Booklet C3: Financing Sexual and Reproductive Health

Health care financing refers to the financial resources raised and used to provide health care services, and the way in which this affects service delivery and how often people use the services.

This booklet will first describe the general aims of health care financing and the principal financing mechanisms. It will discuss three financing mechanisms in more depth: macro-level financing, user fees, and insurance, with the particular example of community-based insurance.

This booklet aims to address the following questions:

- What are the main objectives of health care financing?
- What are the possible ways of financing sexual and reproductive health (SRH) services?
- What is cross-subsidization and how can it be accomplished?
- What are the advantages and disadvantages of user-fees?
- What are key economic issues with regard to insurance?
- What is the role of community insurance for SRH services?

C3.1 Objectives of health care financing

The main issues in health care financing in developing countries are a) the limited availability of resources, b) the potentially catastrophic consequences of health expenditures for poor people, and c) the unequal allocation of resources across services, geographical areas and population groups. Health care financing mechanisms aim to address these problems in different ways.

a) limited availability of resources

According to the most recent estimations, a basic package of essential health care would cost on average about US$ 35 per person per year.[1] How can this be financed in low income countries where the average per capita income is US$ 450 per year? Total health expenditure per person varies between developing countries, for example, from US$ 14 per person in Ethiopia to US$ 114 per person in Kenya in 2001.

However, such aggregate numbers mask who is really paying for health care. Total health care expenditure includes what governments, external donors and households spend on private and public health care. Total expenditure might cover the cost of an essential health care package, but in most developing countries the government and donors' contribution is so low that most of the burden of health care costs falls on households. For example, in Kenya, households pay 79 per cent of the US$ 114 total health expenditure per person.[2]

b) catastrophic expenditure

The high share of private health care financing makes poor households and individuals vulnerable to the effects of sudden, unexpected high levels of health care expenditure. Most of the private health care financing is '**out-of-pocket**' (OOP)

[1] WHO (2001). *Report from the Commission on Macroeconomics and Health*

[2] Information on national health expenditure can be found in the WHO's World Health Reports (WHR). Information on other variables, such as per capita income, can be found in the World Bank's World Development Report (WDR).

spending, directly paid at the point of service delivery. This can place households in desperate situations, where they might have to sell assets and reduce important investments, such as schooling for children. In this way, private OOP health expenditure adds to the economic burden of death or illness: the loss of income-earning capacity. This phenomenon is called 'catastrophic health expenditure' and is a major cause of impoverishment in developing countries.

c) unequal allocation of resources

Furthermore, the distribution of available resources is an important SRH issue. First, resources are distributed unevenly across countries, which mirrors the unequal distribution of wealth in the world rather than the distribution of the burden of diseases. Second, within countries there is often unequal distribution of health care expenditure between rural and urban areas, between men and women, between different income groups, and between age groups. Third, the allocation of health care expenditure between private and public sector also matters, as a lot of people only have access to public sector services.

Moreover, it is important to look at how health care financing is allocated between different interventions. For governments, it is most cost-effective, (best value for money), and if resources are directed at a primary care level and preventative interventions (see Booklet A3). These services are important for the population as a whole but will not easily be financed by the private sector. For example, who would want to pay for prevention of an epidemic if other people would benefit without paying? Moreover, compared to the more expensive tertiary level care, primary health care costs relatively little considering the number of people that can be served. Therefore, if a government shifts resources from more expensive treatments for a few people to less costly interventions that serve a larger group of people, better health can be achieved with the same amount of resources.

Financing mechanisms aim to overcome these problems. The primary objectives of health care financing can therefore be summarized as:

- Increase the amount of resources available and ensure these resources are stable and sustainable over time;
- Improve the efficiency and equity of the allocation of resources to eventually improve the health outcomes;
- Ensure that those who can afford it pay more or subsidize those who cannot afford health care, to avoid catastrophic health care expenditure and the exclusion of poorer population groups;
- Support broader health sector aims, such as quality improvement and responsiveness to needs.

