP =
5.3% of GDP

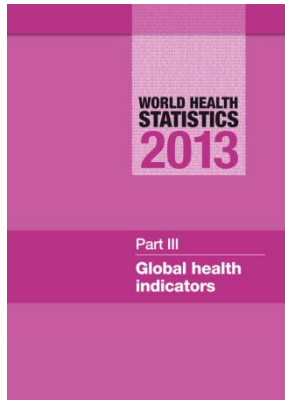


Third-party Payer

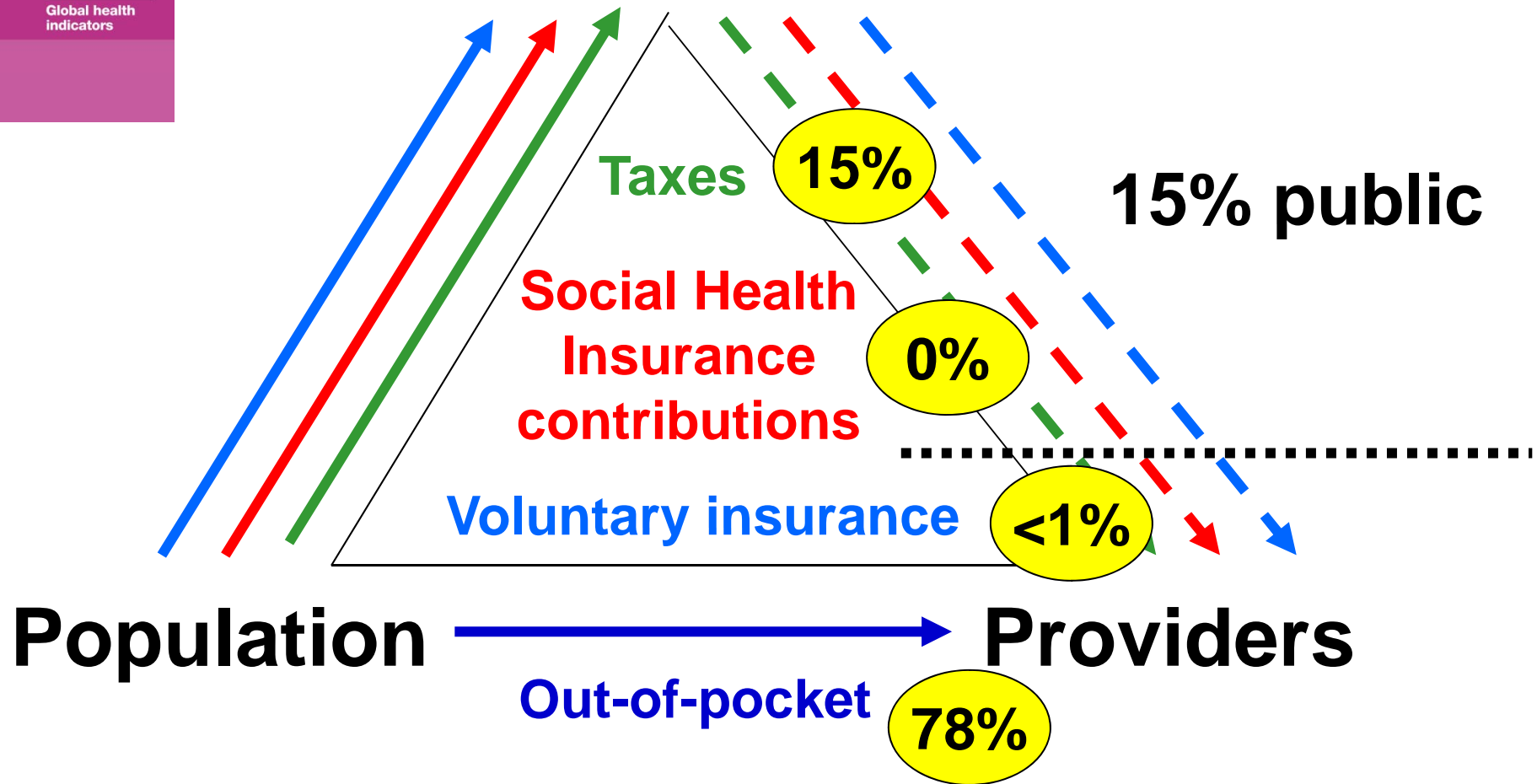


Myanmar 2010

2.0% of GDP

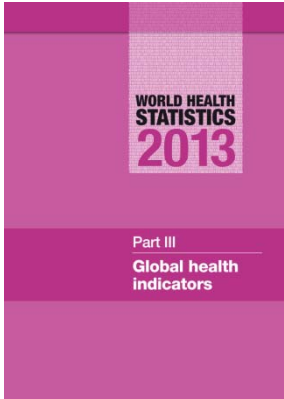


Third-party Payer

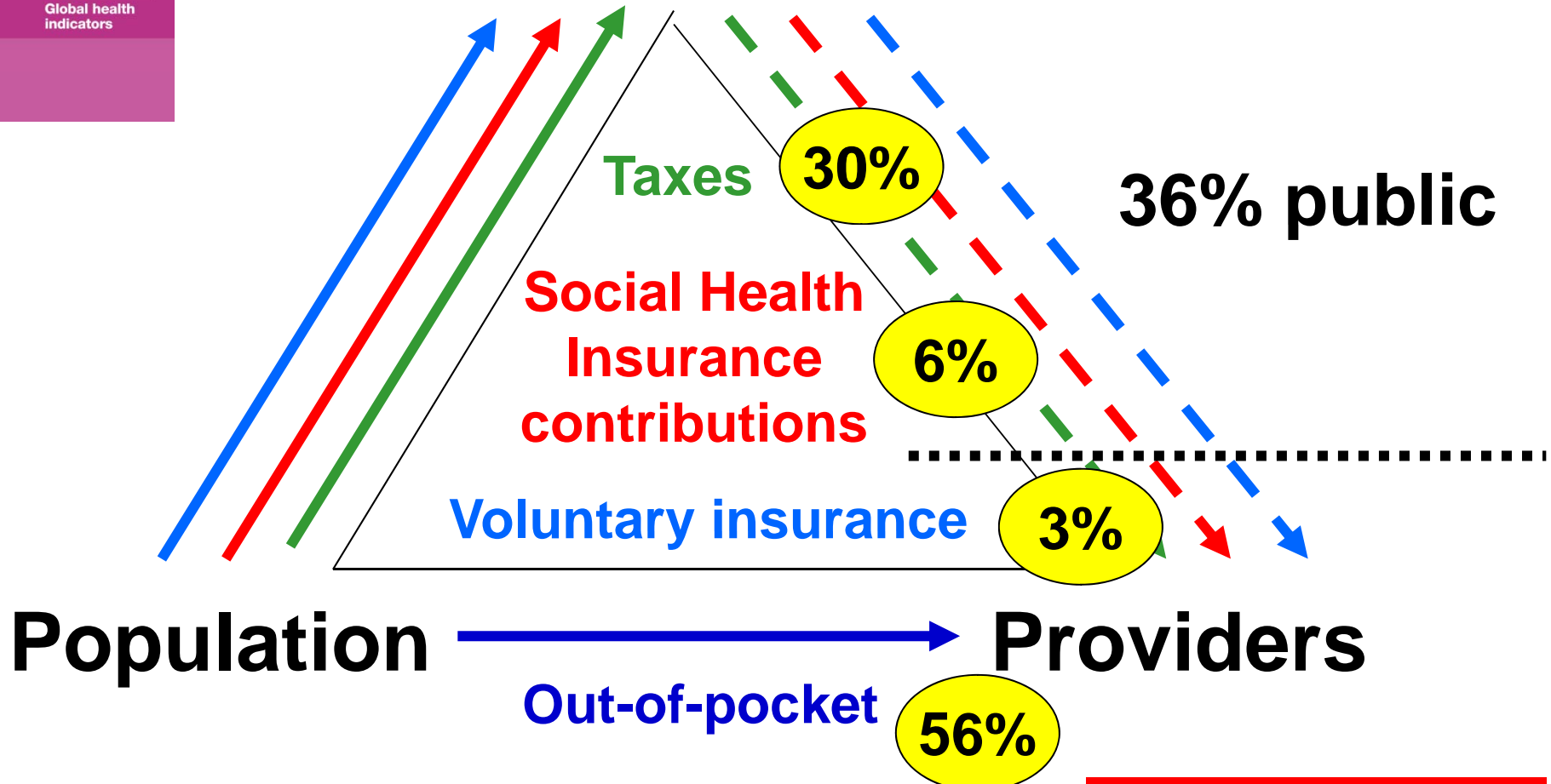


Sierra Leone 2010

20.8% of GDP

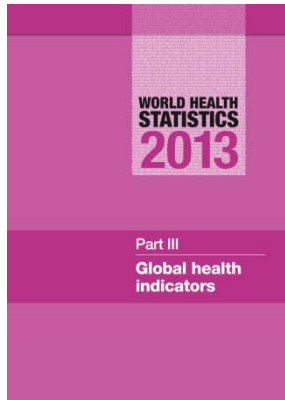


Third-party Payer

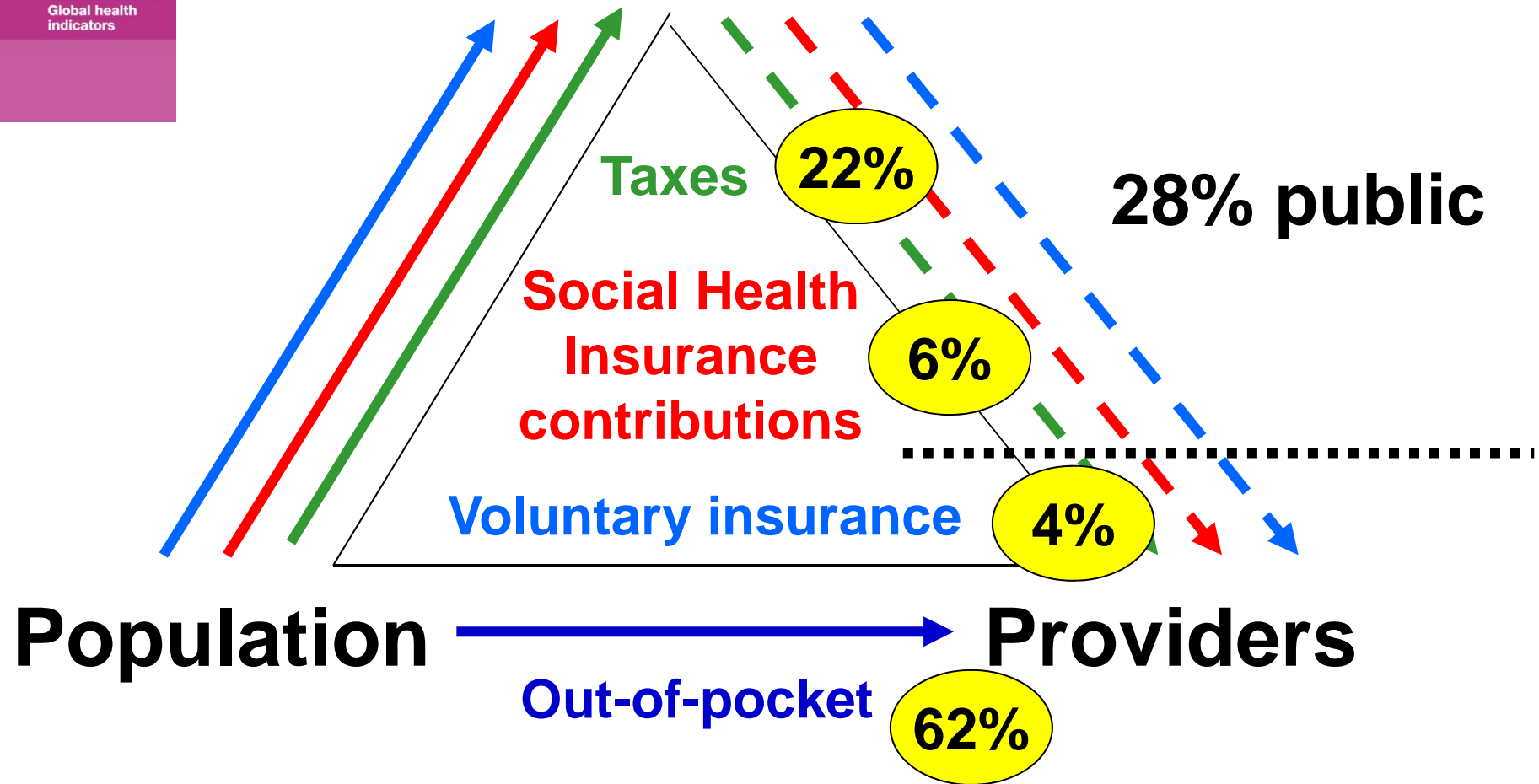


Lower middle income 2010

150 \$PPP =
4.3% of GDP

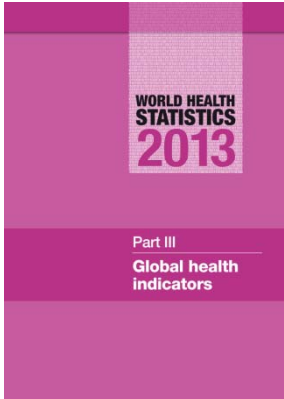


