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How Best to Finance a Health System?

A lecture about economics by Molly Scott Cato during module CEM153 ended with a debate on what should or should not be available 'for sale'. Health care was one of the areas discussed and this paper draws inspiration from those discussions as it looks at the different approaches to funding the health needs of a population. It concludes that direct taxation and SHI schemes are the best tools governments have available in order to provide equitable health care for whole populations. Market-based medical services and those based on a culture of out-of-pocket payments tend to exclude the poorest from health care. Donations play an important role in raising health standards in developing countries, yet philanthropy is not always the motivating factor; instead it is long-term economic gain.

Funding Health Care Provision

The costs of illness and medicine and the implications for social welfare mean that medical care is an especially strategic arena for economic and political thought (Starr 1982). Timely access to health services is impossible without well-functioning health financing systems that enable people to use services without having to suffer financial hardship paying for them (World Health Organisation 2005).

Broadly speaking, governments use 5 different methods for raising money in order to address this (World Health Organisation 2004):

1. Taxation.
2. Social health insurance (SHI).
3. Voluntary or private health insurance (PHI).
4. Direct, out-of-pocket payments.
5. Donation.

Although most countries feature a mix of these models, one method usually predominates due to ideology, historical context, societal expectation, economic organisation, available technology and existing health care infrastructure (Mechanic 1975).

Taxation and the UK's National Health Service

At the end of the second world war the UK's population were enjoying an increased sense of social solidarity and subsequently the Labour Party swept to power on a promise of nationalising vast swathes of British industry. They quickly embarked on a program of public ownership of major utilities, but health care proved troublesome because it required such a radical rethink (Rivett 1998). At

the time Labour were blessed with a brilliant Minister of Health, Aneurin Bevan, who coordinated the party's idea of society fulfilling an obligation for maintaining the health of its people. On 5th July, 1948, Bevan's National Health Service (NHS) Act established comprehensive medical care available to all and free at the time of need, funded mainly through direct taxation. Despite reforms that have taken place in the intervening years (as the different political parties have tried to impose their own ideology), the NHS is still thought of as the prototypical centralised, command-and-control socialised health care system (DiPiero 2004).

Social Health Insurance and the French Socialist Agenda

The foundation of the modern French health system is the socialist national motto of “Liberté, égalité, fraternité” (freedom, equality and brotherhood) and it's raison d'être is universal coverage, individual liberty and patient choice. Much like the UK, the French social health insurance (SHI) scheme was established immediately after the second world war, just when French society was rediscovering its sense of solidarity. It is financed by mandatory payroll levies that are paid into health insurance funds that are administered by unions and businesses (Sorum 2005). All people who make contributions receive a pre-defined entitlement to health care, irrespective of their income or social status (World Health Organisation 2004).

Private Health Insurance and the Market Based US Health Care System

The US health system is unique among developed world countries in that it relies heavily on the private sector and competition among insurers and providers to increase efficiency (Docteur et al. 2003). This system is a result of the American neoclassical ideology of market based economics and the ascendancy of competitive-market thinking after the second world war. Neoclassical proponents favoured macroeconomic spending strategies and were opposed to public policies and social security because they were seen as a threat to efficiency and an interference with market processes (Glaser 1993). Thus, finance is provided primarily through private health insurance - as of 2007, 67.5% of Americans payed for health care in this way (DeNavas-Walt et al. 2005).

Out-of-pocket Payments and the Former Soviet Union Countries

During the 1990's, the Former Soviet Union (FSU) countries moved from socialist welfare systems to US inspired free-market economies. During this transition the region experienced economic recession and substantial contraction in government revenue (Gotsadze et al. 2005). Many of the region's governments have since instigated ambitious health sector reforms and moved to restructure medical financing through schemes such as taxation, voluntary and social insurance and increased private finance (Falkingham 2004). However, due to poor fiscal performance or poor planning, health care providers have been forced to look for finance elsewhere from central government and more often than not they have turned to direct payments (Gotsadze et al. 2005). These out-of-pocket

schemes come in the form of over-the-counter payments for medicines and consultations and treatment fees, or in-kind gifts from patients. These soon become the main source of income for many physicians and nurses in such countries (Falkingham 2004).

Health Care in Low-Income Countries - Donor Financing

A 1993 report of the World Bank noted that:

"*Developing countries, and especially their poor, continue to suffer a heavy burden of disease, much of which can be inexpensively prevented or cured.*" (World Bank 1993)

The report advocates donor financing of low-income countries, arguing that this helps invigorate health care systems, enabling implementation of cost effective medical programs that translate into longer, healthier, and more productive lives for the poor around the world.

Similarly, the WHO's commission on macro economics and health advocates a more prominent role for health care within the economic agendas of low-income countries, in order to give access to essential health services to the world's poor (World Health Organisation 2003). Amongst its key findings are that high-income countries should commit vastly increased financial assistance, in the form of donations rather than loans (which place an additional burden on economies that are already suffering).

Comparing Health Care Financing Models

Wagstaff suggests that social justice derives from a set of principles concerning what a person ought to have available *as of right*, and uses the concept of 'equity' (justice and fairness) whilst comparing health care delivery systems (Wagstaff et al. 1989). The WHO use similar language when urging that their member states should:

"Ensure adequate and equitable distribution of good-quality health care infrastructures" (Gauri 2004).

The WHO use three key metrics to score health system performance for member states. 1) health of the population (both in terms of levels attained and distribution). 2) Responsiveness of the health system and how it meets the the expectations of the population. 3) Fairness in terms of financing and financial risk protection (Tandon & Organization) 2001).