C3.2 Main types of health financing

The main health care financing mechanisms are:

- macro-level financing, including taxation and social security,
- user fees, co-payments or charges,
- pre-payment or insurance schemes, such as community-based insurance schemes,
- efficiency gains through, for example, reforms to funding and purchasing of health care (e.g. public/private mix), and reforming the public health sector (e.g. public sector employment and pay reforms).

This booklet will focus on the first three financing mechanisms.

Macro-level financing

Macro-level financing refers to the financial resources raised by the national government for the public health sector. This includes the salaries of health workers, the supply of drugs and the construction of health facilities. The sources of this financing include taxation, government borrowing, social security and official development assistance (ODA). Ultimately, public financing for the health sector depends on the total amount raised from these sources that is available for the government's expenditure programme *and* the priority government gives to health expenditure.

General taxation is an important component of government revenue, because it allows for so-called '**cross-subsidization'** between richer and poorer population groups. 'Progressive' taxes are based on people's income so that the more affluent pay more. These taxes can subsequently be used for financing public health care services that poorer people can access as well, even though they have not paid for them. In this case, the more affluent tax-payers are effectively subsidizing those who cannot afford it.

Another example of macro-level financing with cross-subsidization is social security. Formally employed people make compulsory contributions – based on the level of their income – to a social fund, which is supplemented by contributions from employers and government. This social fund can be used to reimburse a proportion of the health care costs in the private sector or to finance the public health service. Additional financing needs to be provided by government to fund health care services for those not, or not formally, employed. As such, there will be cross-subsidization within the group of employed people, who earn different levels of income or have different risks of illness but benefit the same from the social fund. *And* there could also be cross-subsidization between the employed and the unemployed, when the latter group benefits from the public services financed through the fund.

User fees

User fees refer to the official charge paid by the patient, at the point of use, for a treatment or service. The fee can be based on actual costs, including supplies used, or a fixed fee for a treatment or an episode of illness. Fees paid can cover the costs in full ('user-charges') or partially ('co-payments'). Generally, user fees are charged for curative rather than preventative services. It is important to stress that user fees are not the only OOP payments made by individuals. These OOP payments also include informal payments, payments in kind (e.g. in exchange for goods) and transport costs.

User fees were introduced in the early 1990s, and are currently the subject of some controversy. The proponents of user fees base their arguments on the need to raise more revenue for health care services. Moreover, the payment of fees is expected to make both the consumer and the provider of health care more aware of the costs and quality of services provided. The collection of fees at the point of service can improve staff motivation and quality of care compared to facilities that receive government resources irrespective of the work they do. User fees can also replace informal fees – such as bribery – by making payments for health care services official. Moreover, when people pay a fee for a service, they are supposed to be more critical about the quality of service they receive and think twice before they use health care frivolously.

As long as the demand for health care is **inelastic** – when demand does not respond much to changes in price – a user fee is not expected to reduce the utilization of essential health care but still limits unnecessary use. Moreover, exemption systems that allow certain people to be excused from paying fees, can be designed around user

fees to ensure that people who cannot afford the fees will still be able to access health care services.

However, those against user fees argue that poor people's demand for health care might be **elastic**: when the price goes up, demand goes down. If that is the case, user fees are bound to limit poor people's access to health care. This is especially worrying when user fees are applied to essential primary health care services. The fees could easily lead to a reduction in the utilization of necessary health care, or to catastrophic health expenditures for poor people. Reduced utilization, of prevention services in particular, could have negative effects on the whole population.

The critics of user fees also worry that exemption schemes are difficult and costly to implement and do not offer enough protection for poor people. Exemption schemes based on income levels are especially costly and ineffective, given the difficulty of identifying poverty. Those based on disease and age might be simpler to manage. Moreover, opponents of user fees point out that the resources raised through user fees are limited, in particular if the costs of collecting and administering the fees are subtracted from the total revenues collected.

