HEALTH FINANCING POLICY BRIEF № 1

Raising revenues for health in support of UHC: strategic issues for policy makers

HEALTH SYSTEMS GOVERNANCE & FINANCING

World Health Organization

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WHO/HIS/HGF/PolicyBrief/15.1

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KEY MESSAGES

- From the perspective of revenue raising policy, moving towards a predominant reliance on public funding for health services is the priority for governments in order to progress towards UHC. Public funds are compulsory and pre-paid (i.e. taxes) whereas voluntary payments are considered private.
- Of primary concern is the overall level of public funding for the health sector; new earmarked revenues for health may bring additional resources, but may be offset by reducing discretionary budget allocations resulting in little if any increase in total public funding available to extend coverage.
- Dialogue between Ministries of Health and Ministries of Finance centres on the priority given to the health sector in government budget allocations. Evidence of improved and more efficient spending on health services is important to make the case for greater investment in the health system.
- Several estimates have been made regarding the level of public funding required to make progress towards UHC. No formula exists however, although evidence shows that when countries rely predominantly on private sources, many households forgo care or face serious financial problems. Ongoing analysis suggests however, that even at low levels of public spending, countries can make significant steps towards UHC.
- At the same time as developing policy on revenue raising, policy makers need to think about how public funds are pooled and used to purchase health services; it is the combination of reforms which drives improvements in health system performance.

1. INTRODUCTION

Recent years have seen a number of countries including Thailand, Turkey, Vietnam and Mexico significantly increase levels of public spending on health in order to make a step-change towards universal health coverage (UHC). This increased funding has focused on the expansion of one or more dimension of health coverage. Moving towards a predominant reliance on public funding for the health system has proved central to improving access to health services. This paper reviews the key policy issues facing Ministries of Health with respect to raising revenues for their health systems, explains how decisions on revenue raising policy have an impact on UHC, and highlights key messages for policy makers. It does so as many international agencies reduce financial support as a result of the recent downward trend in their own resources.

2. CLASSIFYING REVENUES FOR THE HEALTH SECTOR

The 2011 System of Health Accounts differentiates revenue sources as follows:

a) compulsory versus voluntary
b) prepaid versus payment at the time of service use (out-of-pocket)
c) domestic versus foreign

From a health financing policy perspective, public sources include those which are compulsory and pre-paid, whilst voluntary sources are considered private.[1] Categorizing a source as compulsory implies that government requires some or all people to make the payment irrespective of whether or not they use health services. Thus, compulsory sources are also prepaid and essentially the same as taxes. Within this category, some of the most important distinctions are:

a) **Direct taxes** paid by households and companies on income, earnings, or profits, and paid directly to government or another public agency; examples include income tax, payroll tax (including mandatory social health insurance contributions), and corporate income or profits taxes.

b) **Indirect taxes** paid on what a household or company spends, not on what they earn, and paid to government indirectly via a third-party e.g. a retailer or supplier. Common examples are value-added tax (VAT), sales taxes, excise taxes on the consumption of products such as alcohol and tobacco, and import duties.

c) **Non-tax revenues** e.g. from state-owned companies including "natural resource revenues" common in many mineral-rich countries e.g. oil and gas.

d) **Financing from external (foreign) sources** is typically categorized as public when these funds flow through recipient governments.

The key characteristics of private revenue sources are that they are voluntary, i.e. the decision to spend on health is not required by government but is rather a decision made by individuals, households, or private companies. Such payments may be either prepaid (e.g. corporate-funded health services, individual contributions to commercial or community-based health insurance schemes) or paid at the point of service as out-of-pocket spending (OOPS). The latter includes the direct purchase of privately delivered services e.g. diagnostic tests or other items such as

[1] For a discussion of public versus private sources of funding for the health sector see pp 180-183 of the System of Health Accounts located at http://www.who.int/health-accounts/methodology/en/.

medicines, formal patient cost sharing[2] required under a specific health financing scheme, and informal payments to health workers or for key inputs such as medical supplies or medicines that were officially "covered" but not available in practice.

It is important to note that public revenues for health can be managed by private entities e.g. private insurers managing a public insurance scheme as in the Netherlands, in Georgia prior to 2013, and in India. Similarly, private sources may be managed by public entities e.g. government-run voluntary insurance programmes such as in Thailand prior to 2002. This paper focuses on revenue sources, rather than the intermediaries, and considers the implications of different sources for health financing policy objectives. Whilst private financing plays a role in all health systems, evidence clearly shows that it is public financing which drives improvements in health system performance on key UHC indicators such as patient financial protection, and hence is the focus of this paper.

3. REVENUE RAISING POLICY AND HEALTH SYSTEM GOALS

Ensuring a stable and predictable flow of funds to the health sector is an important objective of revenue raising policy, given its importance to avoid disruptions in service delivery (e.g. commodity stock-outs), ensuring timely payment of salaries, and to provide a credible basis for contracting with service providers. Ensuring funds are raised in the most efficient way is also an important consideration. Improving transparency and accountability is an important intermediate health system objective; patients should have clarity with regard to how much, if anything, they will be expected to pay at the point of use (e.g. some form of user charge), and this is an important part of preventing unofficial payments. In this short paper, however, we focus principally on the direct impact of policy on two health system goals, equity in finance and financial protection for service users, whilst also highlighting the importance of stability and predictability for strategic purchasing.

Equity in finance

Equity in finance implies that the distribution of the burden of financing health services is "fair" and is itself an objective of health system financing policy. Measures of equity in finance assess the extent to which financing is progressive or regressive i.e. whether the burden falls disproportionately on the better-off, or worse-off, in society, relative to their capacity to contribute. An equal burden across the population is referred to as proportionate (e.g. each income quintile pays the same percentage of their income). Each revenue source has a different impact on equity in finance: