



COUNTRY CASE STUDIES

TAX AND INSURANCE FUNDING

FOR HEALTH SYSTEMS

FACILITATOR'S NOTES

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OBJECTIVES

The main objectives of this set of country case studies are to:

- Develop an understanding of the key health care financing functions of revenue collection, pooling of funds and purchasing in relation to tax and insurance mechanisms;
- Develop an understanding of the role of tax and insurance in the funding of health services in different contexts, particularly in relation to:
 - Providing financial protection to households against the costs of illness, and
 - Promoting cross-subsidies in the overall health system; and
- Critically evaluate issues relating to achieving universal coverage.

Given the recent emphasis on health insurance as a key health care financing mechanism (e.g. the World Health Assembly's resolution in 2005 on "Sustainable health financing, universal coverage and social health insurance"), many of the country case studies focus particularly on alternative types of health insurance.

PREPARATION FOR CASE STUDY

In preparing for facilitating this case study, the following readings will provide a good overview of the issues that should be covered in the presentation before the case study and the issues that will arise during group and plenary discussion:

Kutzin J (2001) A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*, **56**, 171-204.

(This article presents an extremely useful framework for analysing health care financing systems, looking at the key functions of financing: Revenue collection, pooling and purchasing. This framework is now widely used, including by organisations such as WHO and the World Bank).

McIntyre D (2007). *Learning from experience: health care financing in low- and middle-income countries*. Geneva: Global Forum for Health Research. (Available on www.globalforumhealth.org)

(This monograph provides an extensive review of health care financing experience in low- and middle countries, using the framework outlined in the above article by Kutzin. It highlights key health care financing issues, particularly from an equity perspective.)

TIMING OF THE CASE STUDY

The case study should be preceded by a presentation and/or facilitated discussion.

This should cover the following issues:

- The 'Kutzin framework' (i.e. the key health care financing functions – revenue collection, pooling of funds and purchasing).
- The concepts of:
 - income and risk cross-subsidies;
 - equity in financing (both in terms of who bears the burden of health care financing contributions and who benefits from health care);
 - financial protection; and
 - universal coverage.
- Briefly distinguish between different forms of health care financing, particularly different forms of health insurance (social health insurance, national health insurance, private health insurance and community-based pre-payment or mutual health insurance schemes).

The above presentation and discussion should preferably be provided in the final afternoon session on the day before the case study will be undertaken. In addition, participants should be divided into groups and copies of the country case studies and participant information sheets handed out. Preferably, each participant should be requested to review two country case studies overnight, but ensure that members of each group receive different country profiles so that all countries are reviewed by each group. Groups of six people would be ideal.

The case study will require 3 - 3.5 hours to complete:

- Two to 2.5 hours should be set aside to allow participants to present information on the country profiles they have reviewed and to evaluate the overall health care financing system in each country.
- A further 1 to 1.5 hours should be allowed for briefly presenting the financing system evaluations of the groups and drawing out key issues.

KEY ISSUES FOR DISCUSSION

The table below provides a summary of key issues in relation to health care financing in each country. Some of the key conclusions that can be raised by the facilitator after the group presentations and discussion of the country case studies include:

- Pre-funding (tax and/or health insurance) health care financing mechanisms are critical for financial protection (i.e. to ensure that no household is impoverished because of a need to use health services);
- Fragmentation between many different health care financing mechanisms, including a large number of private insurance schemes and/or community-based pre-payment schemes, and a heavy reliance on out-of-pocket payments limit cross-subsidies in the overall health system;
- Universal coverage (i.e. a system that provides *all* citizens with *adequate* health care at an *affordable* cost) can be achieved with a core of general tax funding, mandatory health insurance – social or national health insurance – or a combination of both;
- If mandatory health insurance is pursued, equity or progressivity in health insurance contributions, and maximum risk pooling, can be promoted by ensuring that:
 - Contributions are calculated as a percentage of income rather than a fixed sum;
 - Contributions are income related with higher income groups paying a higher percentage of their income;
 - There is no cap, or ceiling, on contributions or, if a cap is imposed, it is not set at too low an income level;
 - Those required to contribute to health insurance are not permitted to ‘opt out’; and
 - If a number of health insurance funds or schemes act as financial intermediaries for the overall mandatory health insurance, there should be some form of risk-equalisation for the core benefit package.

Issue	Chile	Costa Rica	Korea	Sri Lanka	Ghana	South Africa
How is revenue collected?	<ul style="list-style-type: none"> • Dedicated payroll tax of 7% for all workers • General taxes (subsidised membership for the poor etc.) • Direct contributions to ISAPREs for ‘top-up’ insurance • Out-of-pocket (OOP) co-payments 	<ul style="list-style-type: none"> • Employer and employee payroll contributions • General tax revenue • National lottery contributions • Dedicated ‘sin’ taxes • OOP for use of private sector facilities – limited 	<ul style="list-style-type: none"> • Employer and employee contributions (<8% of salary; 4.21% for those in formal sector who are not self-employed) • General tax revenue • Large co-payments • Collection by NHIC 	<ul style="list-style-type: none"> • General tax revenue (50% of funds) – progressively structured income tax • OOP payments (50% of funds, paid to private practitioners and pharmacies) 	<ul style="list-style-type: none"> • General tax • Donor funds • Dedicated sales tax for NHI • Payroll deductions for NHI • Individual payments – OOP payments & contributions to mutual health insurance 	<ul style="list-style-type: none"> • General tax • Employer & employee community-rated contributions to private insurers (medical schemes) • OOP payments (co-payments etc. by scheme members & direct payments to private providers & user fees by non-scheme members)
How are funds pooled?	<ul style="list-style-type: none"> • FONASA (public insurer) covers 68% of population (poor and low- to middle-income) • ISAPREs (private insurers) cover 18% (high- & middle-income) – no pooling across individual ISAPREs 	<ul style="list-style-type: none"> • Nearly 90% of population covered by single pool/social insurance (CCSS) • About 10% (richest) pay OOP for private ambulatory care 	<ul style="list-style-type: none"> • Previously fragmented into hundreds of different insurers • Single NHIC pool since 2000 	<ul style="list-style-type: none"> • Through the tax system – 100% of population covered • No insurance and no pooling via OOP 	<ul style="list-style-type: none"> • 16% covered by NHI (formal sector, some informal sector, some poor) • Rest covered by tax funded services, but OOP payments high (no pooling via OOP) 	<ul style="list-style-type: none"> • Through the tax system for the majority of the population, but minority of the funds • Pooling within individual benefit options in schemes (fragmented risk pools); no pooling in MSAs • Risk-equalisation will increase risk pooling between schemes