What, then, is the evidence of the ability of user fees to address the main objectives of financing mechanisms?[3]

- User fees can raise resources, but only limited amounts, rarely more than 10 per cent of recurrent costs.
- User fees may have improved the efficiency of the health services in some instances – by reducing frivolous use – but not significantly. Moreover, there is some evidence that user fees have a negative impact on the utilization of preventative care.
- There is some evidence that user fees are an unequal financing mechanism as they lower the utilization of health care by vulnerable groups such as women, children and poor people. Most exemption schemes appear to be costly and ineffective. Reimbursement systems seem generally slow and costly as well.
- User fees do not provide for any risk-sharing or pooling and are said to have increased the risk of catastrophic health expenditure.
- With regard to broader health sector aims, in some countries where the revenues from user fees were retained at local level, it seems to have motivated staff and made the health service more responsive to patients and communities. This is particularly so when communities are involved in spending the funds. However, in some instances, exemption schemes have had a negative impact on the quality of care provided for poor people.

So, with the present emphasis on policies that favour poor people, user fees are going 'out of fashion' internationally, because of clear evidence that they compromise poor people's necessary utilization of health services. Many countries, however, still see them as a valuable source of income for the health sector and intend to overcome the potentially negative impacts of user fees. One of the proposed solutions is to supplement the user fee financing mechanism with community-based insurance.

Insurance

Insurance and other pre-payment schemes address the problem of catastrophic health expenditure. They offer members of the schemes the possibility of anticipating such expenditure and of pooling (or sharing) risks. Insurance schemes can be

[3] See, for example, Arhin-Tenkorang (2000). *Mobilising resources for health: the case for user fees revisited*, CMH Working Paper WG3/6

organized at a national level (social insurance), at the workplace level for employees (private insurance) or at a community level (community-based insurance or mutual health organizations).

BOX C3.1. Example of community-based insurance schemes.

In community-based insurance schemes, **premiums** are set according to the risk faced by the average member of the community, in other words, there is no distinction in premiums between high- and low-risk individuals. However, unlike social health insurance schemes, enrolment is generally voluntary and not linked to employment status. The schemes are typically small scale. Most cover hospital care, but they can also be used for primary care. Some community-based schemes are organized around the health care provider, but others have emerged from community initiatives. Communities can be formed by geographical locality but also through existing associations or cooperatives. A private non-profit entity holds and manages the funds.

The experience with community-based insurance schemes is still limited and mixed.* Because many people choose not to join the schemes (for most schemes, membership is less than 5 per cent, although for some it is over 80 per cent), these schemes have not raised significant resources for financing health care. Unless schemes are linked to existing institutions, there seems to be a high turnover of members, which reduces the sustainability of the schemes. There is some evidence that the very poorest people are still not covered by community-based schemes, so that they do not provide any protection against catastrophic health expenditure.

* See, for example, Ekman (2004). Community-based insurance in low-income countries: systematic review of evidence. *Health Policy and Planning*, 19(5).

People are expected to make regular payments, whether they are healthy or sick. This entitles them to health care services free or at a low charge when they need them. In this way, by organizing pre-payment, people are assured of health care if they suddenly fall ill. Moreover, because the schemes insure groups rather than individuals, risks are pooled and health care costs can be shared between sick and healthy people, and sometimes rich and poor people.

There are some important economic processes that need to be considered when using insurance as a financing mechanism. These stem from the uncertainty about the probability of someone falling ill and the efficacy of health care. This uncertainty arises because of the lack of data (for example, probability of death) or unequal information between clients and schemes (for example, on latent illness) or between schemes and providers (for example, cost of care). The main issues are:

- adverse selection
- moral hazard
- willingness to pay
- management of risk

Adverse selection

This is a process that occurs when individuals with different risks are charged the same premium, because it is impossible for the scheme to determine in advance the exact probability of someone falling ill. The standard premium will be too high for those with a lower than average risk, so that these individuals opt out, and only those with a higher than average risk remain in the scheme. The premiums will then have to be increased to reflect the new risk profile of the insured. This process continues until only the highest risk groups remain and the insurance scheme cannot be sustained.

Adverse selection can be reduced by allowing different premiums based on different risk ratings. The range of premiums and the information on which the differences are based should be subject to government regulation to ensure that no people are excluded by insurance schemes. Moreover, compulsory membership of a scheme or group membership can help encourage cross-subsidization between different types of people (for example, rich and poor, sick and healthy, young and old) and avoid a scheme with only high risk members. Group memberships often originate from existing associations, e.g. funeral saving groups or barbers' association, which increases the willingness to cross-subsidize.