Third-party Payer

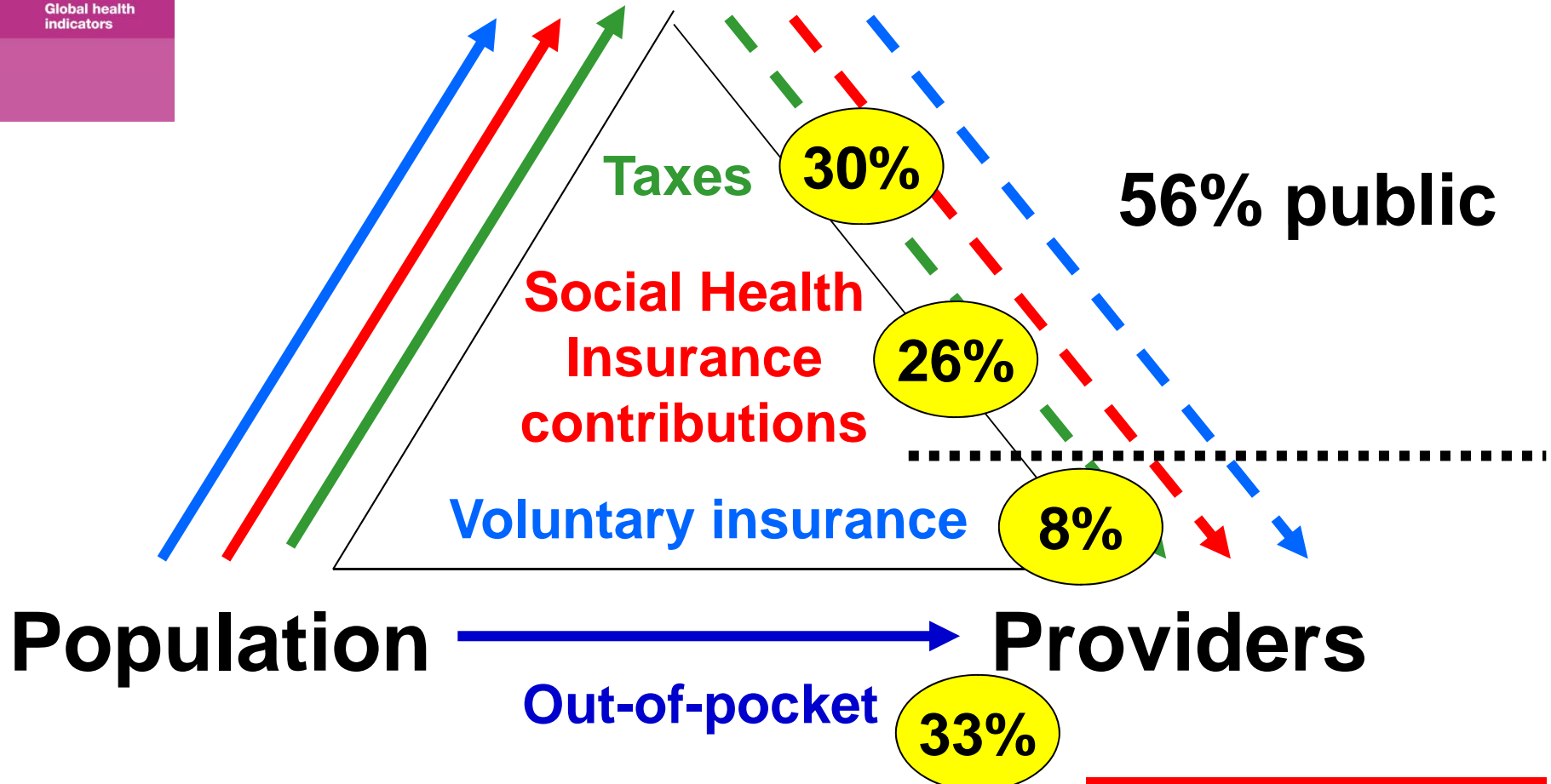


India 2010

3.7% of GDP

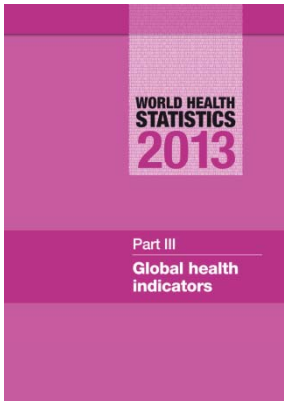


Third-party Payer

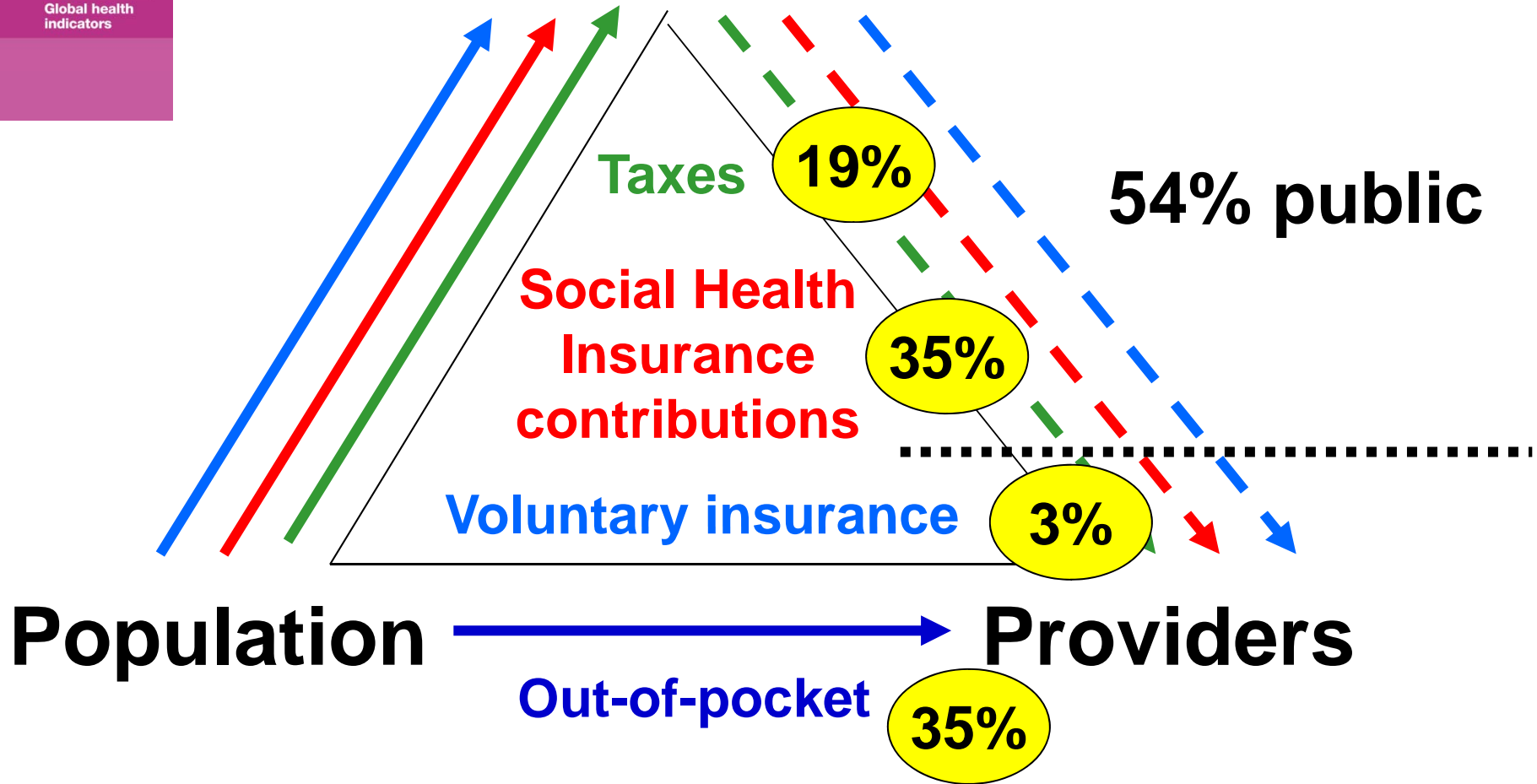


Upper middle income 2010

600 \$PPP =
6.0% of GDP

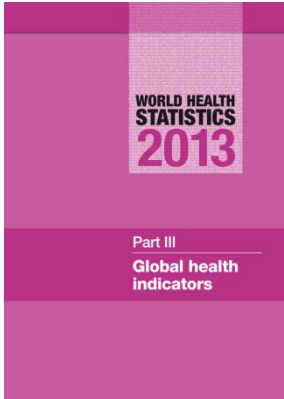


Third-party Payer

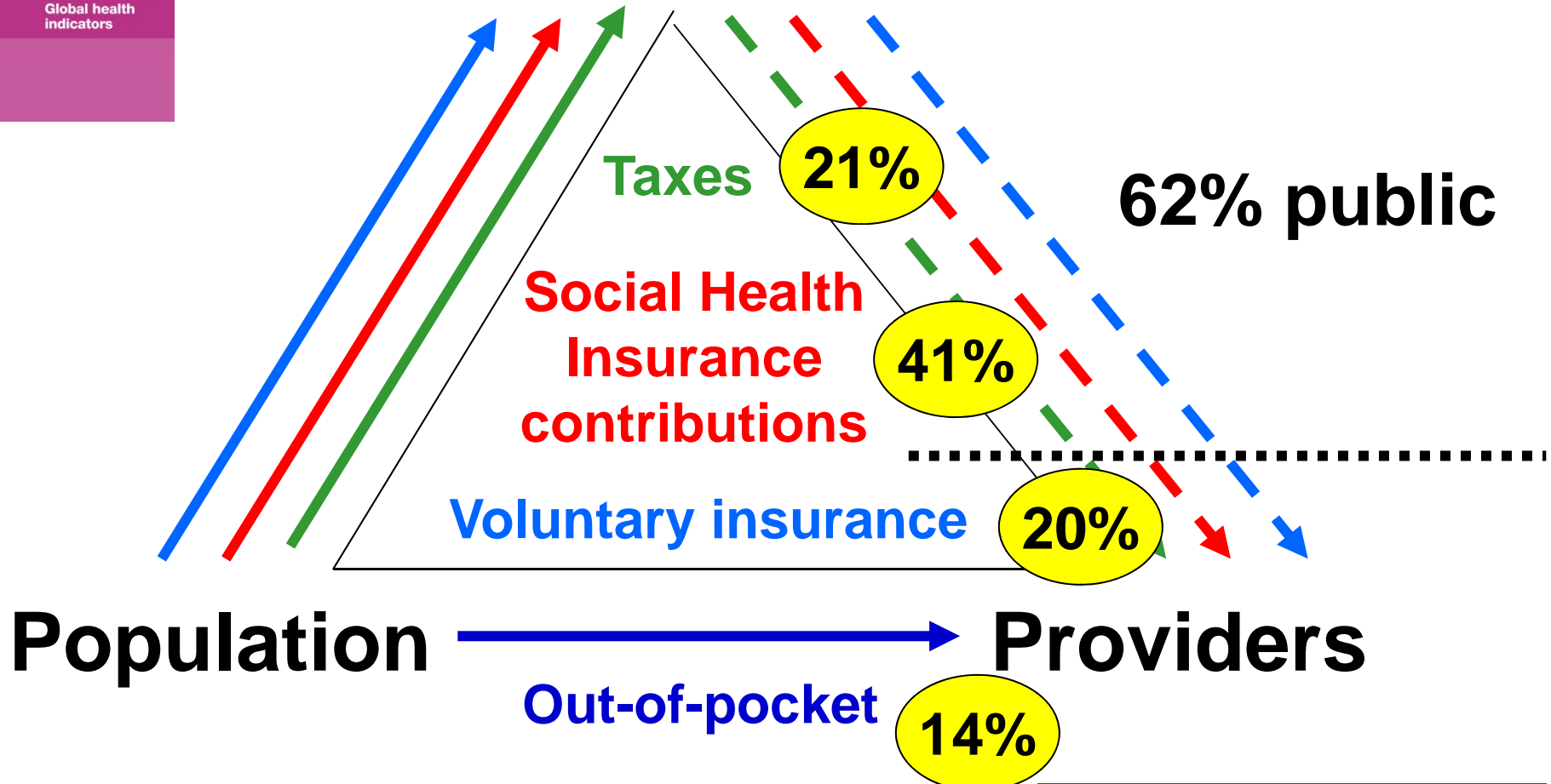


China 2010

5.0% of GDP



Third-party Payer



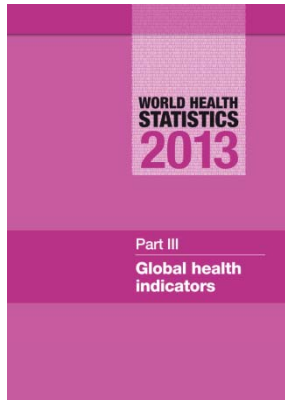
Population

Providers

