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THE CHANGING SCENARIO OF HEALTHCARE FINANCE

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ABSTRACT

This article elaborates the question of where funding for health services comes from and how it is used. After an introduction to the historical development of various countries' provision of health care, it looks at third-party arrangements and out of pocket payments, the distinction between public and private agents in the finance and provision of health services, and the question of the extent to which governments take responsibility for organizing health services.

KEYWORDS: *health finance, health care, social insurance, ability to pay*

OUT-OF-POCKET AND THIRD-PARTY PAYMENT

In a most basic way, health care financing represents a flow of funds from patients to health care providers in exchange for services. As Figure.1 shows, there are two ways of paying for health services:

• *Out-of-pocket payments*: this is the simplest and earliest form of transaction between patient and provider. Access to care depends on ability to pay.

• *Third-party payments*: the uncertainty of need and the great costs of health care mean that people choose to finance health services through payments to a third party, an insurance company or a government. These third parties are involved in the economic transaction between patients and providers.

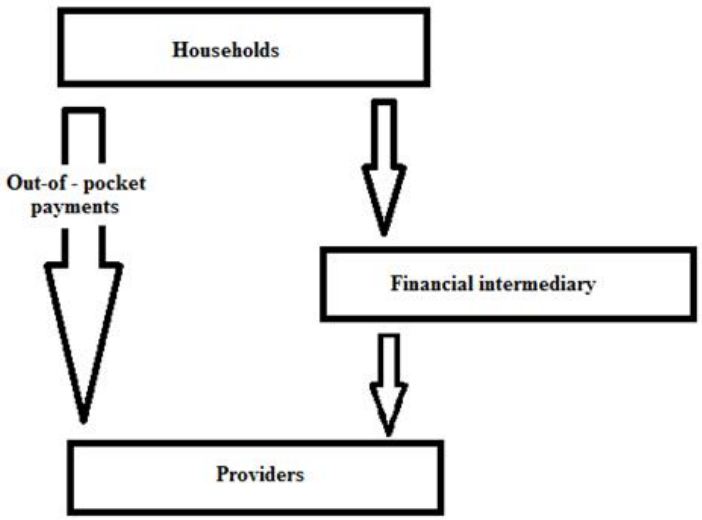

Figure.1 The flow of funds in health care provision

THE EVOLUTION OF HEALTH SERVICE FINANCE

International comparison shows that countries use different ways of paying for health services. For example, France and Sweden have developed distinctly different practices to fund hospitals and to pay for doctors. Latin American countries have social insurance systems whereas in many African countries government funding is common.

To a large extent, these differences are due to historical factors. Analyzing the historical context will make us aware that health finance today has been shaped by cultural and political factors from the past. It will explain why the approach to health finance differs between countries. And this will help us to make more meaningful comparisons between countries and enable to understand the strengths and weaknesses of our own country's health system.

FROM PRIVATE TO SOCIAL HEALTH INSURANCE

Early in the history of health care, *government* or *charities* financed services for groups of the population for whom they perceived a duty of care. For example, hospitals for the poor existed in India, China, Arabia and medieval Europe (Abel-Smith and Campling 1994).

For the more affluent, *private* (or *voluntary*) *health insurance* was pioneered in Europe as early as the eighteenth century. In the nineteenth century, private insurance was developed throughout Europe and spread to North and South America. Meanwhile, *social* (or *compulsory*) *insurance* was introduced in Germany for industrial workers in 1883, building on the existing voluntary precedents. Coverage was extended later to family members, other employees and pensioners. Payroll-based social insurance systems developed steadily in Europe, and later in Latin America and Asia.

ACHIEVING UNIVERSAL HEALTH CARE COVERAGE

Countries have used different means of making health care available to all: *universal coverage* is achieved either through the extension of social insurance or government provision to the whole population.

The Soviet Union extended coverage through government provision in 1938, and that example was followed by the countries of the Soviet bloc after World War II. The UK extended coverage to all in 1948. The British NHS was established as a major part of the social reforms recommended by William Beveridge with the aim of providing health services for the whole population. In the USA, private insurance has assumed a larger role than in Europe. However, even in the USA, publicly funded health care pays a large role for the elderly (Medicare), the poor (Medicaid), and past and present armed services personnel.