Moral hazard

Once a person is insured, there is less need to avoid the risk of ill health or excessive health care costs. There might even be an incentive for both the providers and the clients to get more out of the insurance than what is paid in premiums. This is called moral hazard. It leads to an increase in health care and higher expenditure, so that the costs of insurance will exceed the premiums paid and insurance becomes unsustainable.

Moral hazard can be reduced by limiting what insured patients can claim and, thus, also what providers can charge. Another option is requiring co-payments, so that both the insured and the insurance scheme benefit from minimizing costs. Another disincentive to the excessive utilization of health care is, for example, generating waiting periods for certain non-emergency services.

Willingness to pay

There might be limited willingness to join an insurance scheme because of the uncertainty about the health status of others compared to one's own. There might also be little trust in the management of insurance schemes. Trust and solidarity can be enhanced by linking insurance schemes to existing trusted institutions or organizations, such as micro-finance institutions, community groups or professional associations.

The willingness to join an insurance scheme also depends on the quality of services available through the insurance package. It is, therefore, important that insurance schemes are associated with the providers in a way that improves the quality of services for the insured. The benefit package should cover essential health care services that can otherwise lead to catastrophic expenditures, rather than non-essential services.

Furthermore, people need to be able to afford the insurance premiums and be certain that they can do so for a certain period of time. It is also important that the insured group consists of people of different income groups to allow for cross-subsidization. Governments can stimulate membership of insurance schemes by offering subsidies or exemptions to those who cannot afford to join. However, there is little reason to assume that exemptions and subsidies for insurance premiums would work any better or be less costly than exemptions for user fees (see above).

Management of risk

As discussed, individual and group health risks are difficult to assess. It is impossible to predict sudden changes in health, such as epidemics. It is especially difficult to anticipate the changes in behaviour that insurance might bring about. However, these factors are of crucial importance for insurance schemes in the cost calculations on which the premiums are based. The smaller the group (for example, a community rather than a national scheme), the harder the management of risk will be, because there is less scope for offsetting risks between people or events.

In countries with a longer history of health insurance, specially trained accountants and actuaries undertake the management of risk. However, even on a smaller scale, capacity should be built to assist in designing optimal insurance schemes, based on cost and risk calculations, and in administrative procedures linked to insurance, such as claim handling.

Summary

'Health care financing' refers to raising financial resources for the provision of health care services, and the way in which this impacts on service delivery and utilization. Table C3.2 illustrates how different financing mechanisms have been used throughout the developing world.

It also shows that there is no single optimal health care financing mechanism but, rather, multiple possibilities within a particular context. Financing mechanisms should be combined and complemented with broader health sector reforms to achieve the goals of revenue raising, sustainability, efficiency, equity and risk-sharing, and broader health sector aims, such as improving the quality of services.

Table C3.2 Trends in health care financing

Trend	Objectives	Countries reforming in this way
Introduce or increase user fees in tax-based system	Raise more revenue Encourage more efficient use of resources Create greater accountability to the consumer	Many countries in sub-Saharan Africa
Introduce community-based health insurance in systems currently based on user fees and tax revenues	Reduce financial barriers created by user fees Encourage more efficient use of resources Raise more revenue	Large-scale initiatives in Thailand and Indonesia, numerous small-scale efforts in many other countries, including Zambia, Tanzania, Uganda and India
Shift from tax-based to social health insurance-type systems	Create independent, sustainable source of health finance Raise more revenues	Thailand, many countries in the former Soviet Union and Eastern Europe, to be implemented in Nigeria and Ghana
Consolidate multiple state insurance funds	Increase equity and prevent tiering and fragmentation Increase administrative efficiency	Mexico, Colombia and other countries in Latin America

Adapted from Bennett and Gilson (2001)[4]

[4] Bennett and Gilson (2001). *Health Financing: designing and implementing pro-poor policies.* DFID Health Systems Resource Centre, London