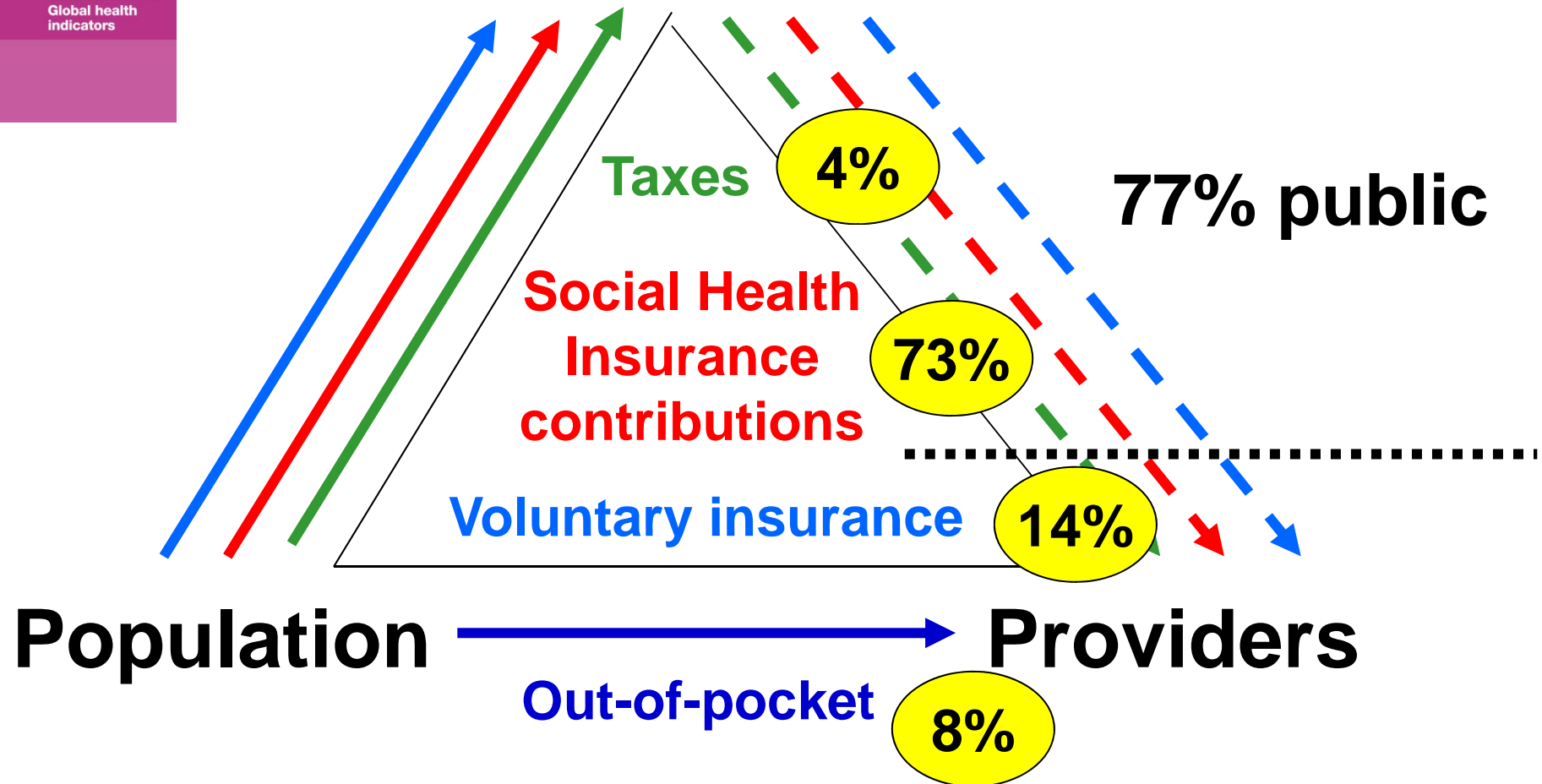
Out-of-pocket

High income 2010

4600 \$PPP =
12.4% of GDP

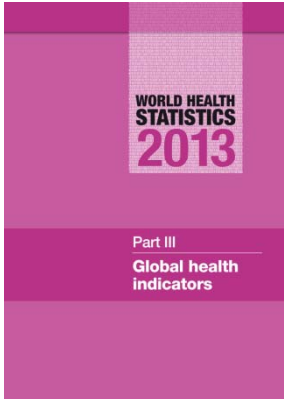


Third-party Payer

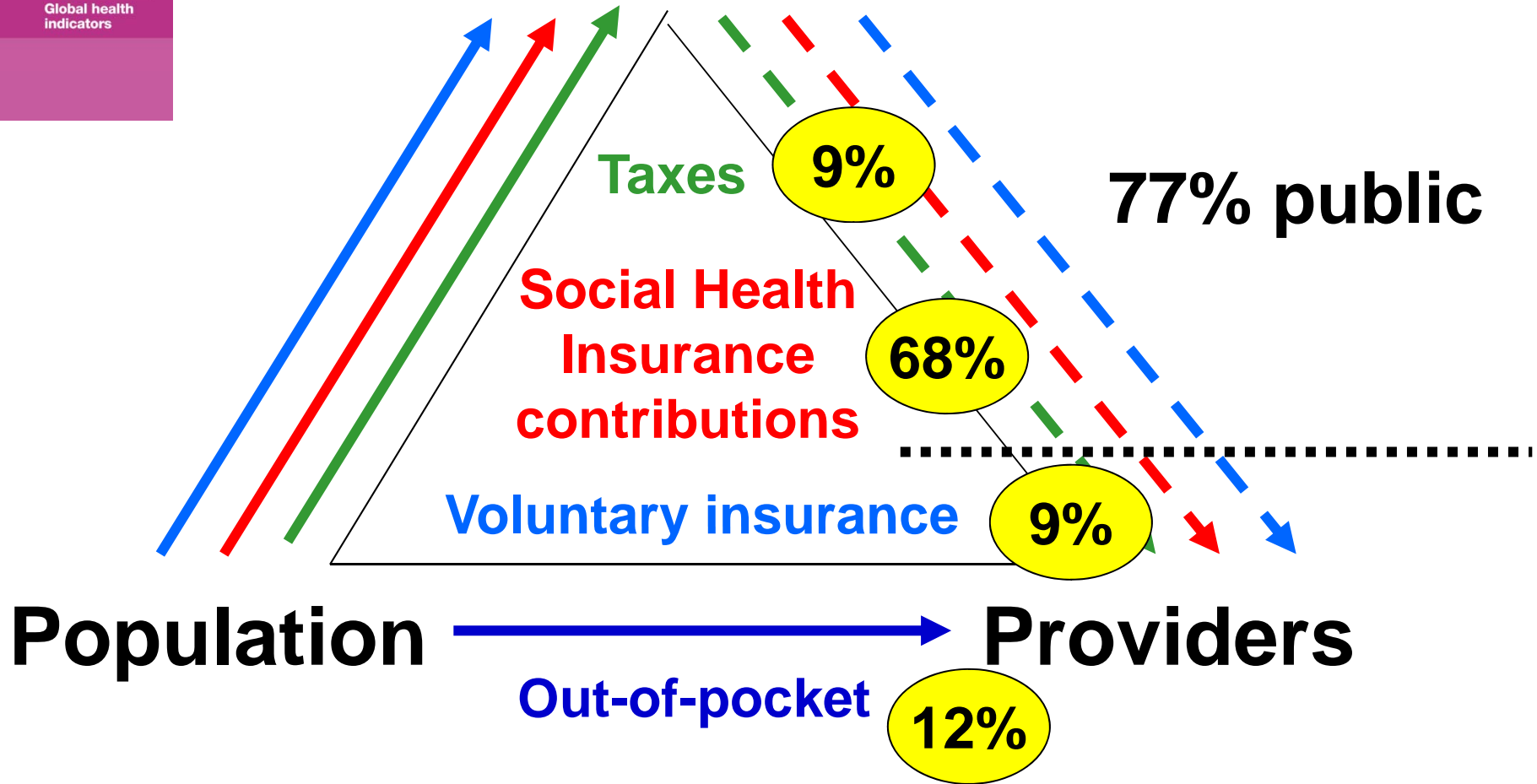


France 2010

11.7% of GDP

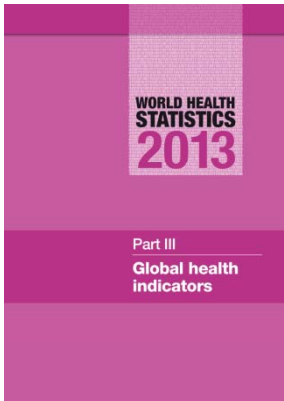


Third-party Payer

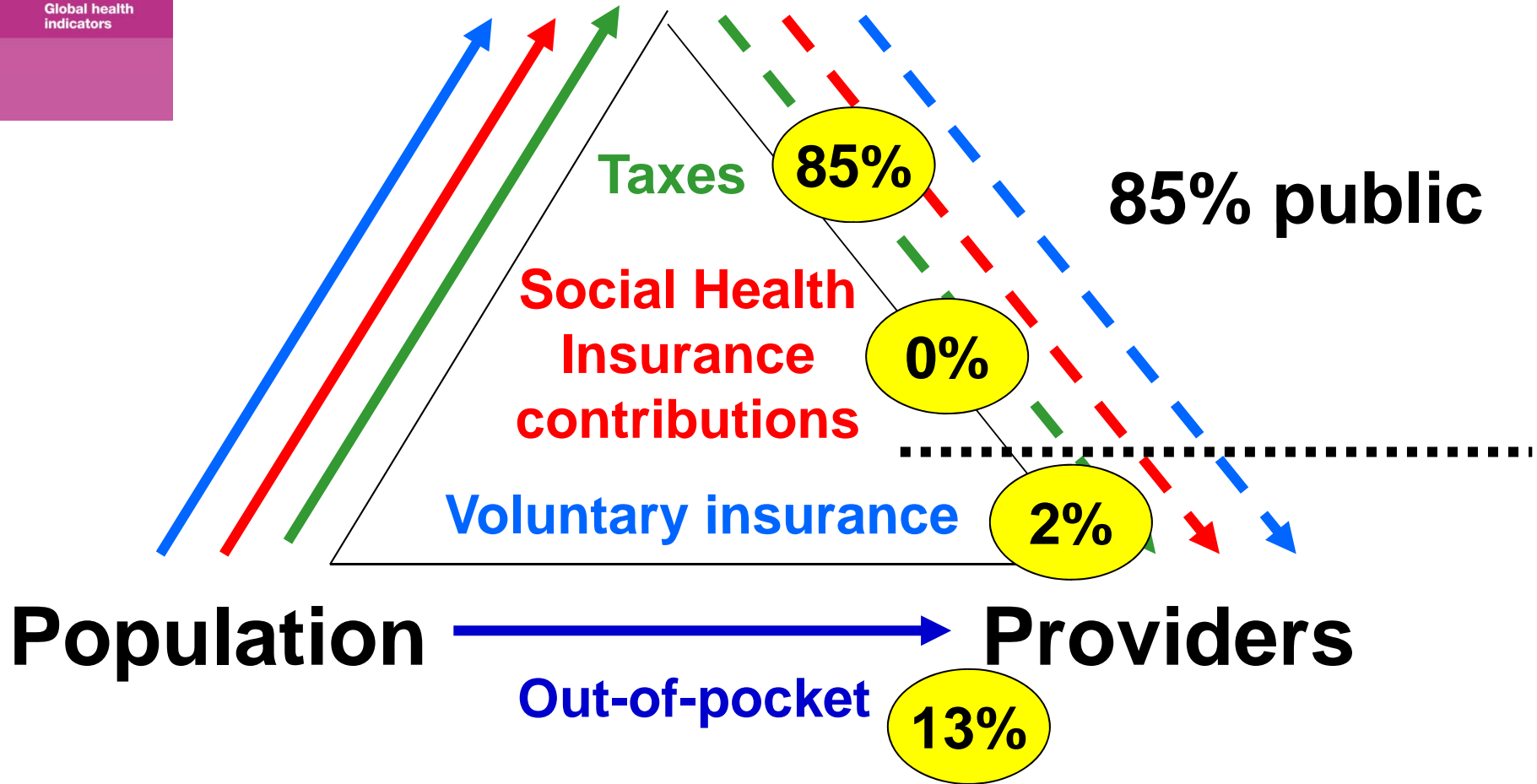


Germany 2010

11.5% of GDP

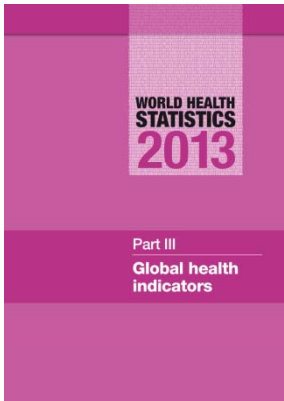


Third-party Payer

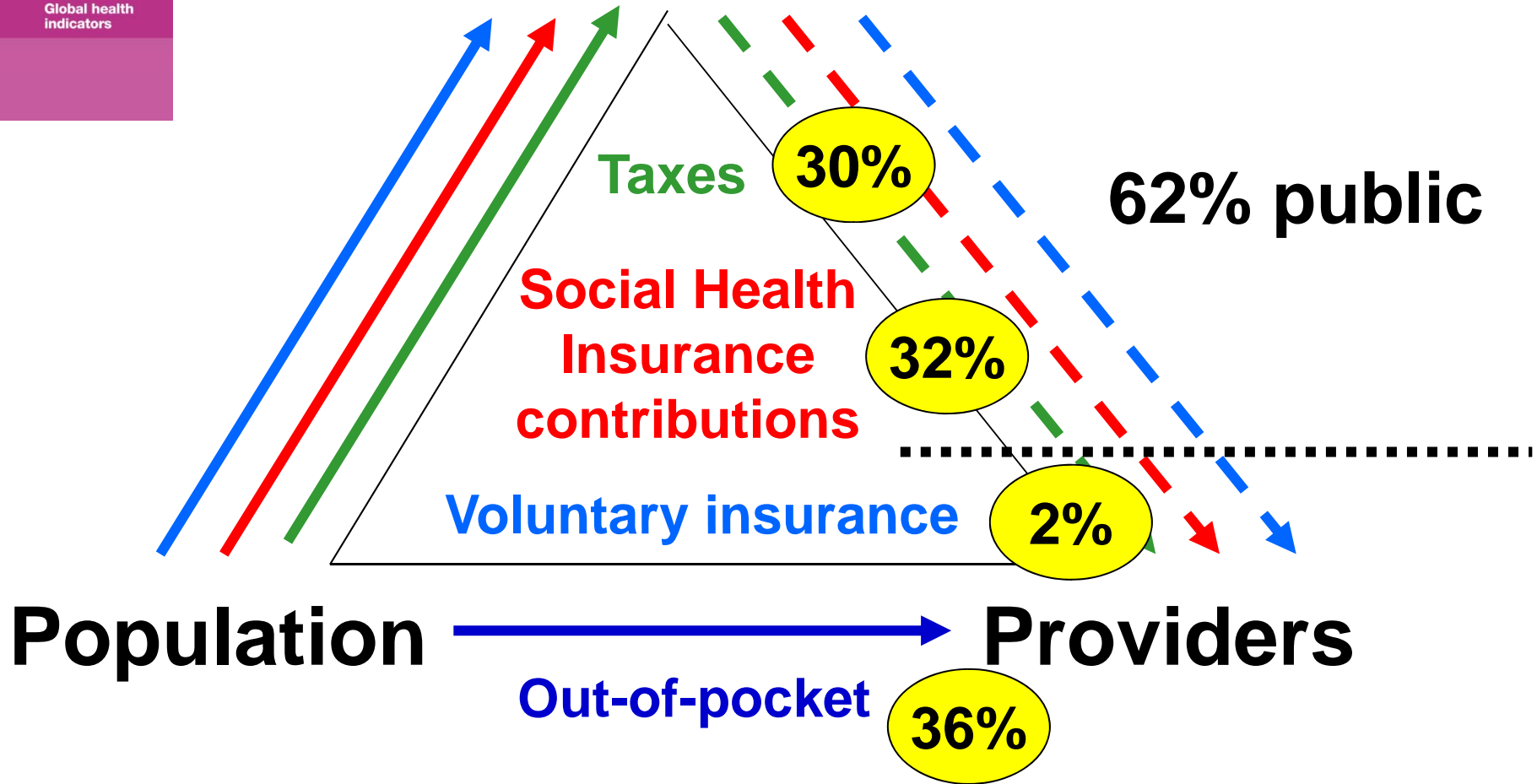


Denmark 2010

11.1% of GDP