The health finance systems of low income countries have been strongly influenced by their colonial past. In British colonies, government funded services for the armed forces and civil services provided the basis for further extension of health care, whereas in French colonies the model was provided by larger firms, which were required to provide services for their employees. To a variable extent, charitable organizations and missions also played a role in financing hospitals. In the post-colonial era these countries made efforts to extend services 'as far as economic growth and available resources allowed' (Abel-Smith and Campling 1994).

TWO MODELS OF HEALTH CARE FINANCE FOR ACHIEVING UNIVERSAL COVERAGE

Two models that are often referred to in connection with attempts to ensure universal health care coverage are the Bismarck model, which is based on compulsory (social) health insurance, and the Beveridge model, based on tax funded services:

- *Otto von Bismarck (1815–98)*: Prusso-German statesman and founder of social insurance in Germany. Bismarck introduced in 1883 a plan based on compulsory insurance protecting workers against accidents, sickness and invalidity.
- *William Beveridge (1879–1963)*: British economist and architect of the British welfare state. The Beveridge Report proposed a tax funded plan to provide 'full preventive and curative treatment' to every citizen of the UK, leading to the foundation of the NHS in 1948.

DEVELOPING METHODS TO PAY PROVIDERS

Methods of paying health care providers have evolved along with the development of funding systems. Finding the optimal means of providing payment has been a constant source of political debate. Strategies used by doctors to gain favourable conditions have included boycotts and takeovers as well as the foundation of their own insurance organizations (Abel-Smith and Campling 1994). Conflicts between the medical profession and financing agents are related to issues of whether:

- doctors should be employed or act as independent contractors;
- payments should be based on a *salary*, on the number of patients cared for (*capitation*), on the items of care provided (*fee-for-service* – FFS), on the quality of their performance or on a combination of these options;
- patients should pay health care providers directly and then claim reimbursement from government or insurance companies or payments should be made directly to the providers by the funders.

THE CHANGING WORLD OF HEALTH SERVICES FINANCE

The means of paying for health care is an issue of concern in most countries. Governments are worried about the economic and political consequences of the increasing cost of providing health services and try to limit spending through tighter controls. There is a large body of literature to suggest that many countries are dissatisfied with the existing methods of finance and delivery of health services. During the last decade, governments have introduced a series of reforms. Though the motives and types of reform may differ, there have been some common themes:

- Separation of purchaser and provider responsibilities. This concept refers to the separation of responsibility for purchasing and providing health care between two different organizations. In general, funders (government and insurance companies) have two options: to run their own hospitals or to act as purchasers and buy services from providers, including the private sector. The underlying idea is that purchasers contract with those providers offering best value for money and that this increases efficiency of service delivery.

- Redefinition of the role of the state in responsibility for health care.
- Encouragement of the private sector.
- Encouragement of competition between providers.
- Alternative sources of funding: economic crises have exacerbated the problems of financing the health sector and governments have sought alternative ways of mobilizing resources.

When considering the last of these it is helpful to distinguish between *macro-level* and *micro-level* changes. Macro-level changes involve a change in the basic principle of funding, such as the move from social insurance towards a system mainly based on taxation in Italy and Spain. Probably the most radical recent changes have occurred in the former Soviet Union and eastern Europe. A large number of former communist countries have undergone a change from government funded services to social insurance. Eleven countries passed social insurance laws between 1991 and 1996 (Ensor and Thompson 1997).

Radical changes have also been taking place in some low income countries where greater use of community financing and patient charges has been pursued. The term 'community financing' doesn't refer to a special finance mechanism; it is related to the way fundraising is organized by local communities. The collective effort of rural communities often has other targets than health, such as crop insurance or credit financing. Community funding for health care is more likely to develop where there are no free government services.

In contrast, micro-level changes don't affect the basic method of funding. Such changes include introduction of co-payments and changes in the way providers are paid.