Health system goals

	Level	Distribution	
Health	✓	✓	Efficiency
Responsiveness	✓	✓	
Fairness in financing		✓	
	Quality	Equity	

Figure 1: WHO Table for Comparing Health Systems

Equity and the UK's NHS

In a 2010 study for the Commonwealth Fund, the NHS ranked first against the health systems of Australia, Canada, Germany, New Zealand and the United States (Cutler et al. 2010). It came first for effective, safe, co-ordinated and patient centred quality. First for financial and administrative efficiency. First for equity too (since little or no financial burden is placed on its population). It did less well in terms of access, since patients often have to wait for specialised services. And badly when considering death rates for health issues that should have been amenable to medical care.

In the 2000 WHO World Health Report the UK also did well, ranking 18th of the 191 countries considered (World Health Organisation 2000).

Equity and French Social Health Insurance.

In 2000, the French social health insurance (SHI) scheme achieved total coverage of its population and the WHO's league table ranked the French health system as the best in the world (World Health Organisation 2000). The French score well on many key metrics - they have a high life expectancy and a very healthy populace, and low infant mortality rate. They also do well in meeting their own socialist

agenda in health provision. Although they do less well in terms of responsiveness and equitable financial burden (because patients must pay for outpatient care directly before getting reimbursed by the national health insurance scheme), the French population like their health system, giving it high satisfaction marks. And all of this is achieved with a per capita spending at 52% of the level of the United States (DiPiero 2004).

However, the French system is not without its problems – in 2004 their health care finances recorded a $15 billion deficit due to high per capita expenditure and high health care costs in proportion to their Gross Domestic Product (GDP). In response, the French government is increasingly relying on tax revenue to fund health care and are also looking to reinforce central control rather than relying more on decentralized market forces (Sorum 2005).

Equity and the US Market-based System

In the commonwealth funds 2010 study mentioned above (Cutler et al. 2010), the US health care system, based on private health insurance, ranked last of the countries compared. It is alone among developed nations in not having universal health care coverage, and so with over 45 million of it's population uninsured and therefore having inadequate medical care (DeNavas-Walt et al. 2005), the US rates very poorly for equity and access to medical services. It is also the least efficient as it spends more per capita and percentage GDP than any other country in the developed world (Kuttner 2008), whilst simultaneously paying less percentage overall health costs per capita than any other developed world nation. Below-average income Americans are also much less likely to visit their physicians when sick than their developed world counterparts (Cutler et al. 2010). Because of all these factors, the US also ranked poorly amongst developed world countries in the 2000 WHO World Health Report, rating 37th overall and behind less developed countries such as Greece, Costa Rica and Columbia.

Equity and FSU Out-of-pocket Payments

The two countries of the FSU mentioned above rank very poorly in the WHO's 2000 league table; Georgia reaching 114th and Tajikistan 154th. This is primarily because of the prevalence of out-of-pocket payments, since results show that such payments create a financial barrier to accessing health services for the poor, because they are less likely to seek care and yet still devote a higher share of their expenditure on medical services. Furthermore, strategies of the poor to overcome these financial barriers contribute even further to declining economic status and worsening health (Gotsadze et al. 2005).

Equity and Low Income Countries Relying Upon Donation

Developing world countries that rely on donation to help fund their medical services have poorly developed medical services that need significant investment

to improve. But whilst donations are necessary in order to raise health standards in such countries, philanthropy is not always the motivating factor. This is clear from the language used by the World Bank, which insists that such financing must be accompanied by governmental reform that involves streamlining the public sector, privatisation of services, and introduction of market principles based on competition (World Bank 1993). In other words, capitalism and economic gain are their clear agenda. They also appear to be advocating a system based on the US health care service, yet that service fails the poor; the very people targeted by the report.

The WHO use similar language when they note that poor health is an important determinant of poverty and that improving health is a key strategy for economic development (World Health Organisation 2003). In fact, the message of "economic gain" is very prominent in all their texts:

"*Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.*" (WHO 1978)

SHI and Taxation

Of the health financing systems considered, SHI and direct taxation are clear winners, with the French ranking foremost in the WHO's league table and the UK also scoring highly (World Health Organisation 2000). SHI seems particular favourable because the French population seem highly satisfied with their health service. Perhaps this is due in part to the people themselves being members of their health schemes and hence aware of what they contribute. However, the French are having to fill their health funding deficit with direct taxation, so it seems that in achieving the goal of universal coverage – a must for any equitable health system – taxation and SHI complement each other very well. What is clear is that some form of pooling of finance and resources by central government is particularly important because it gives scope for increasing efficiency of revenue collection and purchasing and allows for finance innovation. Indeed, the WHO advocate such innovation, highlighting fund generation schemes such as increasing taxation on tobacco, alcohol, air flight and foreign exchange and directing the monies raised into health care (World Health Organisation 2010).

Health care financing is a huge subject and this paper could have looked at a myriad of important topics. For instance; is it right for the UK's corporate pharmaceutical industry to supply drugs to the publicly owned UK health service? Why are consultants allowed to perform privately funded operations in publicly funded operating theatres and use publicly funded staff to help too? What's the role of charity in the UK's health care system and since it's state owned and funded through taxes, why should individuals provide sponsorship and perform

charitable acts to support medical services? Why does the predominately private US system perform so badly and is it possible for a market-based model to perform well? What must be done in order to raise the health care standards of sub-saharan Africa? How much of a role does philanthropy actually play when organisations donate finance to help develop world health care systems? How can a culture of out-of-pocket payments in the FSU be changed and their health care systems reformed so that they are more equitable? All of these are great topics for further research.

The WHO's World Health Report 2000 noted that:

"The purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care. This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so." (World Health Organisation 2000)

Based on the examples of the French and UK health care services, it would seem that direct taxation and SHI schemes are the best tools governments have available in order to meet the objectives of the WHO and achieve just and fair health care access for all citizens.

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