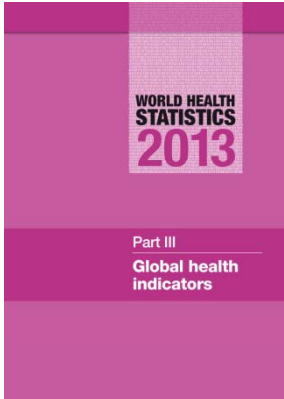


Third-party Payer

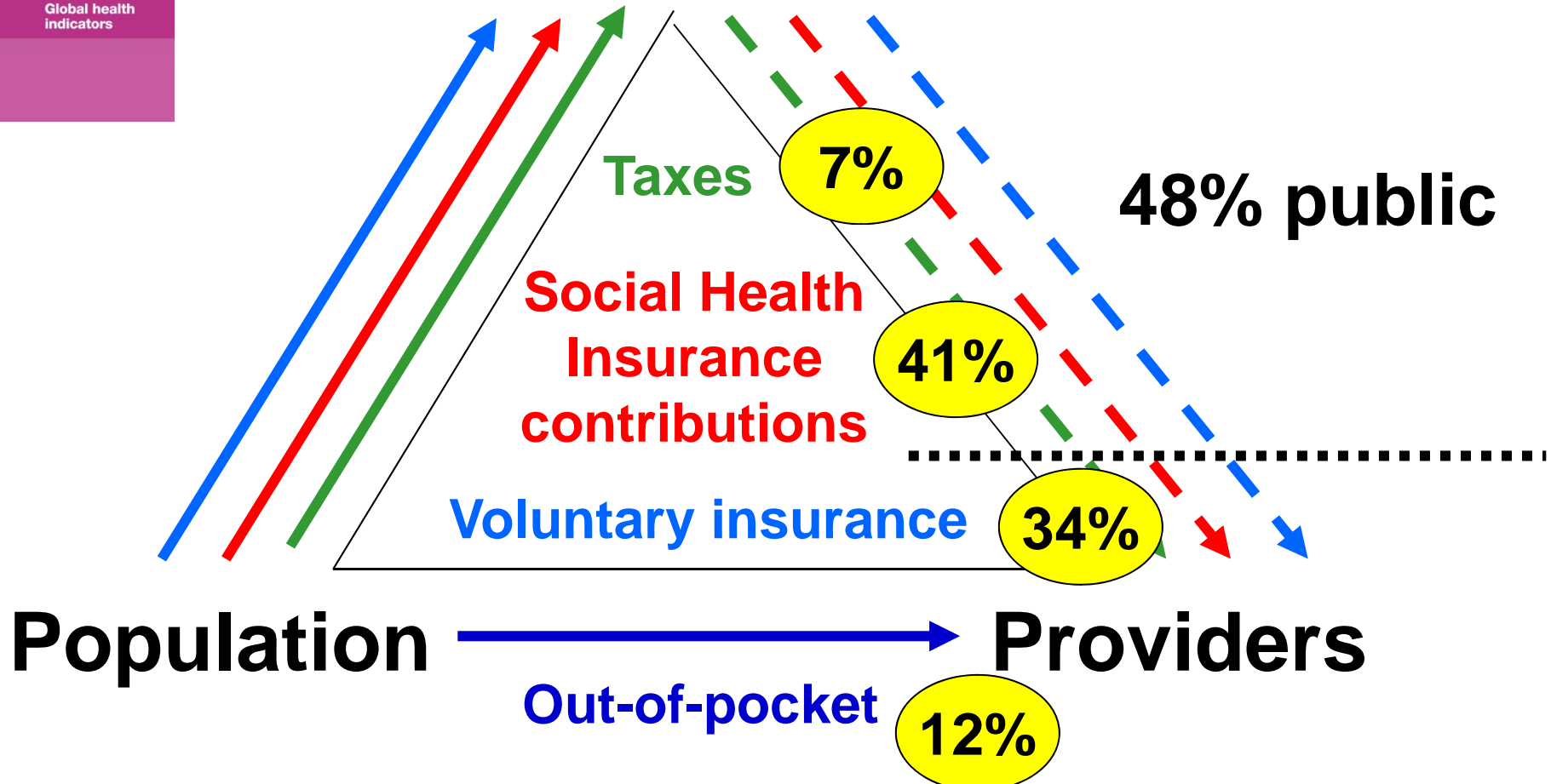


Greece 2010

10.8% of GDP



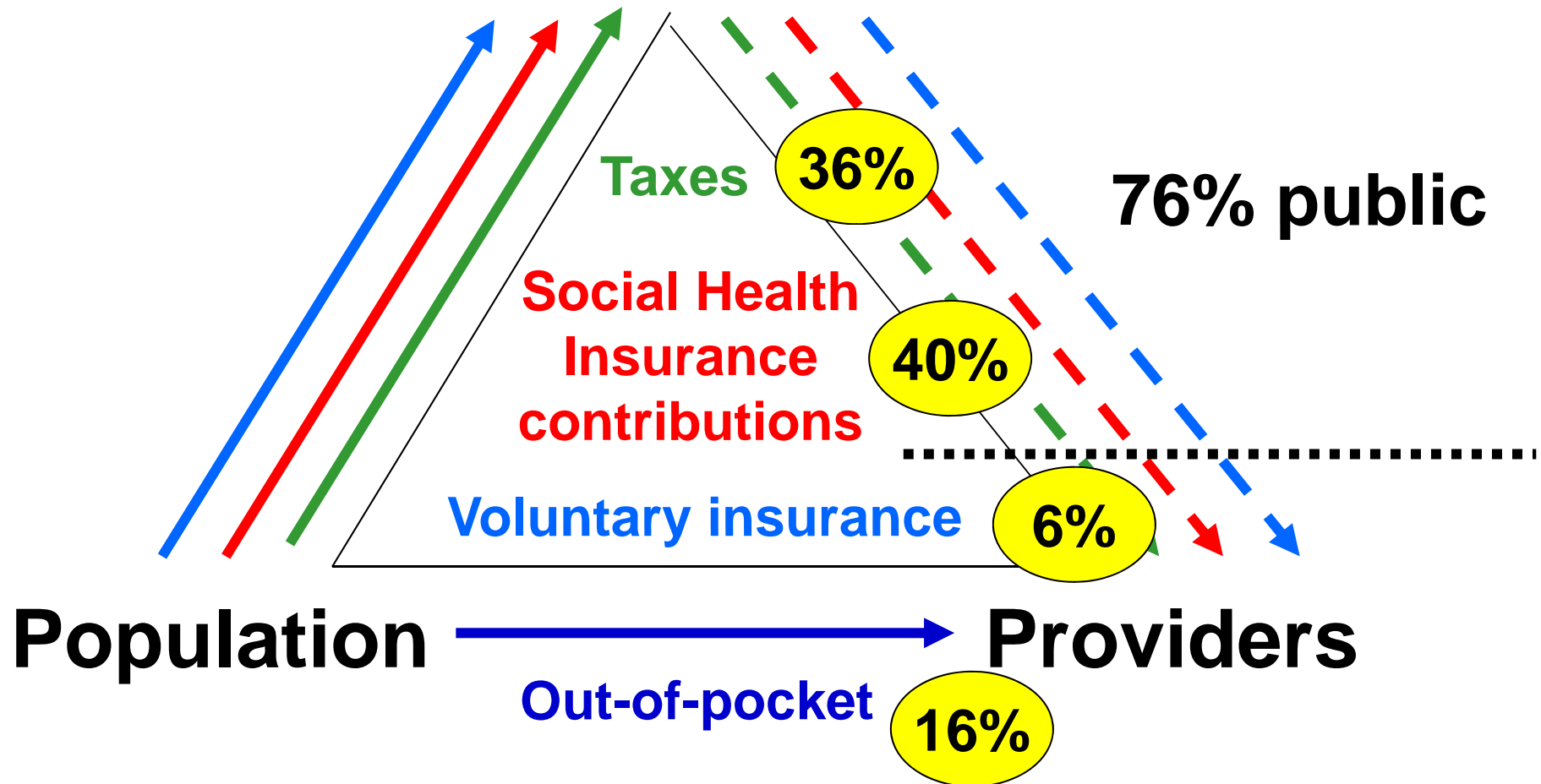
Third-party Payer



USA 2010

8200 \$PPP =
17.6% of GDP

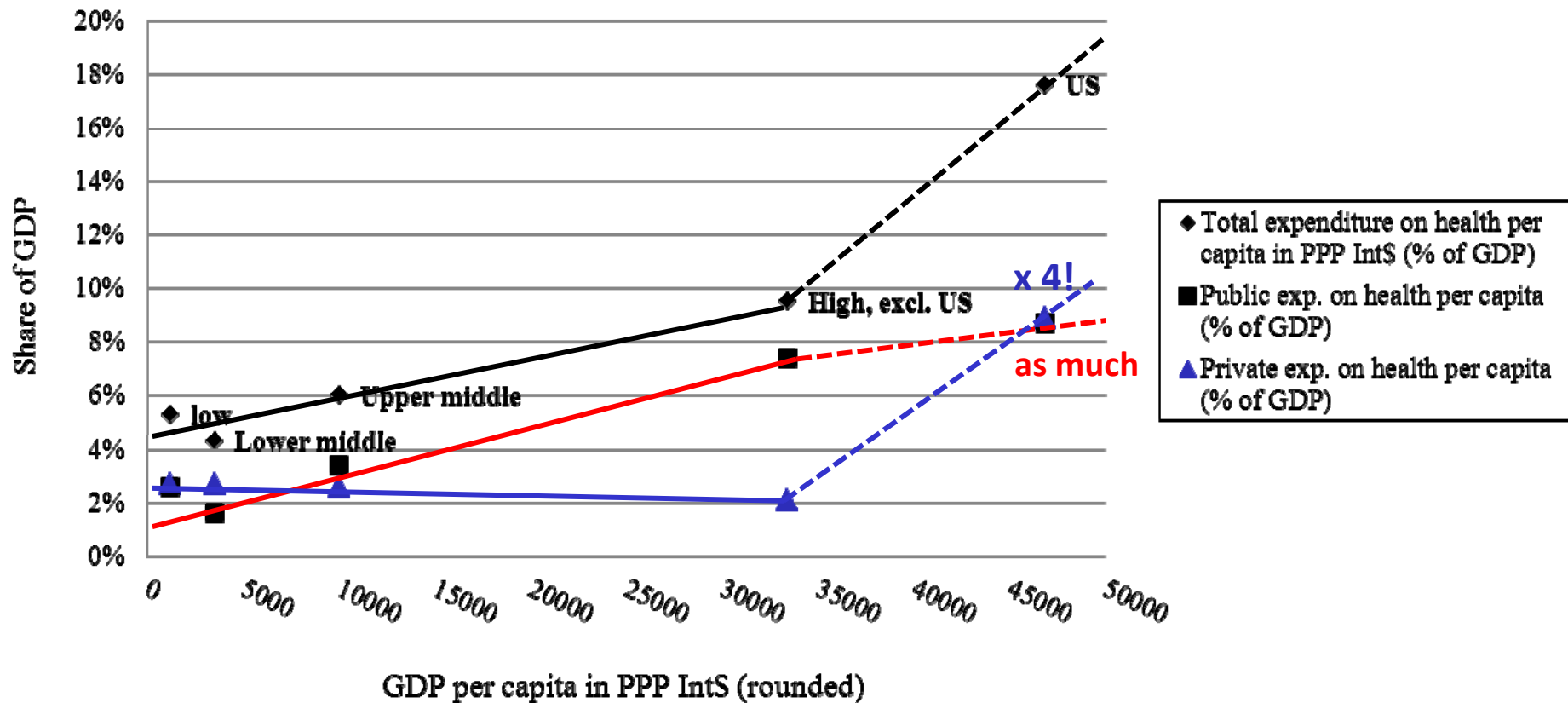
Third-party Payer



High income excl. US 2010

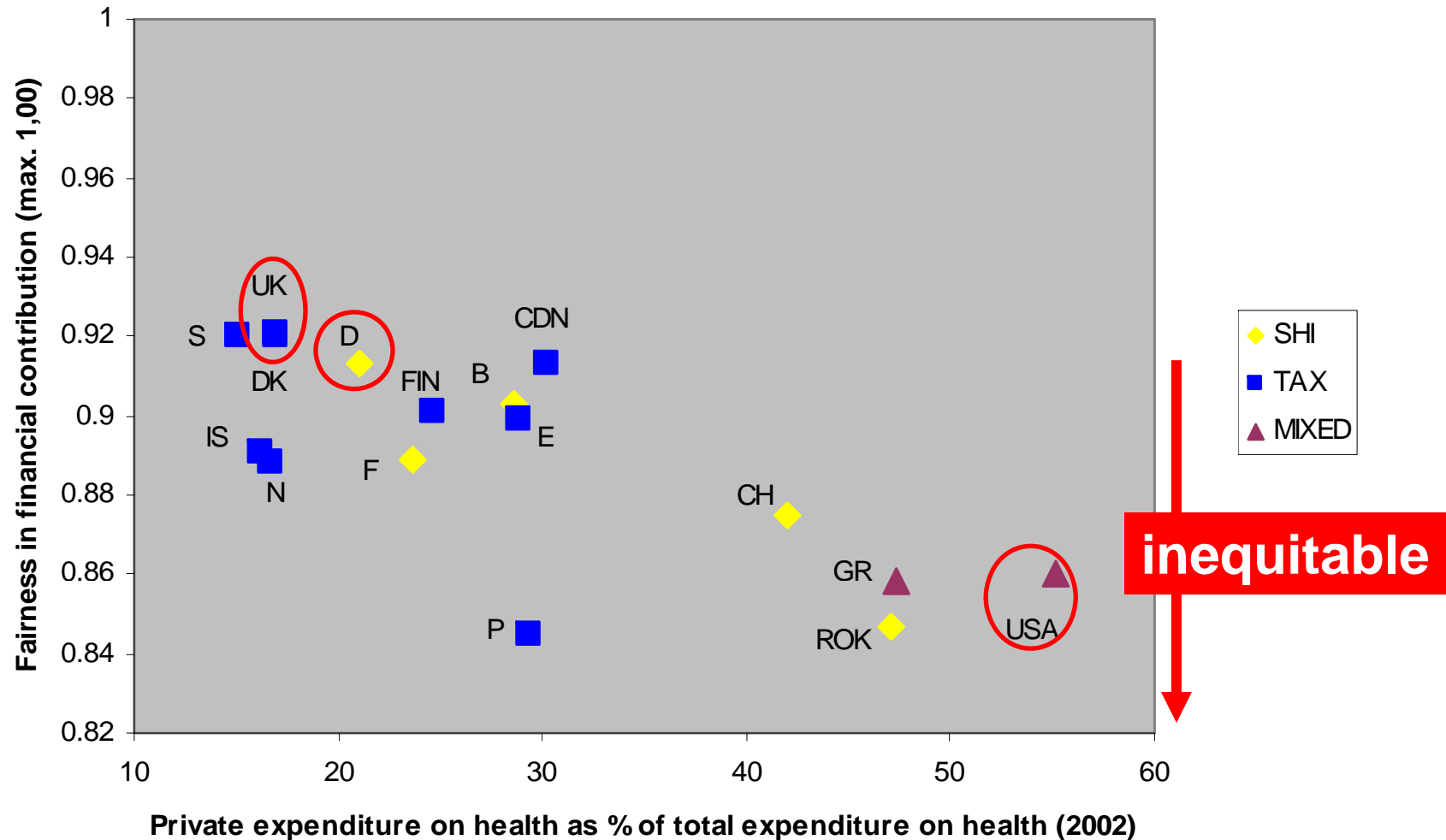
3200 \$PPP =
9.5% of GDP

The richer countries are, the more they spend publicly (with the exception of the US) ...