INCREASING HEALTH CARE COSTS

Why are health services getting more expensive? There are several answers to this question: an ageing population, increased population coverage, technological advance and growing expectations. Some authors (Relman 1988; Hurst 1992) have put forward a three-stage model to explain how health systems have changed during the last 60 years:

1. During the first stage, policies removed the existing financial barriers to health care. New funding arrangements increased population coverage and triggered the *expansion* of health services.
2. The subsequent increase in demand led to a rapid growth of health care expenditure. Often spending grew faster than the gross domestic product (GDP) and policy efforts were focused on *cost control*.
3. From the experience of ever-rising costs, it was realized that cost control alone is not effective. Policies of the third stage aim to *improve efficiency* of service delivery and use.

DEMOGRAPHIC FACTORS

We need to distinguish between *absolute population growth* and *relative changes within a population* towards groups with higher health care needs (the elderly, the very young, displaced populations). Both mechanisms may influence health care costs.

ECONOMIC FACTORS

Economic growth is associated with rising costs for health services. Economic recession has opposite effects. But we need to be aware that unemployment and poverty are related to ill health and put additional strain on health services. When assessing cost escalation, we need to consider relative prices by taking account of the inflation rate. Supply factors also exert important pressures – for example, increasing numbers of doctors and hospitals or payment increases for health workers.

HEALTH TECHNOLOGY ADVANCES

At the beginning of the twentieth century, health services had only a few effective treatments. Since then, the number of effective interventions has steadily expanded – for example, antibiotics (1938), open heart surgery (1954), haemodialysis (1960) and computerized tomography (1973).

DISEASE PATTERNS

Why does the change of disease patterns, which has been observed in many low income countries, affect health care costs? First, new diseases like HIV/AIDS increase the level of ill health in the population. Second, the relative increase in chronic diseases and long-term illness is related to higher treatment costs. With economic development, countries are likely to experience higher health care costs, as deaths among infants from communicable diseases decrease relative to adult deaths from chronic diseases. This trend has been described as the epidemiological (or health) transition. Note that in 1990, 56 per cent of all deaths in the world were from non-communicable diseases. But these figures are unevenly distributed among social classes: non-communicable diseases were responsible for only 34 per cent of the deaths among the poorest 20 per cent of the world as compared to 85 per cent among the richest. This indicates that inexpensive, effective interventions against communicable disease still have a high priority in improving the health of the poor (Christopher *et al.* 1996).

POLITICAL FACTORS

Health budgets are inevitably based on political judgement. There may be additional 'cash injections' before elections or deviations from planned growth rates because of other priorities. Health funds may be diverted officially to support other purposes. Concerns about equity may improve access to services and increase costs. On the other hand, corruption of politicians, civil servants or health care providers may lead to substantial economic losses.

SOME POPULAR FALLACIES OF THE CURRENT DEBATE

Be cautious with estimates of the effect of ageing on health care costs. Recent research has shown that the highest costs occur during the last year of life, irrespective of age. Very old people may even tend to consume fewer resources than younger ones (Hamel *et al.* 1996). In high income countries, the increasingly high costs of dying seem to be a more important factor than the steadily increasing proportion of the elderly.

We should be aware that, contrary to popular belief, *prevention and early treatment* can lead to increased costs in the long run. For example, lifetime health care costs are lower among smokers than among non-smokers, suggesting that early death from smoking prevents paying extra costs of treating other diseases (Barendregt *et al.* 1997). In addition, earlier death reduces the cost of paying retirement pensions.

Another fallacy is related to the effect of *new health care technologies*. New equipment may be expensive initially but may ultimately be more cost-effective than the older technologies it replaces. New technologies can only be justified if they lower costs or improve services. It is important to be aware that it is not technological advance *per se* that escalates

costs, rather the failure to implement the rules of economic evaluation (Normand 1991).

THE PUBLIC–PRIVATE DISTINCTION

A common feature of all health systems is the distinction between public and private health care. This distinction refers to both the finance and the provision of health services. The concept of *ownership* is used to distinguish whether an organization belongs to the private or public sector.

The notion of a public agency refers not only to government organizations but also to public bodies with statutory responsibilities like social insurance companies. The private sector can be divided into *for profit* and *not for profit* organizations. The former include the drugs industry and private hospitals or clinics in which some (sometimes most) of any financial surplus goes out of the organization to the shareholders. Not for profit organizations reinvest any financial surplus in their organization by developing facilities and training staff. The distinction from for profit isn't so clear-cut as some surplus in not for profit organizations can also go out of the organization in the form of enhanced salaries and bonuses.

The following extract from Donaldson and Gerard's (2005) book gives a framework for analysing the private–public relationship.

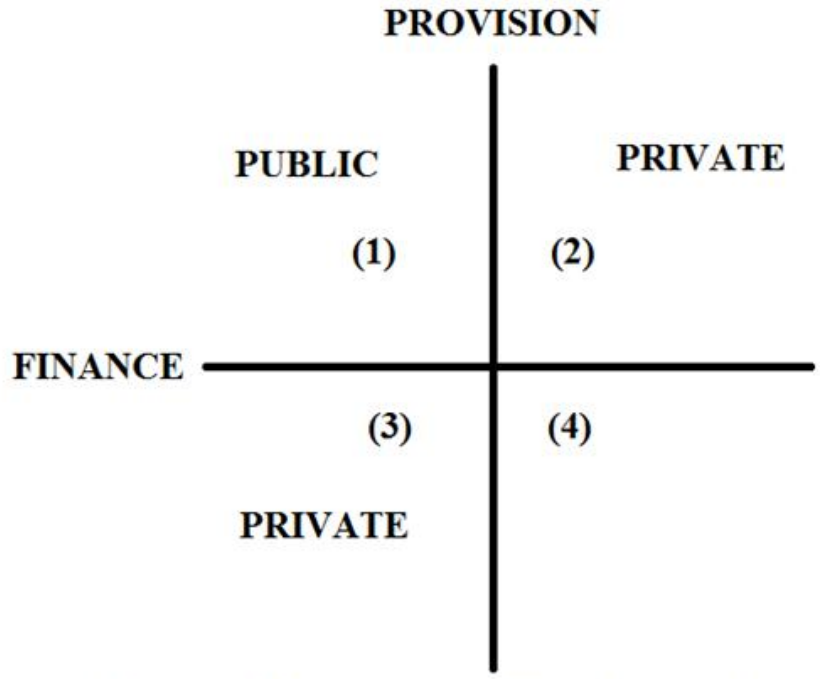

Figure. 2 Public–private mix in health care financing and provision Source: Donaldson and Gerard (2005)

PUBLIC–PRIVATE MIX IN FINANCE AND PROVISION

The organization of financial intermediaries may be on a monopolistic, oligopolistic or competitive basis. In a monopolistic system, the financial intermediary is usually a public agency such as a government or a health corporation. In an oligopolistic system (i.e. one in which there are a small number of large intermediaries) finance can be controlled by public agencies or private agencies, such as insurance companies, or a combination of these. In a competitive system, a large number of small private intermediaries would exist . .

The provision of services, however, does not necessarily have to match the financial organization. For instance, hospital care in many European countries represents a large, vertically integrated health system, in which finance and provision are combined within one organization. Thus, both finance and provision are public as in the case of quadrant (1) in Figure.2. In many countries, general practice would fall into quadrant (2), such care being provided by self-employed doctors who, nevertheless, happen to receive almost all of their income from the public purse . . . Also, it is important to recognise that systems do not have to be vertically integrated in these ways: a third-party private payer, such as an insurance company, could also fit into segments (3) and (4). The basic point is that public finance does not have to match public provision, nor private finance private provision. Public provision could be financed by private arrangements (private insurance, direct charges, etc.) and private provision by public finance (e.g. prospective payments made by government agencies directly to private hospitals).

. . . [There is] a stronger case for government intervention in *financing* rather than in *providing* health care. Control of financial arrangements permits governmental bodies more direction of the health care system in the pursuit of societal objectives: as the collective purchaser of care on the community's behalf, a public body can dictate terms of provision with equal power to both public and private providers. Simply providing public services does not guarantee use by those groups for whom they are intended, because less ill, rich or privately insured patients may be more 'attractive customers' for such hospitals than those more in need of care.

Governments can organize finance, act as purchaser, provide services and regulate health services. In many low income countries, governments have historically had the major role in the provision of health care. Governments see it as the most efficient and equitable method of providing services. Though the private sector may play an increasing role, socioeconomic conditions are such that private care will not totally replace public services. In particular, primary health care in low income countries is reliant on the public sector.

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