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How are services purchased?	<ul style="list-style-type: none"> • FONASA purchases mainly from public facilities • ISAPREs purchases from public and private (for profit and NGO) facilities 	<ul style="list-style-type: none"> • Facilities owned by the CCSS and funded by global budgets (and staff on salary) – comprehensive package • Performance agreements recently used to allocate a percentage of budget • Fee-for-service for private sector doctors (small) 	<ul style="list-style-type: none"> • No active purchasing; simply reimbursement of mainly private providers on a fee-for-service basis • Recent efforts to change reimbursement mechanism (DRGs for key inpatient services) 	<ul style="list-style-type: none"> • Public facilities are allocated budgets by the MOH, which they use to provide services • Private sector services are purchased by individuals on a fee for service basis 	<ul style="list-style-type: none"> • Public facilities are allocated budgets • Mission facilities also have budgets (NGO, donor & tax funding) • User fees at public & mission facilities according to service type • NHI – more active purchasing of comprehensive benefit package 	<ul style="list-style-type: none"> • Public facilities are allocated budgets and staff salaried (plus small user fees) • Private providers paid on fee-for-service basis
What were the motivations for this financing approach?	<ul style="list-style-type: none"> • Development of health system very strongly influenced by ideology of changing governments • Initially, strong public sector based on social solidarity principles • Introduction of private insurance under Pinochet; part of ‘free market’ policies 	<ul style="list-style-type: none"> • Initially seen as ensuring workers rights are met • Social security seen as pillar of democracy • Ensure access to quality health care on universal basis 	<ul style="list-style-type: none"> • Commitment to ensuring that all citizens have access to acceptable quality health care • Universal insurance coverage 	<ul style="list-style-type: none"> • Universal access to free care at all levels of care • Explicit political commitment to social development (and not just economic development) and to social justice 	<ul style="list-style-type: none"> • To provide financial protection for households and to move away from user fees towards pre-payment 	<ul style="list-style-type: none"> • Medical schemes established to ensure healthy workforce and provide for health care needs of high-income employees • Government commitment to health care for all, hence ensuring reasonably strong public sector for those not covered by schemes

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<p>How equitable is financing & what contributes to equity or inequity?</p>	<ul style="list-style-type: none"> • Proportional tax, cap on maximum payroll contributions, anyone can opt out of the public insurer, lower SES groups with public and higher SES groups with private insurers • All suggest inequities • But, the indigent do not have to make contributions yet receive comprehensive care • Recent efforts to guarantee care for key diseases 	<ul style="list-style-type: none"> • Single pool, no cap on maximum payroll contributions, the wealthy can't opt out of the CCSS, full tax funding of vulnerable groups • Similar utilisation patterns across socio-economic groups • All suggest equitable and progressive system with strong cross-subsidies (income and risk) 	<ul style="list-style-type: none"> • Single pool, full tax funding of poor • Proportional payroll deductions • High co-payments compromise equity, both in terms of burden of health payments and distribution of service benefits (lower utilisation by low-income groups) 	<ul style="list-style-type: none"> • Direct taxes are strongly progressive • Indirect taxes are proportional • OOP are mostly incurred by high income groups and are therefore marginally progressive (but only the rich that benefit from these services) • The poor benefit more than the rich from publicly funded hospitals 	<ul style="list-style-type: none"> • The vast majority of funding is via OOP (nearly 70%) which does not allow for cross-subsidies • Flat contribution by informal sector to NHI is not equitable • NHI has potential for considerable cross-subsidies, especially if the poor are appropriately identified and contributions funded from tax & donors 	<ul style="list-style-type: none"> • Public-private mix is main equity challenge: schemes only cover 14% of the population, but about 60% of funds in private sector • Income cross-subsidies through tax system, but no income cross-subsidies in schemes and no income or risk cross-subsidies between public and private sectors

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To what extent are households financially protected?	<ul style="list-style-type: none"> • Poor are protected (no contribution or co-payments) • Middle- and high-income groups pay co-payments up to 20% of cost – can be considerable 	<ul style="list-style-type: none"> • Good financial protection for households • Only the wealthiest use private doctors on OOP basis 	<ul style="list-style-type: none"> • High co-payments compromise financial protection, especially for low-income earners 	<ul style="list-style-type: none"> • Households are well protected as no payment is required at the point of service and there is a good geographic distribution of facilities • But, some (particularly the chronically ill) are incurring relatively high transport costs • Levels of catastrophic spending are low 	<ul style="list-style-type: none"> • Coverage by NHI still quite low (16%) • The remainder continue to bear a heavy burden from user fees 	<ul style="list-style-type: none"> • Free primary care & fee exemptions for poor at public hospitals do provide protection, but low-income employed have to pay OOP for public hospital care • PMB ensures unlimited care for certain conditions, but large OOP payments by scheme members for care outside benefit package and co-payments