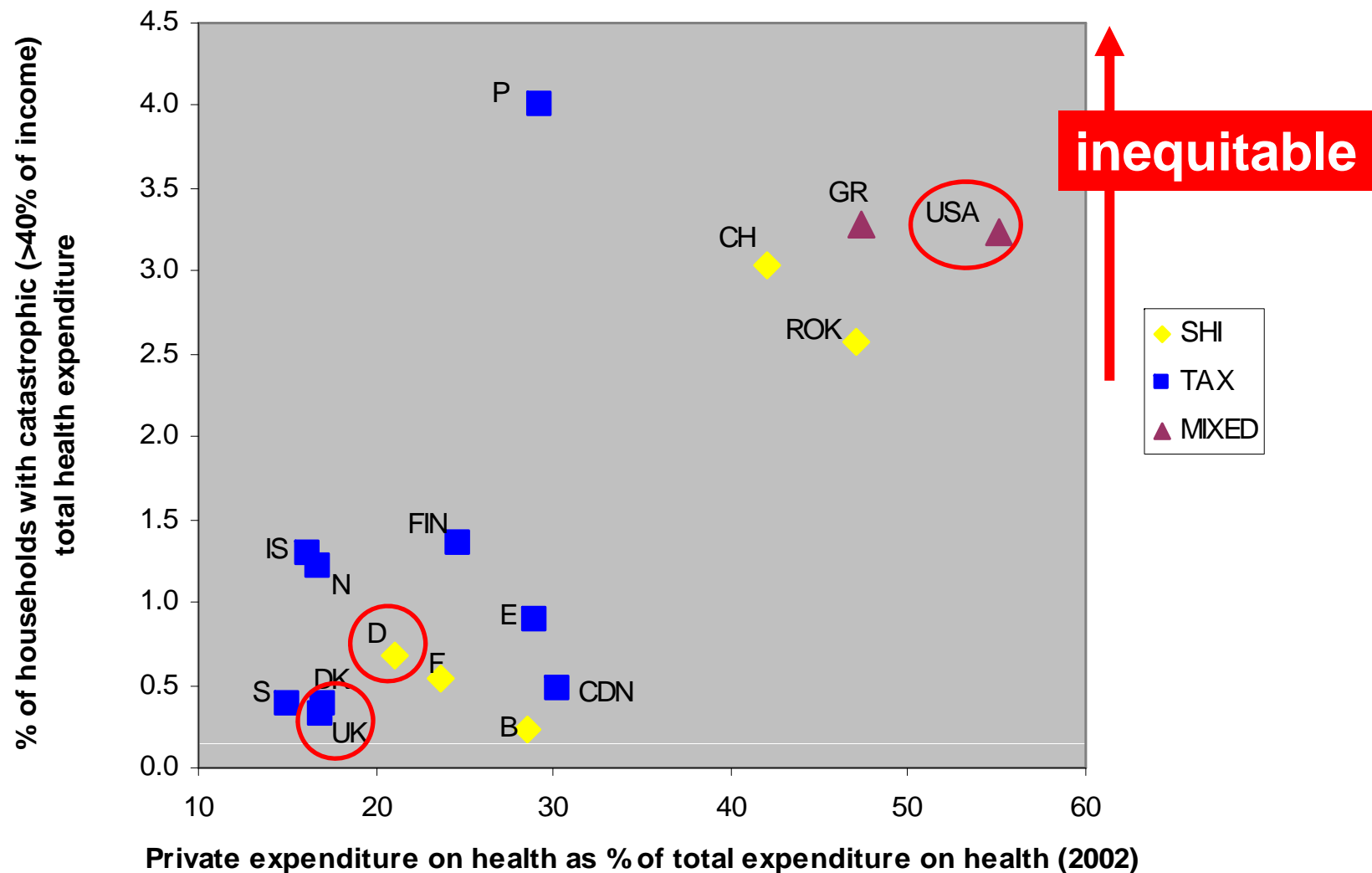


... but is more public better?

Correlation between private expenditure (as % of total health care expenditure) and the level of fairness in financing

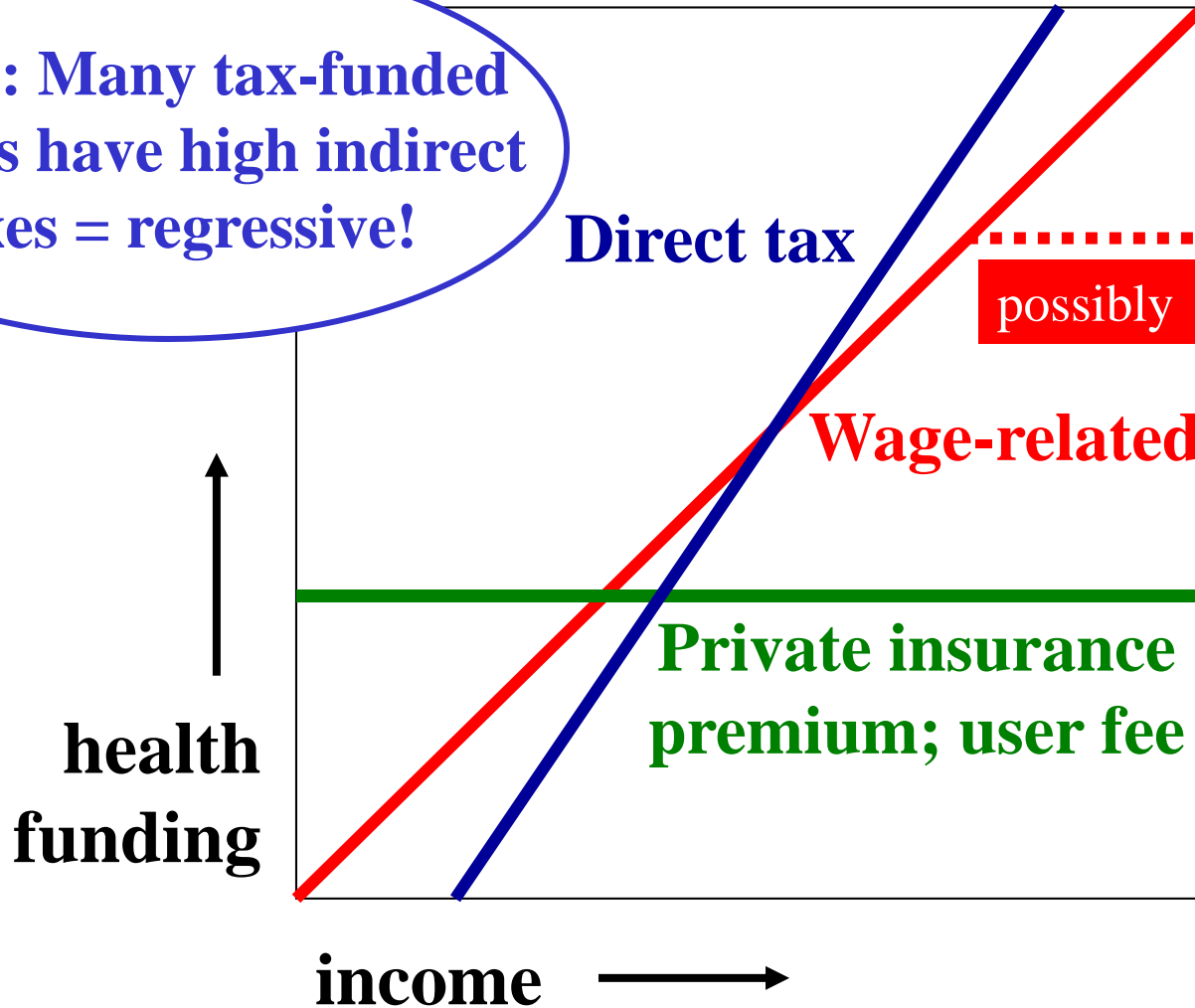


Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure



progressive = equitable = „good“

CAVE: Many tax-funded systems have high indirect taxes = regressive!



proportional = „not so good“

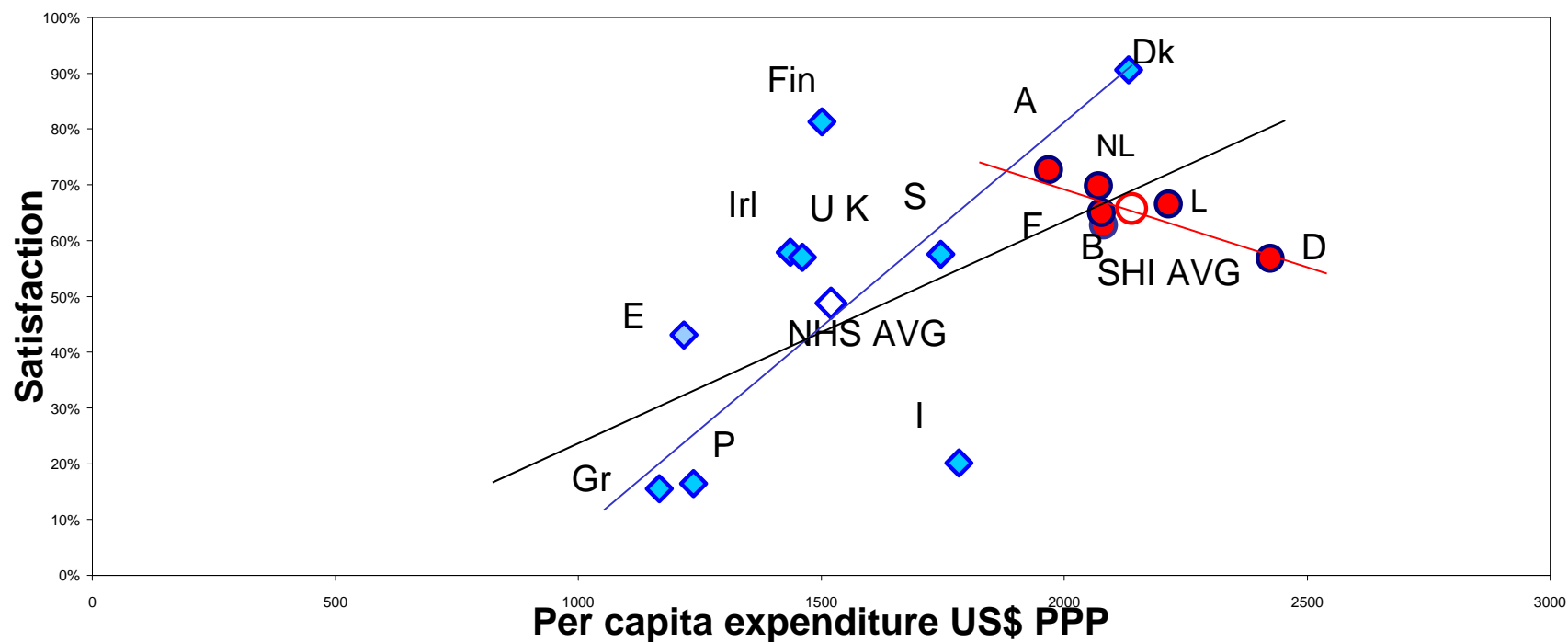
Wage-related contribution

regressive = not equitable = „bad“

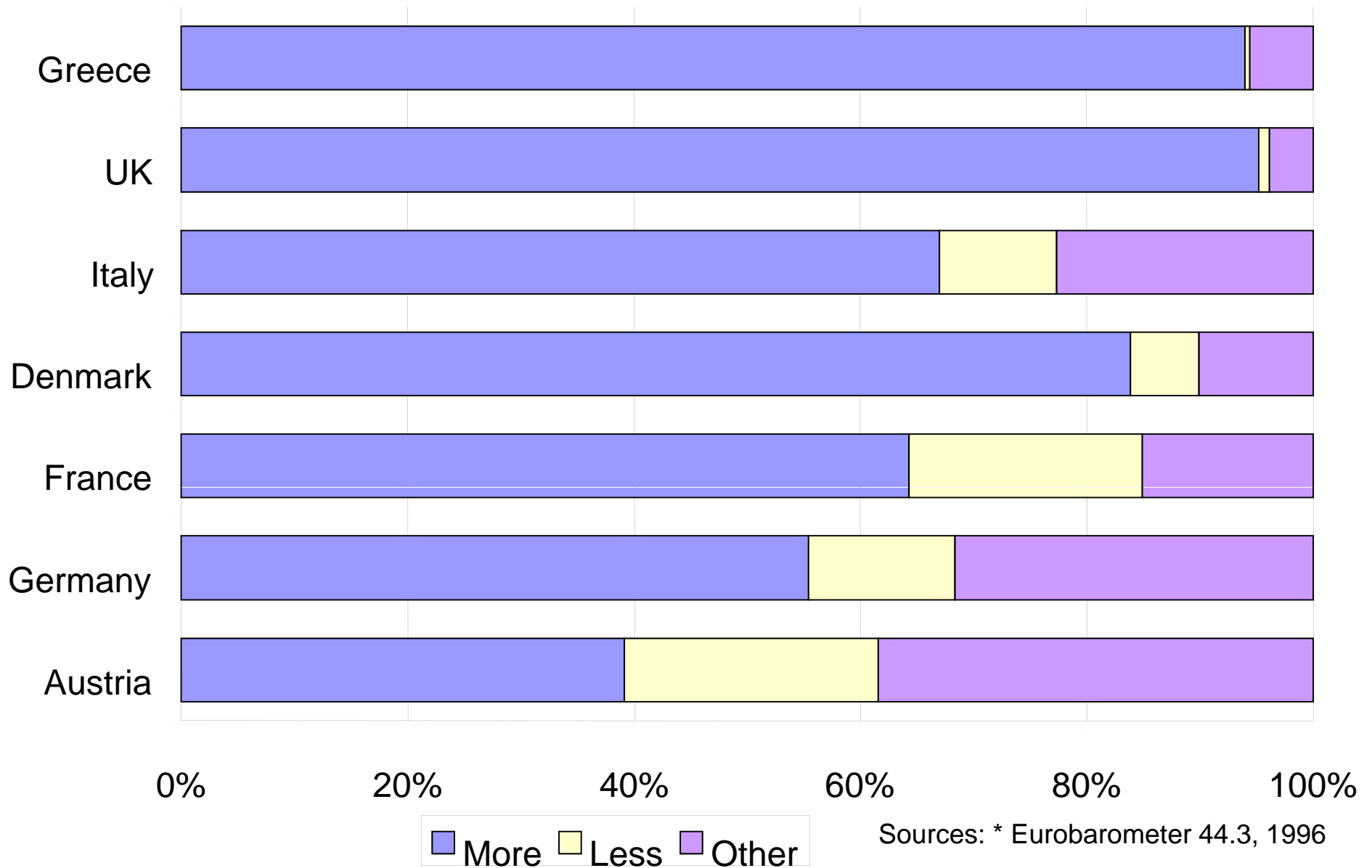
BUT: Low-income households may get (tax-financed) tax-subsidies to pay for insurance premiums.

The more, the better?

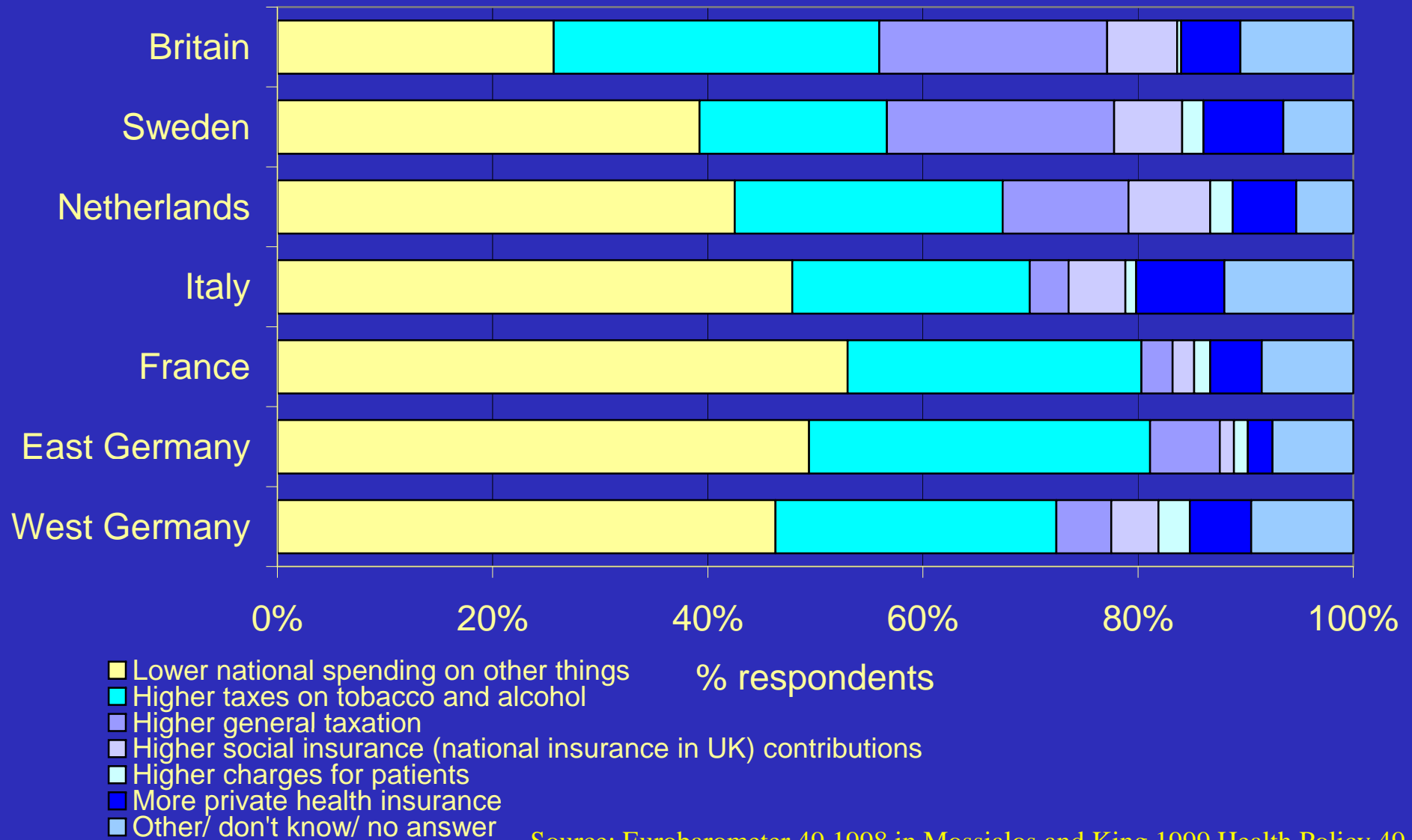
Levels of satisfaction and per capita expenditure in EU-15 countries (2000)



Should more be spent on health?



Where should the extra money come from?



Source: Eurobarometer 49 1998 in Mossialos and King 1999 Health Policy 49

Pooling

allocation

Dependent on risk,
but independent of actual
utilisation

**Contribution
collector**

**Third-party
payer**

Independent of risk,
need and utilisation,
i.e. income-related or
community-rated

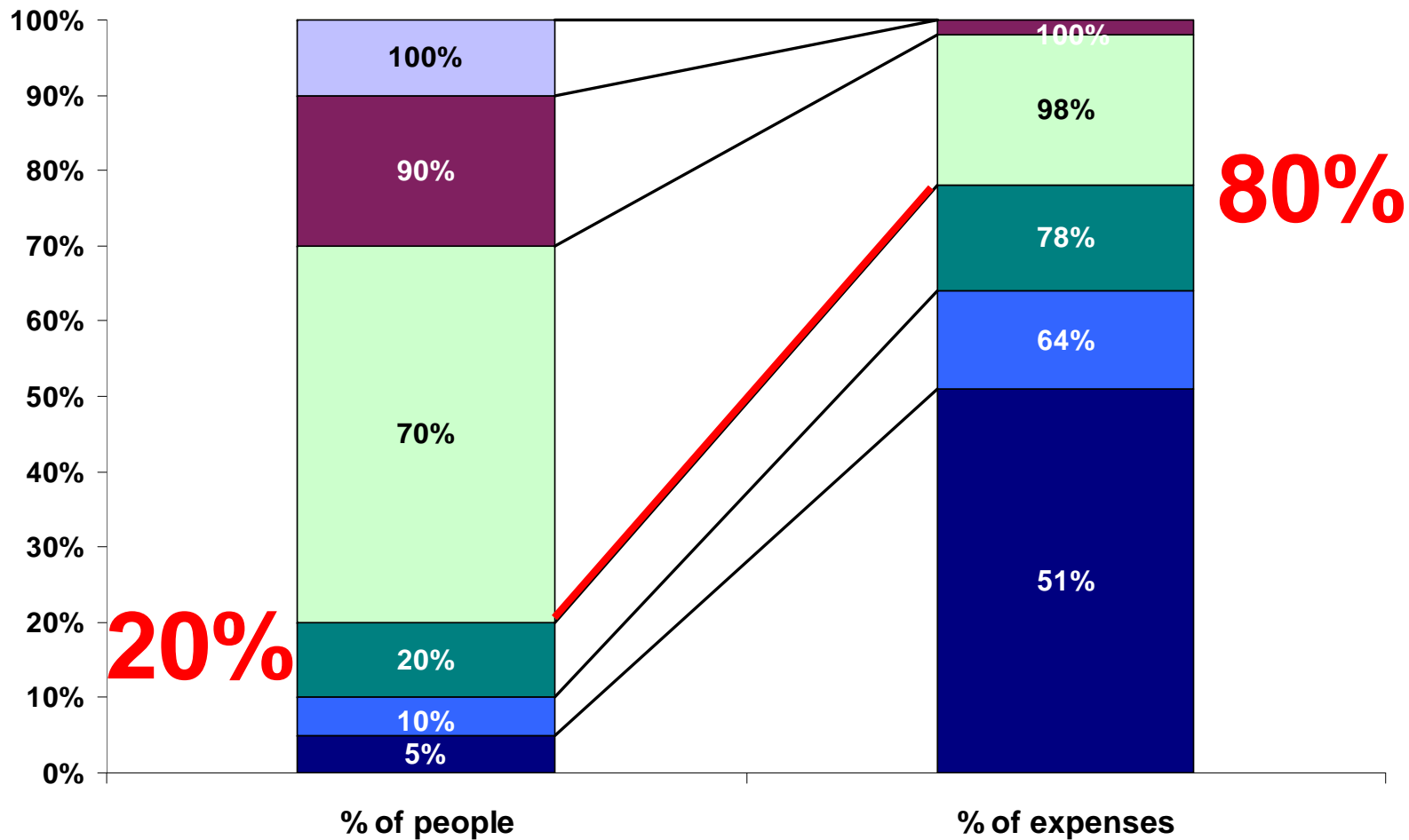
Dependent on volume,
appropriateness (service
= need) and quality,
steered by priorities and
incentives

Population

Providers

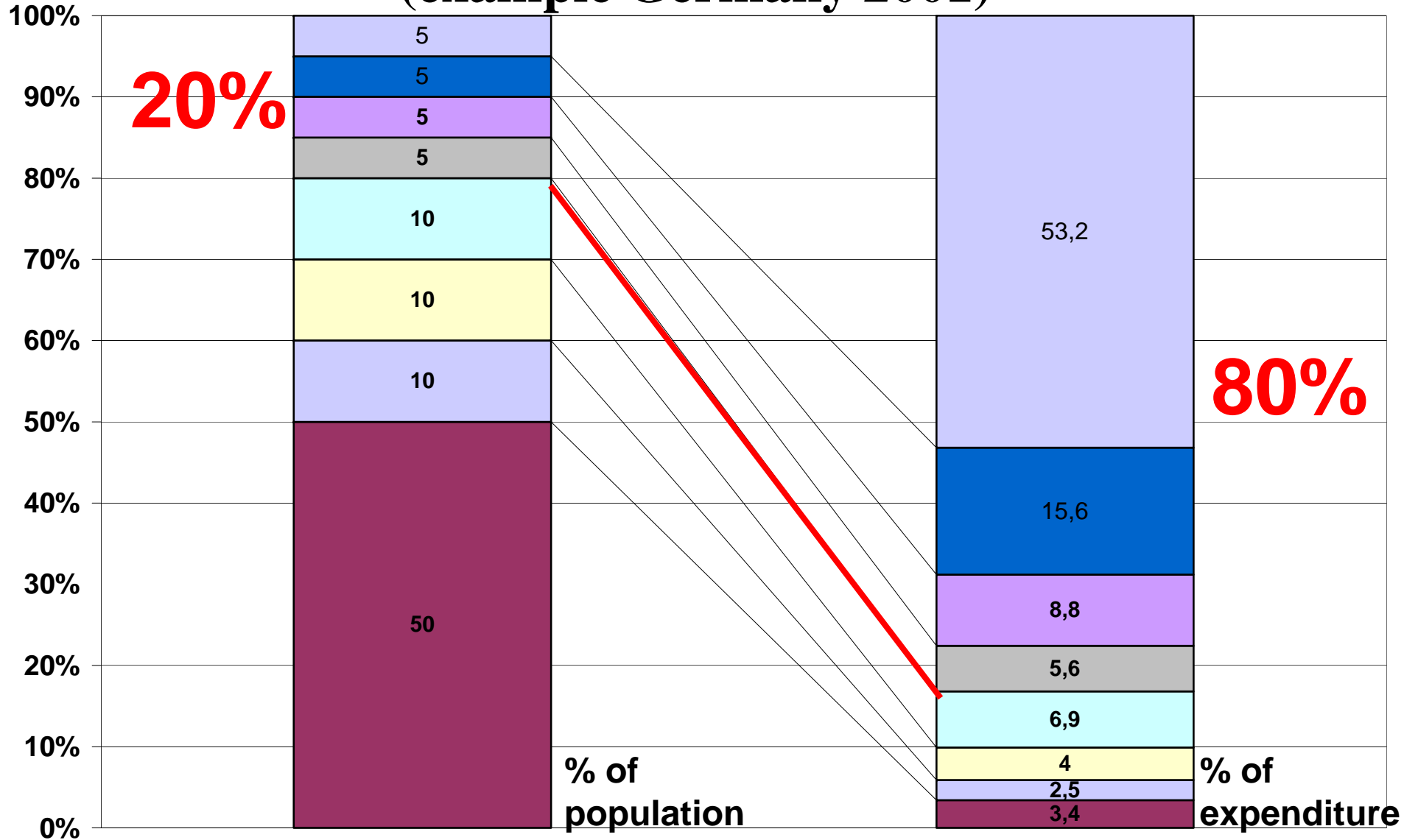
Ability to pay Solidarity Need

Expenditure is highly skewed: 5% of population account for >50% of expenditure (example France 2001)

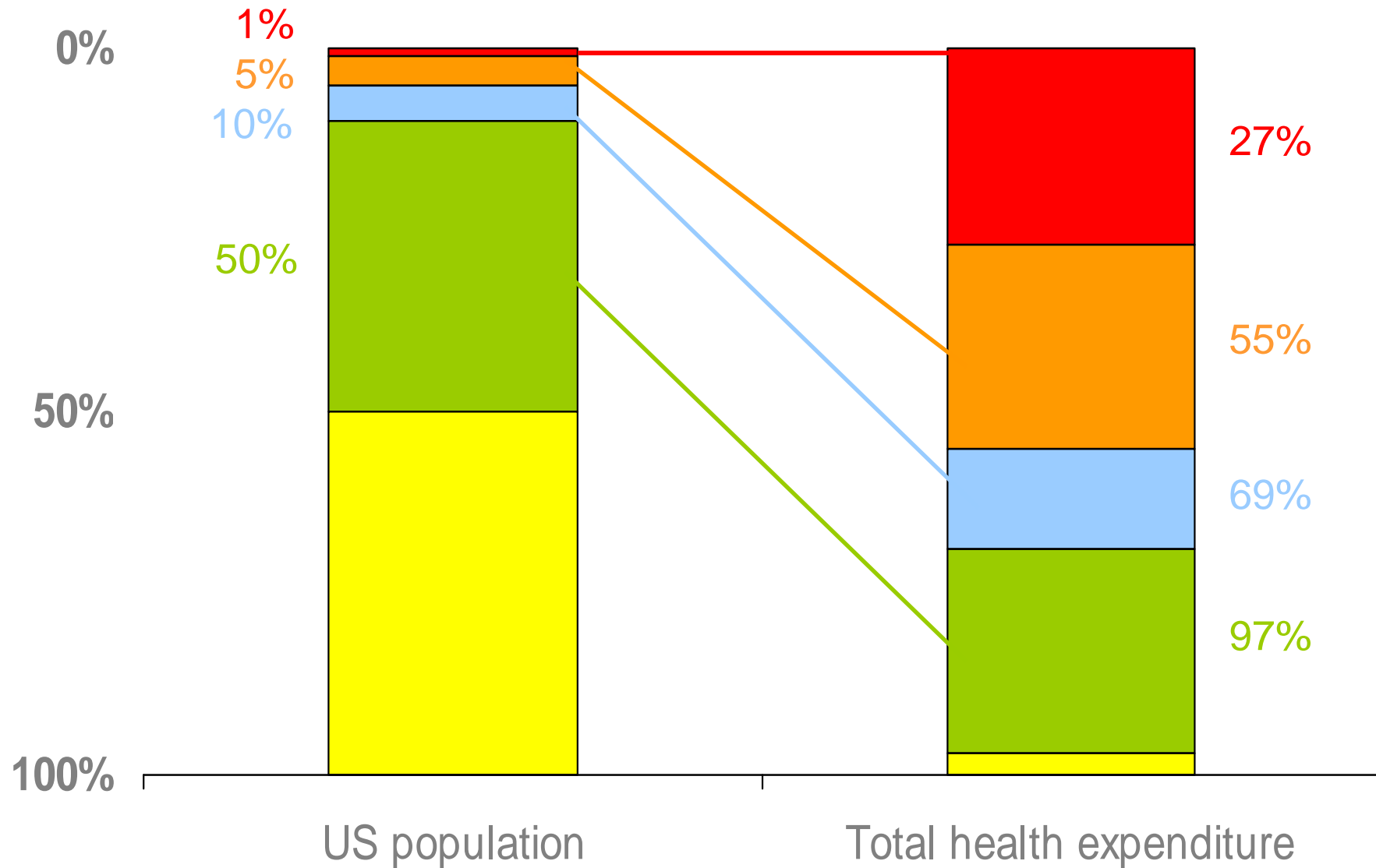


Source : CNAMTS/EPAS

Expenditure is highly skewed: 5% of population account for >50% of expenditure (example Germany 2001)



... and the same picture in the USA



Source: Monheit 2003 and Berk and Monheit 2001

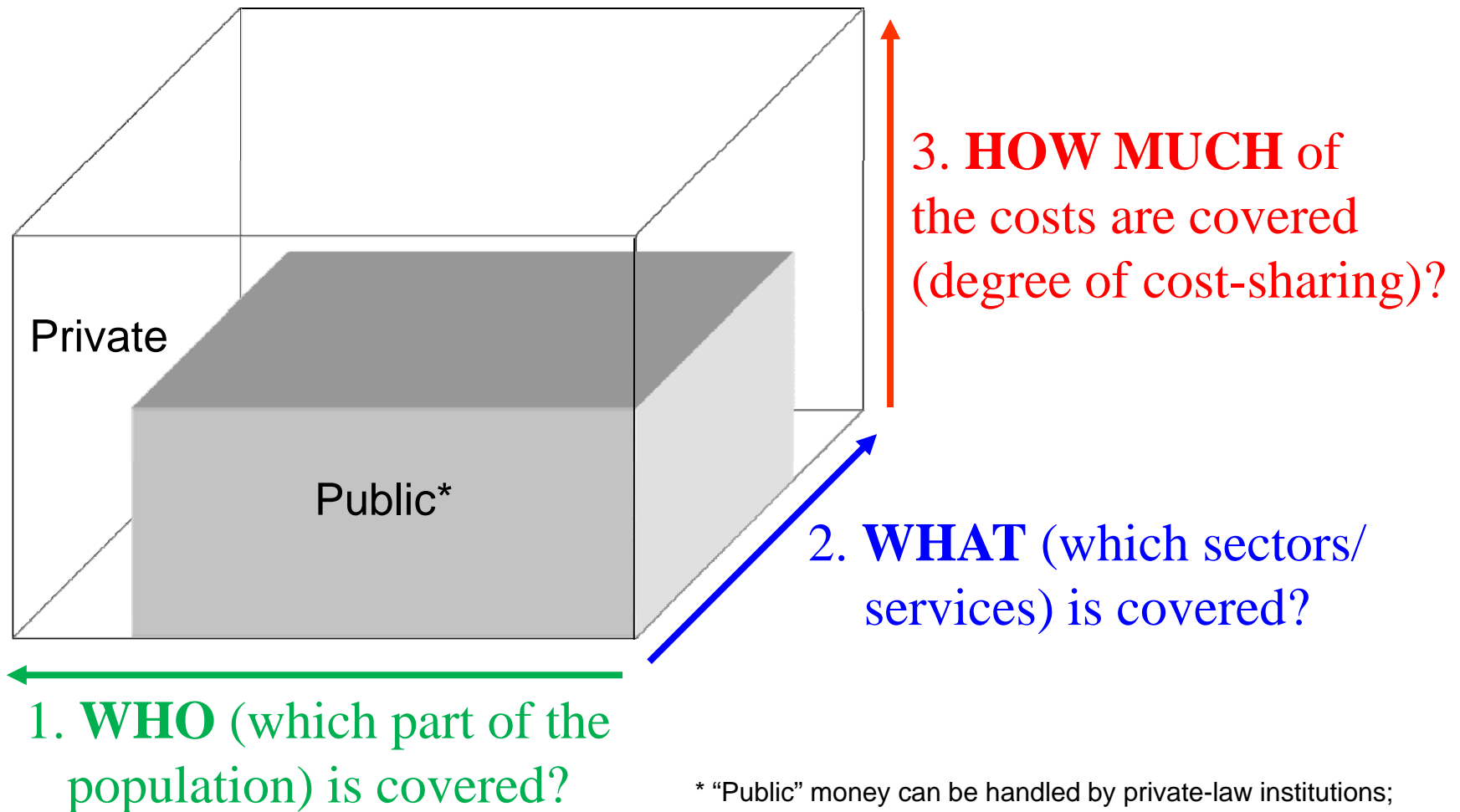
Issues for discussion:

Do allocate to regions with ...

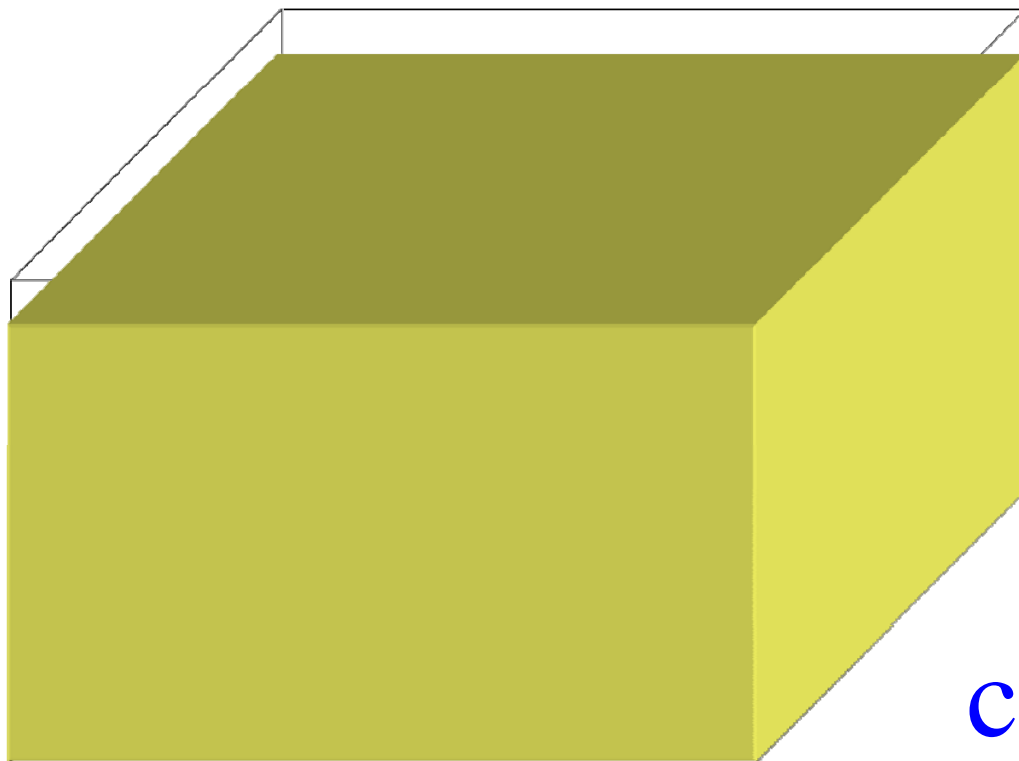
- more elderly
- more ill persons
- lower life expectancy
- more persons in urban areas
- more hospital beds and physicians

more money?

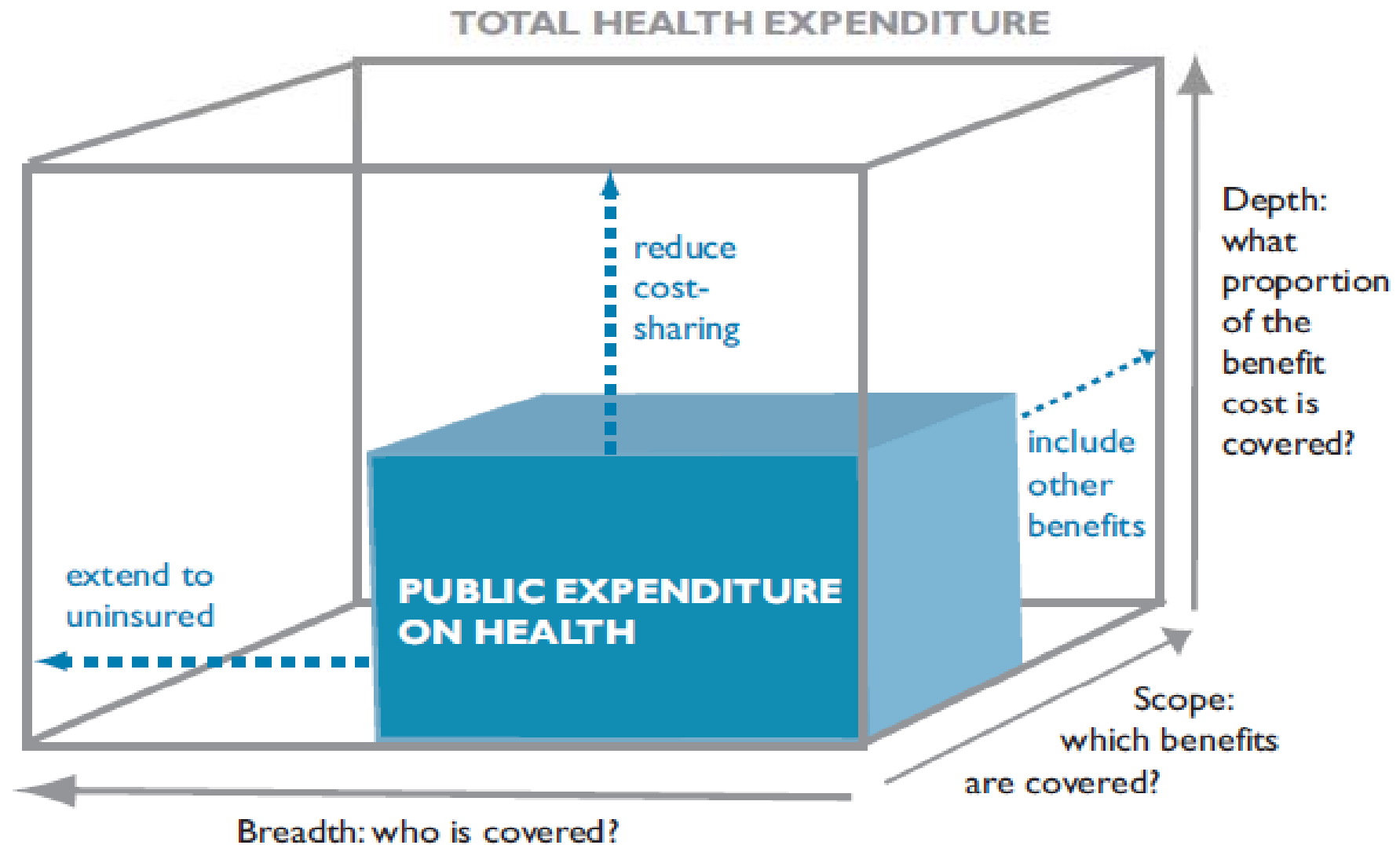
The three dimensions of coverage decisions (visualized by “public” as part of total health expenditure)



* “Public” money can be handled by private-law institutions; “publicly regulated” may therefore be a better term.

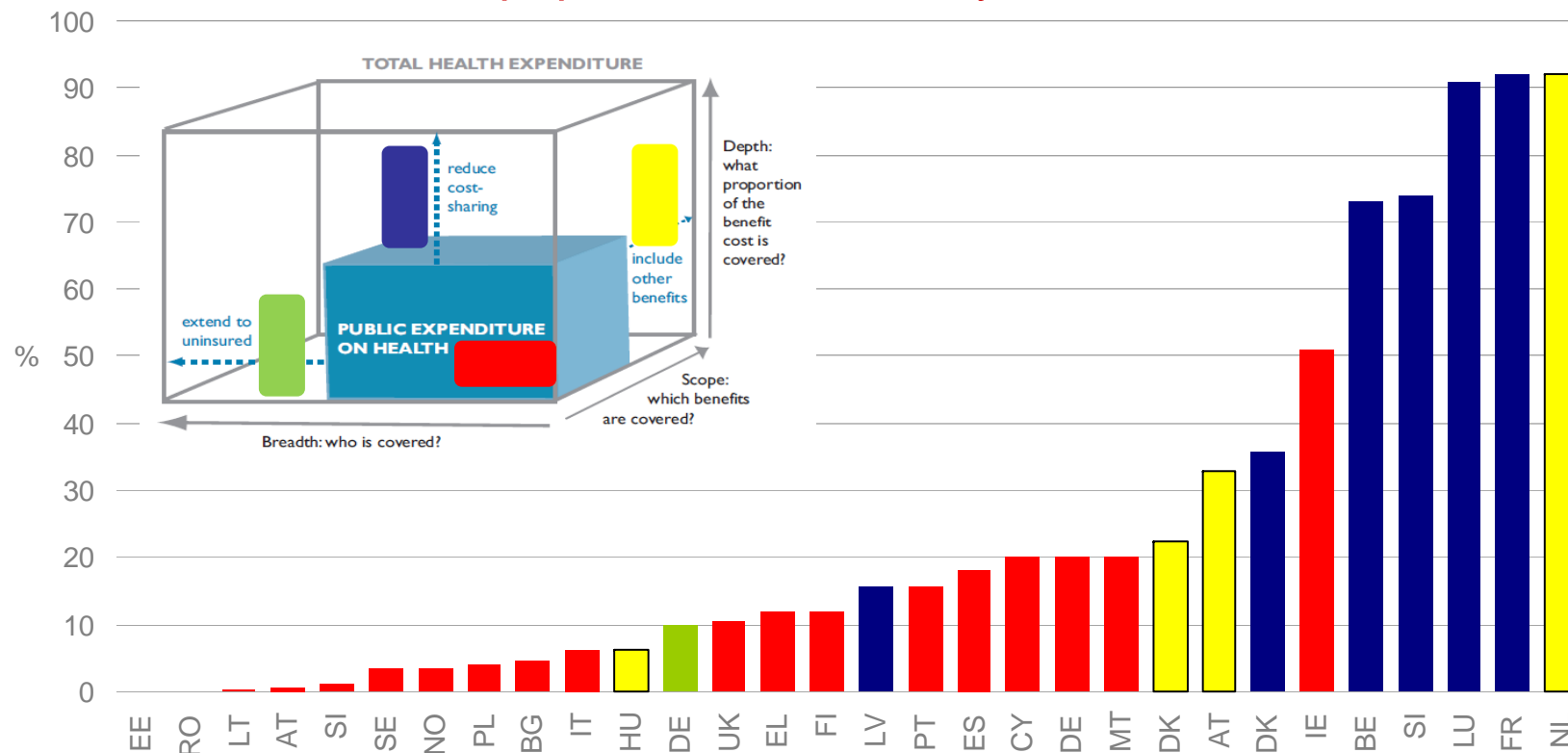


NHS-
principles:
„Universal,
comprehensive,
free at the point of service“



Filling gaps through Voluntary Health Insurance

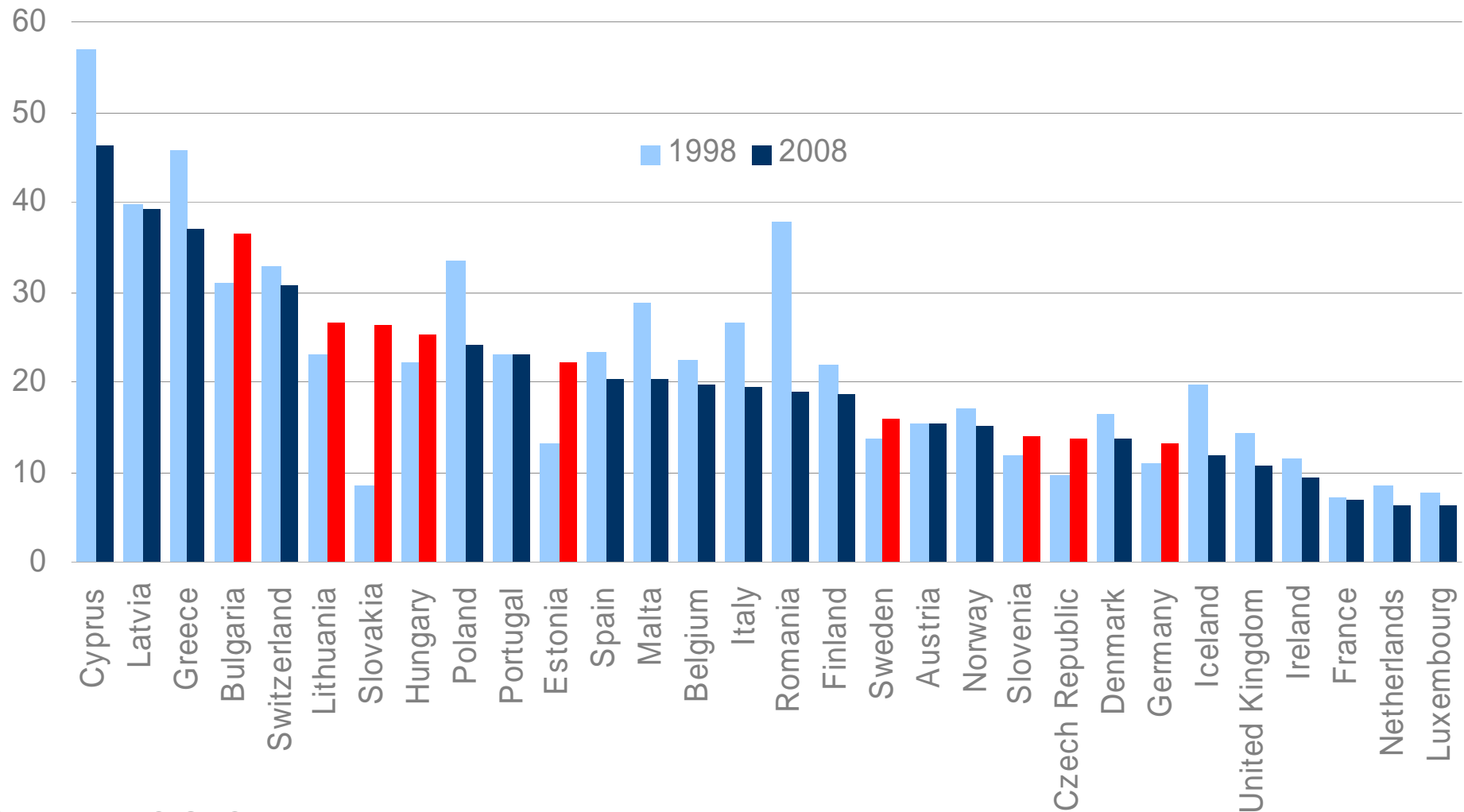
% population covered by VHI, 2008



- Complementary (user charges)
- Complementary (services)
- Supplementary
- Substitutive

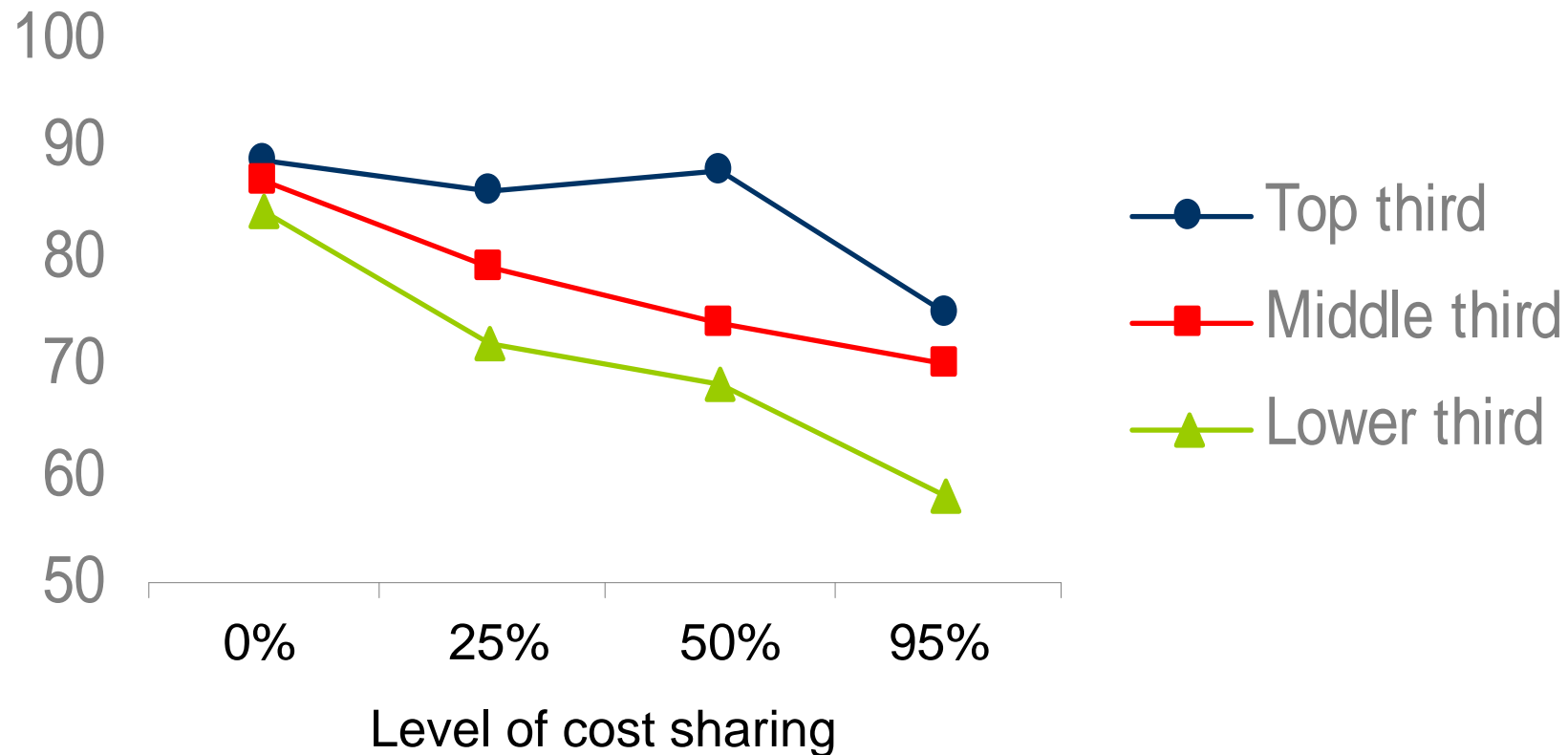
Source for data: Thomson and Mossialos 2009

Out-of-pocket payment as % of total health spending

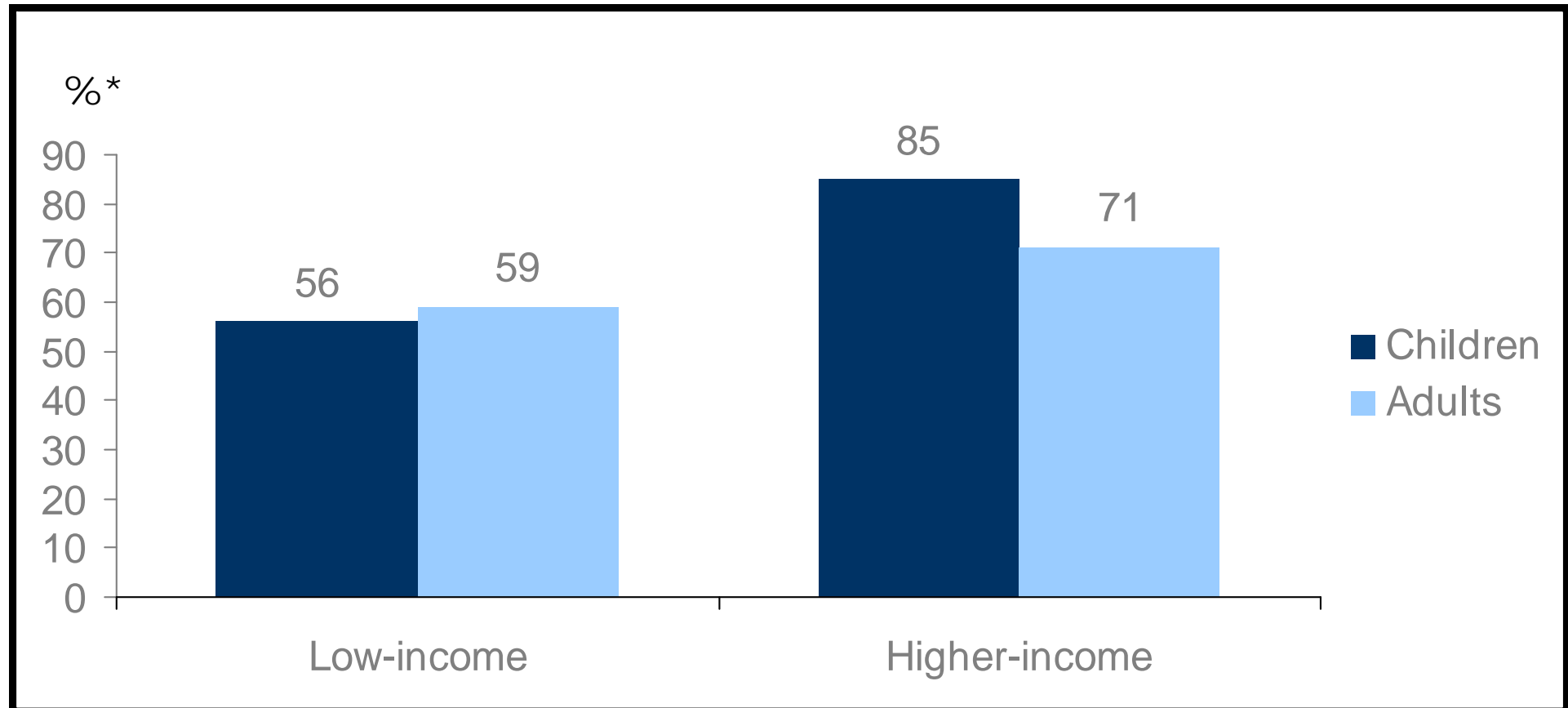


Source: WHO GHO 2011

Cost-sharing reduces use: probability (%) of health care use by level of cost-sharing & income group



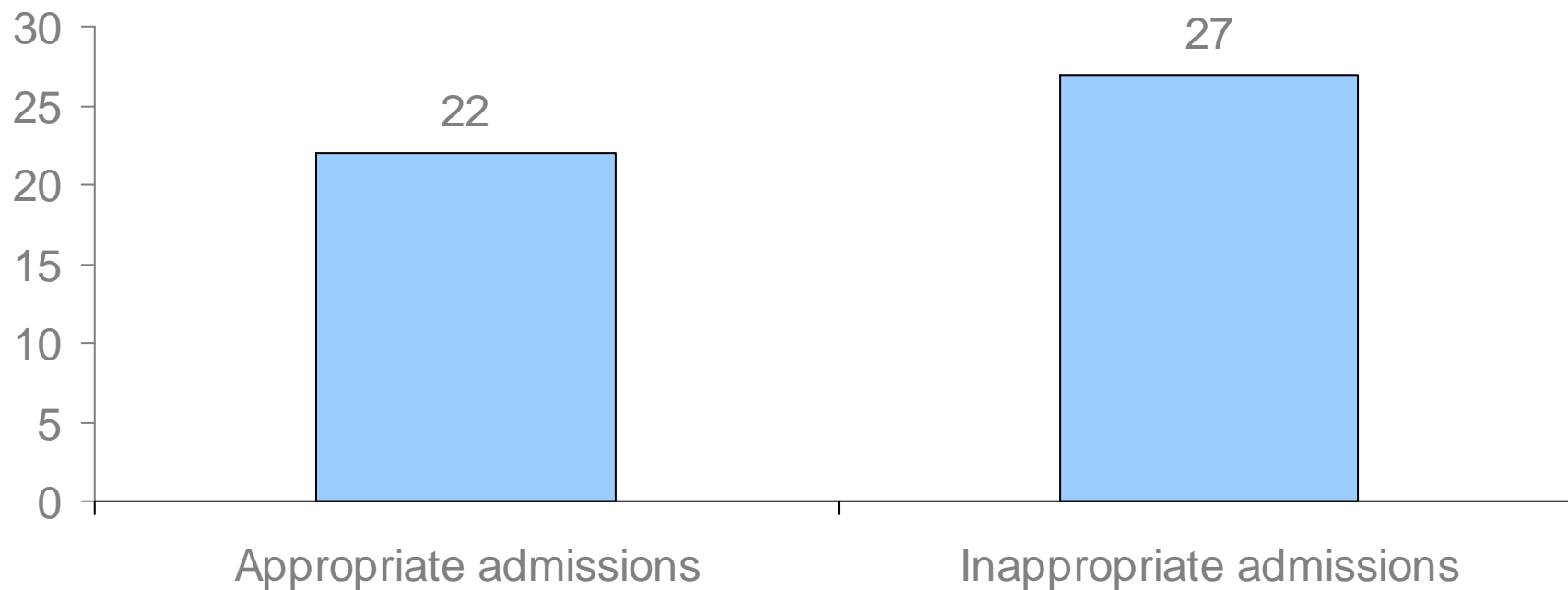
Cost-sharing disproportionately affects poorer people



Probability (%) of receiving highly effective care compared to those with free care (care that is appropriate and necessary for acute conditions)

Source: Lohr et al 1986 (RAND study)

Cost-sharing: a blunt tool with very limited selective effect



% reduction in hospital admissions per 1000 person years among those who had to pay (compared to free care)

Without strong policy design, cost-sharing will damage efficiency (value) and equity

- x** don't create barriers to cost-effective care
- ✓ align incentives across patients, providers, pharmacists
- ✓ protect poorer people & regular users
- ✓ keep it simple: co-payments vs co-insurance
- ✓ caps provide protection & transparency
- ✓ monitor impact of charges & protection